United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: August 15-19, 2011

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Table of Contents

Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

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

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

The Monitor's role is to assess and report on the State and the facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes can help the facilities achieve compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the Settlement Agreement.

Methodology

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

(a) **Onsite review** – During the week of the review, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review. **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. 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.

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

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

Organization of Report

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

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
d) **Assessment of Status:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.
g) **Individual Numbering:** Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

Executive Summary

First, once again, the monitoring team wishes to 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. The facility director, Ralph Henry, was extremely supportive of the monitoring team's activities throughout the week of the onsite review. He was present throughout the campus, available as needed, and responsive to monitoring team requests.

The Settlement Agreement Coordinator was assigned primary responsibility for coordination of document preparation and coordination of activities during the onsite review. The monitoring team appreciated her efforts, however, there continued to be problems in both of these activities, for example, there were numerous challenges in getting some documents prepared correctly.

Second, management, clinical, and direct care professionals continued to be 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. 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, 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. 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.

- Psychological care and services: Little progress was made towards substantial compliance in provision K. Facility senior management should look closely at this and determine ways of making improvements towards the achieving of the many items of the provision. Progress on other provisions will be hampered without these improvements due to the integrated nature of service provision (e.g., provisions, C, D, F, J, R, and S).

- Do not resuscitate orders: Twenty-eight individuals had standing do not resuscitate orders at SASSLC (i.e., 10% of the population). The qualifying conditions raised concern because none of the diagnoses were necessarily considered terminal. The facility needs to look at its DNR practices and ensure they are within the generally accepted professional standard of care. New state policy should provide guidance to the facility once it is

disseminated. Given the high number of individuals with these orders, however, SASSLC might want to begin taking action now; most likely, support and assistance will be needed from state office.

- Integration of clinical services. Provision G requires the provision of integrated clinical services. Overall, SASSLC had made continued progress due, in large part, to the efforts of the medical director. The medical director and senior facility management were taking this very seriously and had engaged in a number of activities towards integrated clinical care.

- New and ongoing projects: SASSLC had initiated a number of new projects and had continued to work on other projects:
  - Engagement and activities continued to be a focus. Some progress had been made (see section S) while additional work was necessary to move towards more meaningful and individualized activities (see sections D and F).
  - PSPs: The facility, under the direction of the QMRP Coordinator, had worked hard on improving the PSP process. A new revision to the process was in the works and the facility was preparing for additional training from DADS and its PSP consultants.
  - Staff retention: The monitoring team met with the three unit directors to learn about the status of a number of projects, including their efforts to improve staff retention and maintain the gains that were described in detail in the February 2011 monitoring report. It appeared that improvements in turnover and staff retention had maintained in two of the three units. This was discussed during the QAQI Council meeting and facility management should continue to support this important project.

- Facility self-assessment: SASSLC provided its facility self-assessment, called the POI. The development of a useful POI has been an ongoing project for all of the SSLCs. In each of the sections of this report, the Monitor comments on the POI. Overall, the SASSLC POI described actions the facility had taken that, in its opinion, were moving the facility towards substantial compliance, and actions it planned to take in the future. While this information was useful to the monitoring team, the POI should describe
  - The activities the facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.
  - How the facility used the findings from these activities to determine substantial compliance or noncompliance.
  - A self-rating of substantial compliance or noncompliance.
  - Action steps/activities the facility planned to engage in to work towards substantial compliance.

- Monitoring tools. DADS central office had distributed self-monitoring tools that lined up with most provisions of the Settlement Agreement. These tools were meant to be more user-friendly and appropriate for use by facility staff than were previous versions. Additional attention will need to be made to ensure the tools are updated and that they are implemented reliably (see section E below).

Fourth, 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

- SASSLC showed continued progress towards substantial compliance. Between 2/16/11 and 8/8/11, 80 restraints occurred. Of these, 38 (48%) were physical restraints; 5 (6%) were mechanical restraints (seatbelt, mittens, or helmet); and 37 46%) were chemical restraints. Fourteen individuals were the subject of restraints. The three individuals with the greatest number of restraints accounted for 52 (65%) of the restraint incidents. Seven individuals had been restrained 5 or more times during the reporting period.
- There continued to be problems with accurate documentation and monitoring of restraints.
- The facility had placed a significant focus on the individuals with the highest number of restraints at the facility. According to psychology staff, this had been effective at reducing the number of behavioral incidents leading to restraints for those individuals.
    - Individual #95 had the greatest number of restraints in the six months prior to the last monitoring team review. She had not had any restraints in the past six months. PST members reported that consistent implementation of her behavior support plan and consistent staffing patterns had been very successful in reducing the need for restraint.
- There was progress toward achieving substantial compliance with item C7.

Abuse, Neglect, and Incident Management

- Investigation of 95 cases of abuse, neglect, or exploitation were conducted by DFPS from 2/1/11 through 7/27/11. The 95 cases included 163 total allegations. Of these 163 allegations, 27 (22%) were confirmed allegations by DFPS (including 10 allegations of physical abuse, one allegation of emotional/verbal abuse, and 16 allegations of neglect), 70 (43%) were unconfirmed allegations, 31 (19%) were inconclusive, 17 (10%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect, and 17 were pending.
- There were an additional 32 serious incidents at the facility that did not involve allegations of abuse or neglect during the same two quarters. This included five deaths and 23 serious injuries.

- There were a total of 893 injuries reported between 12/1/10 and 5/31/11. Note that any time a nurse assessed for an injury, it was counted as an injury in the total number of injuries at the facility, even when there was no injury. The facility had identified a trend in injuries caused by peer to peer aggression. A recommendation was made for PSTs to discuss individuals identified in the trend reports and develop a plan to reduce incidents for those individuals involved.
- The facility needs to further explore trends of injuries and develop a plan of action to address any trends identified in order to reduce the significant number of injuries. Consideration should be given to factors that generally contribute to injuries and incidents at a large facility, such as crowded living areas, inappropriate levels of supervision, and lack of meaningful activities.
- There were still deficiencies found in regards to documentation of notifications and corrective action taken following investigations.
- Interagency meetings continued to be held quarterly with SASSLC, DFPS, and OIG administrative personnel to address systemic issues and were a positive step towards resolving issues regarding outside investigations.
- The facility had taken some steps towards further improvement in this area:
    - Facility staff was inserviced on reporting injuries.
    - DADS had developed an extension request form for internal investigations.
    - DFPS had added an electronic signature for supervisors to use indicating review of investigations.

<u>Quality Assurance</u>

- SASSLC had made little progress in quality assurance. Improvement will be necessary in the key areas of this provision: QA policy, QA plan, QA data collection and analysis, QAQI Council, and the management of corrective actions.
- Progress was seen, however, in two areas in particular. First, the QA report improved since the last onsite review. Second, the QAQI Council met regularly and had good attendance and participation. Attendees were most engaged when data were presented and discussed.
- QA policy was not yet developed and QA plan was not fully in place (a table/matrix existed, but it was inadequate as a QA plan). A QA report was written every month. A system of managing corrective actions was not yet in place. All of these components must be in place for the facility to thoroughly review, analyze, and summarize important data.
- QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, and conducted a variety of audits. The two QA nurses had developed, and implemented, an excellent system for the implementation and management of the 12 statewide self-monitoring tools.
- Corrective actions were not developed or managed as required by this provision.

Integrated Protections, Services, Treatment, and Support

- The facility was considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. DADS had recently initiated a thorough review of the PSP process and hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. The consultant's work had not yet begun at SASSLC.
- Two annual PSP meetings were observed by the monitoring team. In meetings observed, the QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. Most of the information regarding assessments and supports was presented by a team member and very little discussion took place among team members to integrate information shared.
- Information regarding supports that the individuals need throughout the day was more clearly stated in some of the newer PSPs. 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 assurance activities with regards to PSPs were in the initial stages of development. Audit tools had been developed to review both meeting facilitation and the PSP development process.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- SASSLC continued to make progress with provision G and was taking action to address it. The medical director was the lead and was knowledgeable about the provision and steps that would bring the facility towards substantial compliance. The facility had recently created a new position, a medical program compliance nurse. This will likely greatly assist the facility towards meeting this provision's requirements.
- The monitoring team met with the DADS central office medical coordinator and the SASSLC medical director regarding sections G and H. Based on that discussion, it appeared clear that the state and the facilities need to determine how to proceed regarding section H across all of the SSLCs, including the determination of the detail, definition, expectations, and criteria for all of the items of this provision.
- 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 was merely a restating of the wording from the Settlement Agreement and will be insufficient to guide the facility. The policy contained some information that might be useful for provision H.
- The SASSLC medical director developed a facility-specific policy that described how 13 activities should be conducted to support and demonstrate that clinical services were being provided in an integrated manner. The

policy defined these activities in a way that could possibly be used to self-assess whether or not the activities are occurring in the integrated manner intended.

- 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. It is recommended that the facility's QA department play a role in addressing this provision

At-Risk Individuals

- 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.
- 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.
  - Forms had been revised for identifying risk, and a risk action plan had been developed.
  - Risk Guidelines had been developed to be used by PSTs in rating risk factors.
- SASSLC had taken minimal steps towards compliance with this provision including:
  - Employees had attended webinar training on the at risk policy in January 2011.
  - Implementation had begun of the new risk action plan for individuals determined to be at risk. Health care plans were being developed from the risk action plans.
- PSTs, however, were not accurately identifying risk for individuals, even with the new process. All staff needed to be aware of and trained on identifying crisis indicators.

Psychiatric Care and Services

- The facility lead psychiatrist was working to develop policy and procedure. Other new documentation and multidisciplinary clinic practice was expanded to include all facility homes.
- There remained challenges with respect to increased time commitment for clinic (more frequent clinic with fewer individuals scheduled) and increased documentation requirements for other disciplines (e.g., nursing, psychology).
- Psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. In order for psychiatric services to improve, strong leadership and integration among all the necessary disciplines will need to occur.
- Observations of psychiatric clinic revealed improvements in clinical case consultation, a thoughtful approach to psychopharmacology, and improved diagnostics. The psychiatrists 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. The facility clinical staff

has appropriately placed much emphasis on the development of appropriate diagnoses and pharmacological regimens. As this task was becoming more manageable, it was time to expand the focus to include identification and implementation of non-pharmacological regimens.

Psychological Care and Services

- Only minimal progress since the last review was found. These improvements included the implementation of the new simplified data system across all homes and day programming sites, increase in the number of individuals with annual psychological assessments, and improvements in the quality of the Positive Behavior Support Plans.
- Some specific activities toward compliance with this provision of the settlement agreement that the facility is encouraged to focus on over the next six months are ensuring that peer review is occurring weekly, the establishment of external peer review, the establishment of IOA, the routine use of the graphing of data in intervals necessary to make treatment decisions, and 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. In addition, 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 will be required.

Medical Care

- The provision of medical services had made continued progress. The medical staff team had undergone many changes. A series of locum tenens physicians provided coverage in the months prior to the onsite review.
- A database for tracking preventive services was implemented and was a significant improvement in the ability to assess the quality of care provided and compliance with preventive care guidelines. Newly implemented internal reviews and chart audits provided valuable information to the medical staff.
- There was no noteworthy improvement in the actual provision of care. While basic preventive care was provided, deficits were evident in some aspects of preventive care, such as cancer screenings. Problems were also identified with follow-up of chronic issues as well as laboratory monitoring for chronic diseases and medication use.
- The current DNR system allowed execution of DNR orders for conditions that were not terminal. Individuals could and did maintain this status indefinitely.
- The mortality reviews were completed in a timely manner, but the reviews failed to generate any recommendations other than those related to documentation.
- The external review was completed in March 2011 and showed high rates of compliance with essential and nonessential elements. These results were a striking contrast to the findings of the facility's internal audits.

- Although continued efforts were seen in the area of medical quality, an organized and systematic medical quality program was lacking. There was also no progress made in the area of development of clinical pathways.

Nursing Care

- A Chief Nurse Executive and Nursing Operations Officer joined the SASSLC Nursing Department just two to three months prior to the monitoring review. During the CNE's short tenure, she re-established leadership within the Department and took swift action to address some of the more immediate needs of the Department. She reduced RN case manager caseloads, streamlined processes, built bridges with other departments and clinical professionals, and improved the working conditions for the nurses.
- Comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Quarterly and annual nursing assessments were filed in each of the 20 sample individuals' records, but 18 of the 20 nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. Also, as noted in the prior review, across all individuals reviewed, HMPs and ACPs continued to fail to meet basic, minimum standards of practice or the provisions of the Settlement Agreement.
- Since 1/1/11, no more than half of the 20 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across several health and behavior indicators.
- The administration of medication and the management of the medication administration system continued to improve. Although much work still needed to be done to ensure that medications were administered and accounted properly, the facility had taken several steps toward identifying and measuring the nature, severity, and scope of their problems in this area.

Pharmacy Services and Safe Medication Practices

- The pharmacy department had made advances in most provision items. The State Hospital was documenting interactions in the notes extracts, but additional documentation of the resolutions was needed.
- The facility submitted an SSLC Pharmacy Services Policy dated 1/10/11. This policy appeared to be applicable to all SSLCs and was not a local policy. It was not clear that state office had issued an approved pharmacy services policy.
- The QDRRs were completed in a timely manner, but the parameters outlined in the lab matrix were not always clearly utilized. This resulted in sub-optimal monitoring of the use of psychotropics per the lab matrix.

- The MOSES and DISCUS evaluations were completed, reviewed and signed, but appeared to have little relevance to the medical staff apart from the psychiatrists. Physicians were responding to the recommendations of the pharmacists.
- Adverse drug reaction reporting increased, although several ADRs were identified that remained unreported. Drug utilization evaluations were completed, although there were problems related to generation of corrective action plans based on recommendations. There was no facility specific policy related to ADRs and DUEs.
- Medication errors remained a serious cause for concern, even though some progress had been made (see section M). First, there was no process to reconcile liquid medications. Second, it appeared that errors were underreported based on a failure to count every episode of an incorrect administration or omission. Third, medications returned to the State Hospital were not reconciled. The exact extent of the problem of medication errors will remain unknown until these issues are addressed.

Physical and Nutritional Management

- The PNMT was a fully constituted team. Only RN member was a dedicated team member; the others also had significant other clinician duties. Improvements were noted in the team process, particularly related to attempts to use pertinent data to guide decision-making and plan development. Discussions by the group were excellent and it was apparent that the PNMT was moving forward.
- Core team attendance, however, was inconsistent. Team building and consistency will continue to be difficult unless this issue is addressed. Further, some professionals did not come prepared. The team tended to identify interventions without a clear rationale to guide what they needed to track to determine efficacy. There should be a well-outlined plan, a PST meeting with completion of necessary training, and establishment of monitoring frequency and focus. There should be follow-up by the PNMT and guidelines to recognize individual triggers indicating if the plan was not working.
- The PNMPs were of a consistent format and each was current within the last 12 months. SASSLC had incorporated instructions related to bathing for some, and for oral hygiene and medication administration for most individuals. The content of these sections was limited, however, and consideration of presentation strategies, utensils needed, and additional instruction is recommended. Implementation of these plans, while improved, continued to be problematic.
- A strong skills-based competency training for elements of the plans was not provided. Monitoring was scheduled one time monthly for most individuals, while extra monitoring for those who were considered to be at high risk was scheduled as well. Review of the monitoring forms suggested that neither of these schedules was adhered to. Most of the monitoring also occurred for the first shift only.

Physical and Occupational Therapy

- The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated. The assessments were generally improved since the previous review. Information contained within the OT/PT assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. Functional skill performance was outlined more consistently across the domains included in the assessment. The focus however, continued to be primarily on the provision of the PNMP rather than skill acquisition strategies.
- Interventions provided beyond the PNMPs, with a focus on minimizing regression and enhancing skills, were limited and not integrated into the PSP. There were no OT interventions in place at the time of this review, though a number of individuals were identified with limitations in fine motor and activities of daily living skills.
- Implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. In addition, the staff were not confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing.
- The clinicians are commended for their efforts in the development of the current system for monitoring, but clearly, it was a work in progress. Monthly reviews of monitoring results continued to be conducted. This process should become more formalized and perhaps evolve into a facility-wide group to examine trends and specific implementation issues that require collaboration across disciplines.

Dental Services

- The department continued to make advances in the provision of services. Clinic continued in home 637. The new clinic was scheduled to be completed by 2/29/12. In spite of the challenges of a very restricted physical space, the dental clinic staff had continued to enthusiastically provide a variety of basic dental services. The department was well-organized, generated electronic notes that contained good information, and maintained key data related to services.
- The dental director saw individuals in their homes when necessary and the hygienists provided regular in home training on oral care. Regular interactions in the homes allowed the clinic staff to identify and correct problems, such as a lack of toothbrushes in areas and toothbrushes that were clearly unopened and unused. The vigilance with regards to oral home care proved to be beneficial as the facility's aggregate oral hygiene ratings demonstrated marked improvement from September 2010.

- The clinic made good use of its time as demonstrated by high utilization rates. Nonetheless, 26% of all clinic appointments were failed with the majority of those attributed to missed appointments. Refusals represented a small percentage of failed appointments. Little progress had been made in the desensitization program. In fact, it was not clear that the six plans developed and submitted had been implemented. There was some success with implementation of various strategies to overcome barriers to treatment.

Communication

- Though it had been reported that all individuals at Priority 1 had received a comprehensive assessment, only 13 had received one since 2010. There were a number of these individuals who had not received a communication assessment in 20 or more years. Over 50 individuals identified as Priority 3 and 4 had not received an assessment in 10 or more years. The Master Plan for assessment for individuals at all priority levels extended well past the timelines in the Settlement Agreement.
- Approximately 62% of those at Priority 1 had been provided some type of system beyond a communication dictionary, but only 23% of those at Priority 2 had been provided a device. A list submitted identified a total of 83 individuals with one or more AAC systems, an increase from that documented during the previous review. The majority of the systems provided appeared to be individualized and potentially meaningful to the individual. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual was often not possible.
- Systems were selected based on very minimal evidence of consideration, or trials, of various options. The rationale and recommendations did not consistently reflect a careful and thoughtful consideration of AAC systems, skill acquisition potential, and the consideration of learning opportunities. As all individuals had yet to receive a current comprehensive assessment, it was not likely that all had been provided the communication supports they required. In addition, many of those already issued were not consistently implemented throughout the environments frequented by the individual.
- AAC use was not consistently described or integrated into training objectives for the individuals reviewed with AAC. There was no description of expressive or receptive communication skills outlined in the PSPs for 36% of those reviewed and very minimal descriptions of either receptive or expressive communication were included in the PSPs for another 39% of those reviewed.
- NEO staff training in the area of communication was largely lecture only with no opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners.
- Direct support staff in the homes very diligently and routinely provided instruction and language-based active treatment activities. Unfortunately, as identified in previous reports, these activities were most often not functional or meaningful to the individuals to whom they were provided. Engagement in more functional

activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. 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

- 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, the monitoring team noted several improvements since the last review. These include a reorganization of staff responsible for writing, implementing, and monitoring skill acquisition plans; a new procedure for the monitoring of skill acquisition plans; expansion of SPO training methodology; and a new individual engagement form. In addition, the facility began a list to document training in the community, and progress was made in obtaining extended school year services for some of the individuals.
- The monitoring team believes that the facility should focus on the a number of areas over the next six months, including to expand the new format to all SPOs written at SASSLC, ensure that the rationale for each SPO clearly states how acquiring this skill is related to the individual's needs/preference, and ensure that all SPOs include specific activities that staff could engage in to promote meaningfully maintenance and generalization. In addition, the facility should establish a measure of treatment integrity of SPOs, and graph SPO outcomes to ensure that the continuation, modification, or discontinuation of SPOs are the result of data-based decisions

Most Integrated Setting Practices

- SASSLC continued to make progress, albeit it very slowly, towards meeting this provision. The slow progress was evident in the few individuals referred and placed in the community. The monitoring team recommends that the facility's QAQI Council consider initiating a performance improvement team regarding most integrated setting practices and the components of this entire provision T, especially focused on referrals for placement and identification of suitable providers for the individuals at SASSLC. The monitoring team also recommends that the department's data be summarized and graphed every six months, and that the data be incorporated into the facility's QA program.
- The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document.
- Another revision to the PSP process was recently initiated under the guidance of three DADS consultants. The consultants will need to work closely with the DADS coordinator of most integrated setting practices to ensure that the requirements of provision T are included, such as the LOD.

- Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe reasons for not making a referral separately from obstacles to making a placement happen (e.g., provider capability).
- The new CLDP process was being used, including the initiation of the CLDP at the time of referral. The list of essential and nonessential supports in the CLDP focused primarily on the provision if inservices and the scheduling of appointments. There were few supports that were directly related to actions that were to occur day to day for each individual, such as implementation of preferred activities, supports, and services. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns.
- PSTs need to become more involved in the referral process and in the selection of providers. This should include visits to all homes and day programs that are being considered and teaching the individual how to make a decision. PST members should be assertive in finding a good provider and in intervening if it appears an individual may be selecting a provider that will ultimately be unable to meet his or her needs and preferences. Most individuals do not have the experience or capacity to fully assess the competency of providers and their ability to provide what the individual wants and needs over a long period of time.
- Post move monitoring (T2a) was rated as being in substantial compliance. The post move monitoring conducted post move monitoring as required and followed up on supports that were not being implemented. In order to meet the overall intention of post move monitoring, she will also need to intervene when the overall quality of the home, day site, activity program, or medical needs are not being addressed adequately.

<u>Consent</u>

- SASSLC was waiting on the final state policy and training before taking most actions. Some positive steps that the facility had taken in regard to consent and guardianship issues included establishment of a guardianship committee, and creation of an updated list of individuals and their guardianship status. The Human Rights Officer had created a Guardianship Process folder in the facility shared drive to serve as a central location for guardianship information. Information on guardianship was presented at a meeting for families, the Human Rights Committee continued to meet and review all restrictions of rights, and the facility had provided training to the Self Advocacy group of individuals residing at the facility. The Human Rights Officer had also made contact with advocacy and guardianship agencies in the area.
- While the facility maintained a list of individuals needing an LAR, the list was not prioritized and not all PSTs were adequately addressing the need for a LAR or advocate. Other than initial contacts, the facility reported little activity or planning to solicit guardians for those determined to be in need.

- The facility had an active Human Rights Committee in place to review restrictions requested by the PST. Some PSTs were holding minimal discussions around the need for guardians in reference to the capacity for individuals to make decisions and give consent.

Recordkeeping Practices

- SASSLC demonstrated continued progress towards meeting substantial compliance.
- The recordkeeping department should begin to collect data on its own performance. To do so, the CMR and URC should list out the metrics that would be beneficial for their ongoing management of recordkeeping activities as well as be of interest to the facility.
- The active records reviewed by the monitoring team were very neat and organized. Future activities should focus on content, legibility, and signatures of both the observation notes and IPNs. The URC will need to determine what medical consultations had occurred so that she can determine if a consultation note was present. Individual notebooks were in place and available for each individual. Across the facility, they varied in condition, indicating that they were being used by staff. Because the individual notebooks were carried throughout the day, SASSLC should assess whether everything in the individual notebooks is useful to staff. The master records were very organized, very neat, and easy to review. Now that SASSLC had master records and a checklist table of contents, the next step was for the facility to determine what to do about the many items that were missing.
- The requirement to have, and manage, state and facility-policies was not yet being done at SASSLC.
- The conduct and organization of the five monthly reviews of the unified record continued to be done in an excellent manner by the URC. Five reviews were done each month, as required.
- To address the facility's use of the unified records to make treatment and care decisions, the URC had done two activities. First, she did a brief interview of a PST member each month and, second, she looked at the IPNs to see if there were entries from different disciplines. Although these were good steps, more activities will need to be undertaken. Direction will likely be provided by state office in the near future.

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.

II. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>
Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o SASSLC Policy: Use of Restraint Policy
o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities
o PMAB Training Curriculum
o SASSLC Training on Correct Completion of Restraint Checklists
o SASSLC Plan of Improvement
o Training transcripts for 23 SASSLC employees
o List of all restraints used for crisis intervention for the past six months
o List of all chemical restraints for the past six months
o List of all medical restraints for the past six months
o List of all dental restraints for the past six months
o SASSLC “Do Not Restrain” list
o SASSLC Restraint Trend Analysis for FY11
o List of individuals with dental desensitization plans
o Dental desensitization plans for Individual #284, Individual #90, Individual #288, Individual #43, Individual #88, Individual 127, Individual #108, Individual #41, Individual #240, Individual #330
o Restraint Reduction Committee meeting minutes since 2/1/11
o List of all individuals who had a Safety Plan
o Training transcripts for 23 SASSLC employees
o Sample of Daily Incident Review Team Meeting Minutes
o PSPs, Positive Behavior Support Plans (PBSPs), PSPAs, and Safety Plans (if applicable) for:
• Individual #83, Individual #111, Individual #232, Individual #268, Individual #252, Individual #184

o A sample of restraint documentation for behavioral intervention including:
<table>
<tr><th>Individual</th><th>Date/Type
P = Physical
C = Chemical</th><th>Restraint Checklist and Face to Face Assessment</th><th>PSP</th><th>PBSP</th><th>Safety Plan</th></tr>
<tr><td rowspan="4">#83</td><td>5/25/11 P/C</td><td>x</td><td rowspan="4">11/17/10</td><td rowspan="4">11/17/10</td><td rowspan="4">6/15/11</td></tr>
<tr><td>6/14/11 C</td><td>x</td></tr>
<tr><td>6/18/11 P/C</td><td>x</td></tr>
<tr><td>6/18/11 P</td><td>x</td></tr>
</table>
</td></tr>
</table>

	6/18/11 P	x			
	6/20/11 C	x			
#111	5/2/11 P	x	11/18/10	11/18/10	3/30/11
	5/7/11 P	x			
	6/30/11 P	x			
#232	4/12/11 P	x	10/19/10 6/6/11 (A)	10/19/10	4/19/11
	6/5/11 C	x			
	6/16/11 P	x			
#268	4/26/11 P	x	3/7/11 4/26/11 (A)	3/7/11	4/26/11
	6/8/11 P	x			
#184	6/20/11 C	x		7/14/11	
#252	6/20/11 C	x	7/27/10	7/26/10	

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Ralph Henry, Facility Director
- Michelle Enderle-Rodriguez, Quality Assurance Director
- Leticia Jalomo, ANE Coordinator
- Daisy Ellison, Psychology Coordinator
- Audrey Wilson, QMRP Coordinator
- Gevona Hicks, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Morning Unit Meeting 8/16/11
- Incident Management Review Team Meeting 8/16/11
- Annual PSP meetings for Individual #205 and Individual #286
- PSPA meeting for Individual #218

Facility Self-Assessment:

SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11.

The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The facility's Plan of Improvement for section C indicated that the facility had implemented several new processes to address deficiencies noted in the last monitoring report. These processes are discussed below in regards to meeting substantial compliance for each provision in section C.

	The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility was aware of problems with monitoring and documentation of restraints, and was in the beginning stages of addressing those issues. The facility rated itself as being in substantial compliance with items C1 and C2. The monitoring team also agreed with the facility's self assessment rating on noncompliance for items C3 through C8. Positive steps taken to address noncompliance by the facility are noted in the summary section. The facility had made some progress in addressing restraint issues for specific individuals who were the subject of the greatest number of restraints during the last monitoring visit. The facility needs to ensure that a process is in place to identify and address trends or systemic issues in regards to restraint application, monitoring, and documentation.
	Summary of Monitor's Assessment: Based on information provided by the facility in a list of all restraints used for crisis intervention, between 2/16/11 and 8/8/11: • 80 restraints occurred; • 38 (48%) were physical restraints; • 5 (6%) were mechanical restraints (seatbelt, mittens, or helmet); and • 37 (46%) were chemical restraints. • 14 individuals were the subject of restraints. • The three individuals with the greatest number of restraints (Individual #83, Individual #111, and Individual #232) accounted for 52 (65%) of the restraint incidents. • Seven individuals had been restrained 5 or more times during the reporting period. There had not been significant reduction in the use of restraints since the last monitoring visit. The facility had placed a significant focus on the individuals with the highest number of restraints at the facility. According to psychology staff, this had been effective at reducing the number of behavioral incidents leading to restraints for those individuals. Individual #95 had the greatest number of restraints in the six months prior to the last monitoring team review. She had not had any restraints in the past six months. The monitoring team talked with her support staff about strategies that had been effective in reducing her number of restraint incidents. Team members agreed that consistent implementation of her behavior support plan and consistent staffing patterns had been very successful in reducing the need for restraint. According to the facility POI, action taken by the facility to address compliance with section C since the last monitoring visit included:

	• A training curriculum was developed on completing restraint checklists. • Designated staff was trained to review restraint checklist prior to submission to the Psychology Director. • A tool was developed to assess the need for dental restraints. • The facility began graphing the use of dental and medical sedation and restraints. • Procedures were developed to address instances where individuals had three or more restraints within a 30-day period. QMRPs and psychologist were in serviced on the procedure. As noted throughout section C, there continued to be problems with accurate documentation and monitoring of restraints. SASSLC had made progress toward achieving substantial compliance with item C7. As was recommended in the last review, all individuals reviewed had PSPA meetings following more than three restraints in a rolling thirty-day period, and the minutes from these meetings were organized so as to ensure that each of the issues below were discussed. This item was rated as being in noncompliance because the PSPA minutes reviewed did not consistently identify the specific factors suggested to affect the behaviors provoking restraint, or include an action plan of how to address these issues. Additionally, there was no indication that the PBSPs were implemented with integrity, there was no evidence of the modification of PBSPs as necessary, and there were no specific procedures for training replacement behaviors (when necessary, practical and possible) for behaviors that provoke restraint.

#	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 policies, procedures, and plans	<u>Prone Restraint</u> Based on facility policy review, prone restraint was prohibited. Employees were trained during New Employee Orientation and annual PMAB training, that prone restraint was prohibited. Based on review of other documentation, including a list of all restraints and a sample of restraint checklists, prone restraint was not identified. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral incidents. Sample #C.1 was a random sample of restraints for the four individuals with the greatest number of restraints and two other individuals (randomly chosen). The individuals in this sample were Individual #83, Individual #111, Individual #232, Individual #268, Individual #184, and Individual #252. • Individual #83 had the greatest number of restraints, accounting for 27 (34%) of the 80 restraints for crisis intervention since 2/16/11. • Individual #111 had the second greatest number with 13 (16%) of the restraints. • Individual #232 had 12 restraints (15%), Individual #252 had 8 restraints (9%), Individual #268 had 7 (9%) restraints, and Individual #184 had 2 restraints (3%) during the reporting period.	Noncompliance

#	Provision	Assessment of Status	Compliance
	governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Based on a review of 16 restraint records for individuals in Sample #C.1 involving six individuals, 0 (0%) showed use of prone restraint. <u>Other Restraint Requirements</u> Based on document review, the facility policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner, 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 16 restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In 11 of the 16 records (69%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. The following were the five that did not indicate an immediate and serious threat. o The restraint checklist for Individual #232 dated 6/16/11 indicated that he was restrained after refusing to talk to staff, becoming verbally aggressive, and passing a barrier. o The restraint checklist for Individual #111 indicated that he was restrained for "heading to the gate." o The restraint checklist for Individual #232 dated 6/20/11 indicated that a chemical restraint was administered when he "was sitting on grass by apartments." o On the restraint checklist for Individual #232 dated 6/18/11, behavior exhibited was marked "other: part of PSP." o The reason for restraint section of the restraint checklist for Individual #83 dated 6/14/11 was not completed. • For the 16 restraint records in the sample, a review was completed of <u>the description of events leading to behavior that resulted in restraint</u>. The checklists reviewed described the individual's behavior prior to the restraint, but only one (6%) restraint list in the sample indicated either what activity the individual was involved in at the time of the restraint or what was occurring in the environment that might have triggered the behavior leading to restraint. o The checklist for Individual #111 dated 5/7/11 indicated that he was walking away from campus because he missed his grandmother and wanted to go home. The nursing notes for this incident were more specific in stating that he told staff he wanted to go home with his grandmother and became upset when staff told him that he could not go. Including information on what happened prior to the restraint incident on the restraint checklist will assist the PST in developing strategies to	

#	Provision	Assessment of Status	Compliance
		address specific behaviors before they escalate to dangerous behaviors. Some examples where events leading to restraint were not adequately documented included: o In the area for the description of events on the restraint checklist for Individual #111 on 6/30/11, staff documented "refused to listen to staff on walk back to home." o On the restraint checklist for Individual #83 dated 6/20/11 the description of events leading to the behavior noted "person served left the campus with 1:1 staff." Staff did not document in what activity the individual was involved prior to the incident. o Similarly, the restraint checklist for Individual #83 (5/25/11) documented "unauthorized departure off campus." • In all 16 of the records (100%), staff documented 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. 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. It was not evident that restraints were not used in the absence of, or as an alternative to, appropriate programming and treatment. As noted above, documentation did not always indicate what activities individuals were involved in prior to restraint. Based on observations in the homes and day program building, although there was progress made in overall engagement data being collected, engaging individuals in more individualized and meaningful programming of interest would significantly reduce behavioral incidence leading to restraints. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 16 restraints, 16 (100%) were documented as approved restraints techniques. <u>Dental/Medical Restraint</u> The facility provided a list of medical pretreatment sedation/ medical restraints between 1/12/11 and 6/6/11: • 38 individuals were the subject of restraints, • 62 incidents of restraint occurred.	

#	Provision	Assessment of Status	Compliance
		Information on this list was not sufficient to determine how many of these restraints were for routine exams or how many were used for procedures that would typically require sedation. The dental clinic was gathering data on restraints used for dental procedures and had begun to develop desensitization plans to address dental restraints. A similar action towards identifying medical restraints was not in place. The facility was 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 all interventions attempted prior to restraint. Further, it was not evident that adequate treatment and programming was being consistently implemented that might reduce the number of behavioral incidents leading to restraint.	
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 six individuals in Sample #C.1 were reviewed. Of these, four of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint. A sample of restraint documentation for 10 physical restraints was reviewed to determine if the restraint was terminated as soon as the individual was no longer a danger to him/herself or others. Seven of 10 (70%) restraints reviewed indicated that the individual was released immediately when no longer a danger or when he met the conditions of the SPCI. Restraints in the sample lasted from less than one minute to 15 minutes in duration. • The restraint checklist for Individual #83 dated 5/25/11 indicated that she was released when medical procedure was completed. The restraint was implemented for unauthorized departure from the facility. • Staff completing the restraint checklist for Individual #83 dated 6/18/11 and the restraint checklist for Individual #268 dated 4/26/11 did not document behavior at the time of release. The facility POI indicated that the Psychology Director was reviewing restraint documentation for compliance with this provision. The facility self-rated C2 as being in substantial compliance. To maintain substantial compliance with C2, staff will need to accurately document behavioral indicators used to determine when individuals were released from restraints.	Substantial Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as	The facility's policies related to restraint are discussed above with regard to Section C1 of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Review of the facility's training curricula revealed that it included 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. A sample of 23 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • Twenty-one (91%) had current training in RES0105 Restraint Prevention and Rules. • 14 of the 21 (67%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • Twenty-three (100%) had completed PMAB training within the past twelve months. • 14 of the 23 (61%) completed PMAB refresher training within 12 months of previous restraint training. The facility POI indicated that training procedures for new employees had been updated to include procedures for applying mittens, wristlets, arm splints, and helmets. Additional training on completing restraint documentation was also implemented. The facility is not in substantial compliance with this provision item. Employees will need to complete training annually as required by the facility policy to gain substantial compliance.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or	Based on a review of 16 restraint records (Sample #C.1), 16 (100%) indicated that restraint was used as a crisis intervention. Facility policy did not allow for the use of restraint for reasons other than crisis intervention or medical/dental procedures. The facility had not developed medical desensitization plans for all individuals who required the use of restraint for routine medical care. According to a list provided to the monitoring team, dental desensitization programs had been developed for 62 individuals who needed pretreatment sedation or restraint to have work completed. Further clarification of this list indicated that not all 62 plans were yet developed or implemented. A sample of 10 plans that had been implemented was submitted to the monitoring team for review. • Seven of the plans in the sample were identical and did not include	Noncompliance

#	Provision	Assessment of Status	Compliance
	eliminate the need for restraint.	individualized strategies: for Individual #43, Individual #88, Individual #127, Individual #108, Individual #41, Individual #330, and Individual #240. • Two other plans for Individual #90 and #288 were also identical to each other and did not include individualized strategies. • The plan for Individual #284 was a good example of a desensitization plan that included individualized strategies. Her plan included specific instructions integrating recommendations from other disciplines. For example, the plan noted that she should be in the most upright position in her wheelchair. The dentist for the facility indicated that informal desensitization strategies were being used with a majority of the individuals requiring dental restraints. These strategies need to be documented in a formalized plan in order to ensure consistent implementation and evaluate progress towards desensitization. The facility maintained a "Do Not Restrain" list. There were 98 individuals at the facility that had been identified for placement on this list for which restraints would be contraindicated due to medical or physical conditions. There was no indication that any of the individuals on this list had been the subject of restraint in the last six months. PSTs should discuss the need for restraints during medical and dental procedures, and desensitization plans should be developed that include individual specific strategies to try to reduce or eliminate the need for restraint. The facility is not in compliance with this provision. The facility POI also indicated noncompliance with this provision item.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints	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 16 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 15 out of 16 incidents of restraint (94%), there was assessment by a restraint monitor. o There was not an assessment by the restraint monitor for Individual #83 on 6/14/11 • In 13 out of 16 instances of restraint (81%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o The restraint assessments for Individual #232 dated 6/5/11 and 6/16/11 did not indicate what time the assessment was completed. o The restraint assessment for Individual #111 dated 5/2/11 indicated that the restraint monitor arrived 19 minutes after the restraint began.	Noncompliance

#	Provision	Assessment of Status	Compliance
	at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	• In 15 instances (94%), the documentation showed that an assessment was completed of the application of the restraint. • In 15 instances (94%), the documentation showed that an assessment was completed of the circumstances of the restraint. Based on a review of 16 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 15 (94%) of the instances of restraint. The exception was the restraint checklist for Individual #111 dated 5/7/11. Nursing notes indicated that monitoring did occur, but that information was not documented on the restraint checklist. • Monitored and documented vital signs in 15 (94%). • Monitored and documented mental status in 15 (94%). Although requested by the monitoring team, a sample of documentation for restraints used for medical care was not submitted for review. The facility will need to submit this documentation for review for substantial compliance to be fully assessed. The facility had made significant improvements in documenting the assessment and monitoring of restraints used for crisis intervention. For the next monitoring visit, the facility will need to provide documentation regarding the monitoring of restraints used for medical interventions to the monitoring team to allow determination of compliance with this provision.	
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	A sample of 16 Restraint Checklists for individuals in non-medical restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 10 (63%), continuous one-to-one supervision was indicated as having been provided. o The restraint checklist for Individual #83 dated 5/25/11 and 6/20/11, Individual #184 dated 6/20/11, and Individual #252 dated 6/20/11 did not indicate the level of supervision while restrained. o The two of the three checklists in the sample for Individual #232 did not document 1:1 supervision during restraint. • In 16 (100%), the date and time restraint was begun were indicated. • In 16 (100%), the location of the restraint was indicated. • In 0 (0%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Zero indicated what events were occurring that might have led to the behavior (see section C1 for a	Noncompliance

#	Provision	Assessment of Status	Compliance
	injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	list of exceptions). • In 16 (100%), the specific reasons for the use of the restraint were indicated. • In 16 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 14 (88%), the names of staff who applied/administered the restraint was recorded. The exception was the restraint checklist for Individual #83 dated 6/18/11 at 8:48 and Individual #232 dated 6/5/11. • In 10 (100%) of 10 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In nine (90%) of 10 physical restraint incidents, the date and time the individual was released from restraint were indicated. The exception was the restraint checklist for Individual #83 dated 5/25/11. • In 16 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were recorded. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 15 minutes in duration. In a sample of 16 records (Sample #C.1), restraint debriefing forms had been completed for 15 (94%). The exception was for a restraint involving Individual #83 dated 6/14/11. The facility's self assessment indicated that the facility was not in compliance with section C6. The monitoring team agrees with this finding. Restraint documentation should indicate the level of supervision during restraints. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming. 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 times in any rolling thirty day period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to SASSLC documentation, during the six-month period prior to the onsite review, a total of five individuals were placed in restraint (and/or received chemical restraint) more than three times in a rolling thirty-day period. Three of these individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
		(i.e., Individual #83, Individual #232, and Individual #268) were reviewed (60%) to determine if the requirements of the Settlement Agreement item C7 were met. PBSPs, safety plans, functional assessments, and personal support plan addendums (PSPAs) that occurred as a result of more than three restraints in a rolling thirty-day period were also reviewed for all three individuals. All three of the PSPAs indicated individual's biological and psychological factors. Only one (Individual #83) of the three PSPAs reviewed (33%), however, indicated if the team indicated that any of these factors were related to the behaviors provoking the restraint. Simply listing medications and diagnosis, for example, is not likely to be useful in better understanding the behaviors provoking restraint. Identifying the adaptive skills, and biological, medical, and/or psychosocial factors (if any) hypothesized to be affecting these dangerous behaviors will be useful in developing an action plan to decrease the likelihood of these behaviors in the future. Individual #83's PSPA did indicate that her recent change in medications may be affecting her increase in psychiatric behaviors that resulted in dangerous behavior that provoked her restraint. None of the PBSPs reviewed (0%) indicated an action plan to address the identified factors affecting dangerous behavior. For example, in order to achieve substantial compliance with this provision item, Individual #83's PSPA's would have needed to include the action to further evaluate the effects of these medication changes, to make changes in the medications, etc. The minutes from all PSPA meetings following more than three restraints in a rolling thirty-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	
	(b) review possibly contributing environmental conditions;	All three PSPAs reviewed (100%) identified potential environmental factors that were suggested to affect the behavior provoking restraint. For example, Individual #268's PSPA minutes following more than three restraints in a rolling thirty-day period indicated that the team hypothesized that being too hot, and too much noise contributed to his self-injurious behavior (SIB) which often required the use of restraint. No suggestions, however, for reducing (or monitoring) heat and/or noise to prevent the future probability of restraint were documented in Individual #268's PSPA minutes. All PSPAs should reflect a discussion of possible contributing environmental factors, and if any are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	Noncompliance
	(c) review or perform structural	This item is concerned with a review of potential environmental antecedents to the	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessments of the behavior provoking restraints;	behavior that provoke restraint. Two of the PSPA's reviewed (66%) discussed potential antecedents affecting the behavior provoking restraint. For example Individual #232's PSPA indicated that the cancelling of an outing or being told to wait often lead to physical aggression that required restraint. None of the PSPAs reviewed, however, discussed an action plan to eliminate these antecedents, or reduce their effects on the dangerous behavior. Examples could include attempting to teach Individual #232 to wait by starting with very short intervals and gradually increasing them over time, and/or offering alternative preferred events if outings need to be cancelled.	
	(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. Two of the PSPAs reviewed (67%) clearly discussed possible functions of the behavior provoking restraint. For example, Individual #268's PSPAs suggested that his SIB that often leads to restraint might be maintained by pain attenuation. Individual #83's PSPA indicated that the team hypothesized that her dangerous behavior did not have any obvious environmental social functions of her behavior. One of these PSPAs also included an excellent example of an action plan based on the hypothesized function. Individual #268's PSPA suggested the establishment of a pain management program to decrease the motivation for his SIB. All PSPAs should document a discussion of variables that may be maintaining the dangerous behavior that provokes restraint. This discussion should also include how these functions will be addressed to prevent restraints in the future.	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	SASSLC achieved substantial compliance in this section of this provision item. All three individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Three (100%) were based on the individual's strengths; • Three (100%) of the PBSPs reviewed specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors) ; • Two of the three (Individual #83 the exception) PBSPs reviewed (67%) 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 four plans); and • All three (100%) PBSPs specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. All three of the PBSPs reviewed (100%) to weaken or reduce the behaviors that	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	provoked restraint contained clear, precise interventions based on a functional assessment (see K9). The four Safety Plans of the individuals in the sample were reviewed. The following represents the results: ▪ In all three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In all three of the safety plans reviewed (100%), the maximum duration of restraint authorized was specified; • In all (100%), the designated approved restraint situation was specified; and • In all of the safety plans reviewed (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%), were integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see K4 and K11 for a more detailed discussion of treatment integrity at the facility).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	There was no evidence that the PBSPs for any of the individuals reviewed were modified (when necessary) to decrease the future probability of him requiring restraint. There did appear to be at least one example of a PBSP that should have been modified, but was not. Individual #232's PSPA (dated 4/13/11) indicated that structured schedule appeared important to decreasing the behavior provoking restraint. His PBSP (dated 1/25/11), however, did not include the use of the structured schedule.	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.	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, Incident Management Review Team Meeting (IMRT) meetings, Daily Unit meetings, and Human Rights Committee (HRC) meetings. Restraint incidents were also referred to the PST for follow-up. PSTs met following restraint incidents to review restraints. See C7 for comments on review by the PST. A sample of Face-to-Face Debriefing and Review Forms related to 16 incidents of non-medical restraint was reviewed by the monitoring team. The review form had an area for signature indicating review by the Unit Director and the Incident Management Team.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In review of 16 restraint review forms for sign off by the Unit Director and IMC Designee, 0 (0%) were reviewed by either the Unit Director and/or the IMC Designee. Campus Coordinators were now responsible for completing a review of each restraint incident. There was no indication that this review resulted in recommendations when restraints were not appropriately implemented or documented. As noted throughout Section C, restraint documentation contained errors in documentation and monitoring. None of the Restraint Review forms in the sample addressed errors or incorrect procedures in documentation, application, or monitoring of the restraint. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation.	

Recommendations:

1. 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 (C1).

2. Circumstances leading up to restraints should be documented to provide clear indication that a restraint was used as a last resort measure and not in the absence of adequate treatment or programming (C1, C2, C6).

3. Accurately document behavioral indicators used to determine when individuals were released from restraints (C2).

4. Employees will need to complete retraining annually as required by the facility policy (C3).

5. PSTs should discuss the need for restraints during medical and dental procedures and desensitization plans should be developed to try to reduce or eliminate the need for restraint (C4).

6. 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 (C8).

7. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation (C8).

8. Complete all of the requirements for provision item C7 (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:** Documents Reviewed: o DADS Policy: Incident Management #002.2,dated 6/18/10 o SASSLC Procedure: Facility Abuse and Neglect Reporting Procedures dated 3/25/11 o SASSLC Procedure: To Ensure Protections Following Allegations of ANE dated 3/25/11 o SASSLC Procedure: Reassignment and Conduct of Alleged Perpetrators in Allegations of ANE dated 3/225/11. o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o Information used to educate individuals and their LAR on identifying and reporting unusual incidents. o Incident Management Committee meeting minutes for each Monday of the past six months o Sample of Unit Level Meeting minutes o SASSLC Plan of Improvement o Three most recent five-day status reports o Training transcripts 24 employees o Acknowledgement to report abuse for all employees hired in the past two months (58) o Training and background checks for the last three employees hired o Training transcripts for facility investigators o Training transcripts for DFPS investigators assigned to complete investigations at SASSLC o Abuse/Neglect/Exploitation Trend Reports FY11 o Injury Trend Reports FY11 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 terminated based on background checks o A sample of acknowledgement to self report criminal activity for 24 current employees o Injury reports for three most recent incidents of peer-to-peer aggression incidents o List of all serious injuries for the past six months o List of Injuries by individual since 2/1/11 o List of all A/N/E allegations since 2/1/11 including case disposition o List of OIG cases and the disposition o List of employees reassigned due to ANE allegations o A sample of for injury reports for serious injuries of unknown cause

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

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#39202607	Physical Abuse	Unconfirmed	4/28/11 9:14 pm	4/29/113:24 pm	5/7/11
#39184728	Physical Abuse	Inconclusive	4/27/11 6:27pm	4/28/11 12:05 pm	5/16/11
#39228307	Physical Abuse	Unconfirmed	5/1/11 1:00 pm	5/2/11 11:13 am	5/11/11
#39332148	Physical Abuse	Unconfirmed	5/10/11 9:05 am	5/13/11 9:31 am	5/27/11
#39343207	Neglect (5)	Confirmed (4) Other (1)	5/10/11 3:48 pm		5/30/11
#39414387	Physical Abuse (2) Neglect (1)	Confirmed (1) Other (1) Confirmed (1)	5/16/11 11:59 am	5/19/11 12:32 pm	6/17/11
#38991351	Neglect (2) Physical Abuse (1)	Confirmed (2) Confirmed (1)	4/11/11 11:53 am	4/12/11 3:33 pm	5/11/11
#39498852	Physical Abuse (1)	Inconclusive	5/21/11 6:33 pm	5/22/11 7:38 pm	5/31/11
#39664587	Neglect	Confirmed	6/3/11 3:03 pm	6/5/11 2:21 pm	6/23/11
#39677447	Neglect	Unconfirmed	6/6/11 9:28 am	6/6/11 4:35 pm	6/16/11
#39876027	Neglect	Unconfirmed	6/21/11 9:55 am	6/22/11 4:25 pm	7/1/11
#40014868	Neglect (1) Physical Abuse (1)	Unconfirmed Unconfirmed	6/30/11 6:41 pm	7/2/11 1:37 pm	7/20/11
#40121067	Physical Abuse (1)	Confirmed	7/11/11 10:16 am	7/12/11 2:30 pm	7/28/11
#40208465	Neglect (2)	Unconfirmed (2)	7/20/11 10:32 am	7/21/11 1:55 pm	7/28/11
#40210945	Neglect	Inconclusive	7/21/11 7:20 pm	7/23/11 4:31 pm	7/31/11
#40210936	Neglect	Unconfirmed Referred Back	7/21/11 8:38 pm	7/22/11 4:28 pm	7/29/11

#40210924	Emotional /Verbal Abuse	Unconfirmed	7/21/11 8:42 pm	7/23/11 5:04 pm	7/28/11
#39914928	Physical Abuse	Unconfirmed	6/23/11 12:50 pm	6/24/11 6:24 pm	6/30/11
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of Incident**	**Began Investigation**	**Closed Investigation**
#39685327	Neglect	Referred Back Administrative and Rights Issue	6/6/11	6/6/11	6/9/11
#40210941	Neglect	Referred Back Other	7/20/11	7/21/11	7/26/11
#39596051	Neglect	Referred Back Clinical Issue	5/22/11	5/28/11	6/3/11
#38866024	Neglect	Clinical Issue	3/29/11	3/29/11	unknown
Sample D.3	**Type of Incident**	**Date of Incident**			
#11-046	Serious Injury	4/7/11 11:45 am			
#11-047	Serious Injury	4/10/11 10:00 am			
#11-065	Serious Injury	7/5/11 6:10 pm			
#11-054	Serious Injury	6/5/11 10:45 am			
#11-70	Serious Injury	7/18/11 6:05 pm			

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs
- Ralph Henry, Facility Director
- Michelle Enderle-Rodriguez, Quality Assurance Director
- Leticia Jalomo, ANE Coordinator
- Daisy Ellison, Psychology Coordinator
- Audrey Wilson, QMRP Coordinator
- Gevona Hicks, Human Rights Officer
- Individual interviews with six individuals

	Observations Conducted: o Observations at residences and day programs o Morning Unit Meeting 8/16/11 o Incident Management Review Team Meeting 8/16/11 o Annual PSP meetings for Individual #205 and Individual #286 o PSPA meeting for Individual #218
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. The facility's POI for section D did not indicate that any new processes had been implemented to address deficiencies noted in the last monitoring report. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility POI indicated that SASSLC was in substantial compliance with all sections D of the Settlement Agreement except sections D2a, D2c, and D3i. 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. As discussed below, the monitoring team did not find evidence to support substantial compliance with provisions D2a, D2b, D2c, D3a, D3e, D3f, D3g, D3h, or D3i. The facility POI noted some processes that were in place to address certain provisions, but did not indicate if those processes were audited for effectiveness or state what actions had been taken to address any deficiencies. The facility did not appear to have a quality improvement process in place to address issues identified in the monitoring report. The facility was holding daily unit meetings to review all incidents and injuries. Observation of these meetings indicated that this was an effective process for ensuring that incidents were reviewed and appropriate recommendations were made regarding incidents. The facility will be establishing a separate incident management department over the next few months. This should be a positive step to addressing some of the issues in this report.
	Summary of Monitor's Assessment: According to a list provided to the monitoring team, investigation of 95 cases of abuse, neglect, or exploitation were conducted by DFPS at the facility from 2/1/11 through 7/27/11. The 95 cases included 163 total allegations. Of these 163 allegations, 27 (22%) were confirmed allegations by DFPS (including 10 allegations of physical abuse, one allegation of emotional/verbal abuse, and 16 allegations of neglect), 70 (43%) were unconfirmed allegations, 31 (19%) were inconclusive, 17 (10%) were referred back to the facility because they did not meet the DFPS definition of abuse or neglect, and 17 were pending. There were an additional 32 serious incidents at the facility that did not involve allegations of abuse or neglect during the same two quarters. This included five deaths and 23 serious injuries.

	There were a total of 893 injuries reported between 12/1/10 and 5/31/11. Of these injuries, 488 were reported in the 3rd quarter of FY11 including 13 serious injuries resulting in fractures or sutures. It should be noted that any time a nurse assessed for an injury, it was counted as an injury in the total number of injuries at the facility, even when there was no injury. The facility had identified a trend in injuries caused by peer to peer aggression. A recommendation was made for PSTs to discuss individuals identified in the trend reports and develop a plan to reduce incidents for those individuals involved. There were no other recommendations regarding the reduction of injuries at the facility. The facility needs to further explore trends of injuries at the facility and develop a plan of action to address any trends identified in order to reduce the significant number of injuries occurring at the facility. Consideration should be given to factors that generally contribute to injuries and incidents at a large facility, such as crowded living areas, inappropriate levels of supervision, and lack of meaningful activities. The facility had completed very few activities to address deficiencies noted in the last monitoring report. A new Quality Assurance Director had been appointed in the past six months. She was responsible for both the quality enhancement department and the incident management department. Plans were underway to separate the two departments, which should allow for a greater focus for both departments. Interagency meetings continued to be held quarterly with SASSLC, DFPS, and OIG administrative personnel to address systemic issues. As noted in section D3e below, investigations completed by DFPS still did not always commence within 24 hours of the initial report as required by the Settlement Agreement. The facility had worked with DFPS to minimize the numerous cases with lengthy extensions since the last review. Timelines for completion had improved significantly at the facility. Interagency meetings with DFPS, OIG, and the facility were a positive step towards resolving issues regarding outside investigations. Other steps taken to work towards substantial compliance included: • The facility Abuse and Neglect Policy was revised to mandate cooperation with all agencies involved in investigations. • The facility had developed a checklist for OIG document requests. • Facility staff was in serviced on reporting injuries. • DADS had developed an extension request form for internal investigations. • DFPS had added an electronic signature for supervisors to use indicating review of investigations. • The facility Incident Management Coordinator position was posted. There were still deficiencies found in regards to documentation of notifications and corrective action taken following investigations. As evidenced in this report, there had been little improvement in these areas since the last monitoring visit.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. 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 with both information on identifying abuse and neglect and steps to be taken if abuse or neglect was either suspected or witnessed. Posters, however, were not consistent throughout the facility and some were difficult to identify. • 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 by calling the 800#. All staff wore badges that contained reporting information on the back. • Employees at SASSLC were required to sign a form titled Acknowledgement of SASSLC Employee Responsibility for Reporting Abuse/Neglect Incident(s) form annually. A sample of these forms was requested by the monitoring team for a random sample of 23 employees and all employees hired within the past two months. The facility provided a copy of the signed acknowledgement for 58 (100%) of the new employees. Current forms were not provided for 12 of the 23 employees in the random sample (52%). • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 23 current employees at the facility were reviewed for current ABU0100 training. Of these, 23 (100%) had completed the course ABU0100 in the past 12 months. Documentation of disciplinary action was reviewed for four cases in which DFPS substantiated an allegation of abuse or neglect. In all four cases, timely disciplinary action was taken for all employees involved in confirmed allegations. • For DFPS case #39414387, physical abuse by one employee was confirmed and neglect by another employee that witnessed the incident was confirmed. Video evidence showed that one employee used an individual's gait belt to drag her across the floor, while the other employee witnessed the event. Both employees	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		were suspended according to disciplinary letters provided to the monitoring team. The employee charged with neglect was suspended for one day and the employee charged with abuse was suspended for two days. The facility review indicated termination in the recommendation section of the review document. • For DFPS case #40121067, an employee was terminated following a confirmed allegation of physical abuse where the employee physically attacked an individual by grabbing him by the neck, slamming him into a closet, then throwing him to the floor. • For DFPS case #39343207, one employee was terminated and another was demoted following confirmations of neglect. In this case, staff failed to provide appropriate support and supervision resulting in a serious incident between two individuals. • For DFPS case #39557807, an employee was suspended for 10 days for confirmed neglect for failing to provide appropriate supports, which resulted in a serious injury to the individual. The facility was found to be in substantial compliance with this provision. It is recommended that the facility choose one poster with clear information regarding reporting abuse and neglect and use that poster throughout the facility for easy identification of the information.	
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	According to DADS Protection From Harm – Abuse, Neglect, and Exploitation Policy, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. This was consistent with the requirements of the Settlement Agreement. With regard to serious incidents, the facility policy addressing Incident Management required that all serious incidents be reported to the facility director immediately, reported to DFPS immediately if abuse or neglect was suspected, to DADS regulatory within 24 hours, and to DADS state office the next working day, if required. It further specified requirements for reporting certain types of incidents to other outside agencies. This policy was consistent with the requirements of the Settlement Agreement.	Noncompliance

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	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 a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 107 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 107 allegations, there were: • 52 allegations of physical abuse, o 9 were substantiated, o 21 were unsubstantiated, o 11 were inconclusive, o 4 were referred back to the facility for investigation, and o 7 outcomes were pending. • 11 allegation of verbal/emotional abuse, o 1 was substantiated, o 7 were unsubstantiated, and o 3 were inconclusive, • 42 allegations of neglect, o 12 were substantiated, o 8 were unsubstantiated, o 8 were inconclusive, o 11 were referred back to the facility for investigation, and o 3 outcomes were pending. • 2 allegation of exploitation. o Both were inconclusive. The facility investigators conducted investigations for 32 additional serious incidents during the same time period. The incidents included: • Choking – 1 • Serious Injuries, peer to peer aggression – 6 • Serious Injuries, determined cause – 14 • Serious Injuries, undetermined cause – 3 • Sexual Incidents – 2 • Unauthorized Departures – 1 • Deaths - 5 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 and other serious incidents. From the investigations since 1/1/11 reported by the facility, 27 investigations were selected for review. The 27 comprised three samples of investigations:	

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		• Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation. • Sample #D.3 included investigations the facility completed related to serious incidents. Based on a review of the 18 investigative reports included in Sample #D.1: • 15 of 18 (83 %) reports in the sample indicated that DFPS was notified within one hour of the incident or discovery of the incident. o DFPS Case #38991351 was investigation of a case of confirmed abuse which occurred on 4/9/11, but was not reported until 4/11/11. Staff who witnessed the abuse were also found neglectful for not reporting the incident. o DFPS case #39498852 was the investigation of an unknown serious injury that was discovered on 5/21/11 at 4:30 pm. It was not reported to DFPS until 6:33 pm on 5/21/11. o DFPS case #39343207 involved investigation of a sexual incident that occurred on 5/10/11 at 12:45 pm. It was reported to DFPS at 3:20 pm on 5/10/11. • Eighteen (100%) indicated, the facility director or designee was notified within one hour. • 12 out of 12 (100%) indicated OIG or local law enforcement (when appropriate) was notified within the timeframes required by the facility policy. • Zero (0%) investigation reports in the sample indicated that the state office was notified of the incident. Evidence was not maintained in the investigation file that was provided to the monitoring team. In reviewing Sample D.3 (serious injuries), one of five (20%) was reported immediately (within one hour) to the facility director/designee. The facility director was not notified within one hour in the following incidents: • Individual #318 sustained a laceration on his head on 4/7/11 at 11:45 am. According to the UIR, the director was not notified until 3:00 pm. • Individual #127 sustained a serious injury to his head at 10:00 am on 4/10/11. The director was not notified of the injury until 3:07 pm. • Individual #196 sustained a serious injury to his eyebrow requiring sutures at 10:45 am on 6/5/07. The director was notified of the incident at 3:00 pm. • Individual #214 sustained a laceration to his head on 7/18/11 at 6:05 pm. The director was notified at 2:27 am on 7/19/11.	

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		The facility had a standardized reporting format. The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents other than abuse and neglect. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which should have contained information about notifications was not included in investigation files in 16 out of 18 investigation files in Sample #D.1. This was previously cited in the February 2011 monitoring report. Based on a review of eight incident reports included in Sample #D.2 and Sample #D.3: • Five (63%) utilized the standardized reporting format. These five were investigations not involving allegations above abuse or neglect. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All employees signed an acknowledgement form annually. A sample of this form was requested for 58 new employees hired in the past two months and for a random sample of 24 other employees at the facility. Eighty-one employees (99%) in the sample had signed this form. A form was not provided for one employee in the sample. The facility POI indicated that it was not in compliance with D2a, but did not justify the rating. The POI indicated that employees had been in serviced on reporting injuries as of 6/7/11 in regards to compliance with this provision. The monitoring team agreed that the facility was not in compliance with this requirement. The facility needs to complete a UIR for each unusual incident, including abuse and neglect allegations, as described in state policy. The facility needs to ensure that all serious incidents are reported to the facility director and outside entities as required.	
	(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	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. The facility did have a system in place for assuring that alleged perpetrators were removed from 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 employment. This information was not included in the investigation file for investigations involving abuse and neglect. Based on a review of 18 investigation reports included in Sample D.1, in every instance where an alleged perpetrator (AP) was known, the AP was immediately placed in no contact status. Additionally, the monitoring team was provided with a log of employees who had been reassigned since 2/7/11. The log included the applicable investigation	Noncompliance

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	employee poses no risk to individuals or the integrity of the investigation.	case number, the date of the incident and the date the employee was returned to work if the employee was not discharged or had resigned. Review of 18 investigation files included in Sample D.1 showed there were no instances where staff who had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment posed a risk to individuals or the integrity of the investigation. Based on a review of the 18 investigation files in Sample D.1, there was not clear documentation that adequate additional action was taken to protect individuals in each case. Since the facility did not complete a UIR for each investigation, it was impossible to track preliminary action that was taken by the facility to ensure all safeguards needed were immediately put into place. Copies of nursing assessments were generally included in the investigation file, but additional actions that might have been taken in regards to changes in level of supervision, repairs to physical property, or additional medical monitoring were not documented. The facility POI indicated that the facility was in substantial compliance with this item. The monitoring team did not rate the facility in substantial compliance with D2b. The facility needs to ensure that information regarding preliminary action taken is clearly documented by the facility in a standardized format for each allegation of abuse or neglect.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. 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 23 staff training transcripts was reviewed (Sample #C.2). 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: • 23 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 8 (67%) of 12 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 23 (100%) employees had completed competency based training on unusual	Noncompliance

#	Provision	Assessment of Status	Compliance
		incidents (UNU0100) refresher training within the past 12 months. • Two (17%) of the 12 employees (employed over one year) 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 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. This is a repeat finding from the February 2011 monitoring report.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter. A random sample of this form was requested for 23 current employees at the facility. Twelve (52%) employees had signed this form within the past 12 months. 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. Disciplinary action was taken in each case in the sample where an employee did not report witnessed abuse or neglect. The facility was in substantial compliance with this item.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report	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 six individuals, all six (100%) said that they would tell a staff person if someone hurt them or they saw someone being hurt. None of the individuals were able to point out the poster with the #800 on it at the home. As noted above,	Substantial Compliance

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	unusual incidents, including allegations of abuse, neglect and exploitation.	having a clear easy to read and recognize posting that is consistent throughout the facility would help individuals recognize this information. The facility POI indicated that an abuse and neglect pamphlet is included in the PST invitation letter that is sent out to families to educate and support individuals and their primary correspondents. It further noted that this information is shared with individuals and their families at PST meetings. The facility was in substantial compliance with this item.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • individuals' rights, • information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was also a rights officer position at the facility. Information was posted around campus identifying the rights officer. The rights officer was well known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. The facility's POI indicated compliance with this item and noted that the Human Rights Officer monitors homes monthly to ensure the posters remain in place. The facility was rated as being in substantial compliance with this provision item.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Documentation of investigations confirmed that DFPS routinely notified appropriate law enforcement agencies of any allegations that may involve criminal activity. DFPS investigative reports documented notifications. Based on a review of 18 allegation investigations completed by DFPS (Sample #D.1), in twelve for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in twelve (100%). OIG found evidence of criminal activity in one of the cases in the sample. 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, the facility prohibited any retaliatory action towards person(s) reporting suspected abuse, neglect, or exploitation. 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 were concerns noted related to potential retaliation by coworkers in DFPS investigation #38991351. The facility review noted the concern, but did not document how this was addressed. However, it was evident based on the sample reviewed, staff routinely reported incidents when abuse or neglect was suspected. The facility rated itself in substantial compliance with this item. The monitoring team agrees with that assessment. 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 utilized a Significant Injury Audit Tool quarterly that reviewed a sample of injuries of non-typical nature, such as injuries to the head, breasts, buttocks, and genital areas to determine if injuries were routinely reported for investigation. Sample #D.3 included investigations completed on a sample of serious injuries. The facility completed investigations on all serious injuries. Home staff was responsible for completing an initial injury report form for both serious and non-serious injuries. Additionally, a sample of injury reports was reviewed for discovered injuries. The following is a summary of that review. • Individual #61 – ankle fracture 2/12/11 - facility investigated; • Individual #194 – laceration to eye 3/5/11 – facility investigated; • Individual #261 – fingers fractured, multiple bruising to face and knee 3/26/11 – facility investigated; • Individual #47 – hand fracture 3/14/11 – facility investigated; • Individual #65 – ankle fracture 3/29/11 – DFPS investigated (referred back to facility as administrative issue); • Individual #271 – multiple bruises 4/14/11 – DFPS investigated (inconclusive); • Individual #249 – laceration to chin 5/31/11 – facility investigated; • Individual #136 – laceration to head 5/21/11 – DFPS investigated	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		(inconclusive); • Individual #277 – laceration to head 6/6/11 – DFPS investigated (unconfirmed); • Individual #106 – laceration to head 6/17/11 – facility investigated; • Individual #170 – laceration to lip 6/26/11 – facility investigated; • Individual #41- laceration to head 7/5/11 – facility investigated; • Individual #277 – laceration to eyebrow 7/5/11 – facility investigated. For each of the 13 (100%), the facility had conducted an investigation to try to determine the cause of the injury. A sample of Daily Incident Management Meeting (DIMM) minutes since the last monitoring review were reviewed and indicated that injuries of both known and unknown cause were routinely reviewed by the committees. Observation of both the Daily Unit Meeting and Daily Incident Management Meeting during the monitoring visit confirmed that injuries were reviewed by both teams and follow-up recommendations were made when warranted. The POI rated this section as being in substantial compliance. The monitoring team agreed with this compliance rating.	
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	The DADS Incident Management Policy • described a comprehensive manner of the conduct of all such investigations; • addressed training requirements for investigators including training in working with people with developmental disabilities; and DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on working with people with developmental disabilities.	Noncompliance

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	within the direct line of supervision of the alleged perpetrator.	Fourteen DFPS investigators were assigned to complete investigations at SASSLC. The training records for DFPS investigators were reviewed with the following results: • Fourteen investigators (100%) had completed the requirements for investigations training. • Fourteen DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SASSLC had 13 employees designated to complete investigations. This included the Lead Investigator, Facility Investigator, three Campus Administrators, and eight Campus Coordinators. The training records for facility investigators were reviewed with the following results: • Eleven (85%) facility investigators had completed CIT0100 Comprehensive Investigator Training. Two campus coordinators had not completed this course; • Thirteen (100%) had completed UNU011 Unusual Incidents within the past 12 months; • Six (46%) had completed Root Cause Analysis according to training transcripts reviewed. Seven of the Campus Coordinators had not completed this course; and • Nine (69%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. The facility POI rated this item in substantial compliance. The facility remained out of compliance with this provision. All facility investigators should have completed CSI0100, RCA O100, UNU0100, and MEN 0300.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	A sample of investigations was reviewed for indication of cooperation by staff with outside investigators. An administrative referral was made to the facility due to concern noted regarding employees lack of cooperation with the DFPS investigator in DFPS case #39685327. The facility review form noted that staff failing to cooperate received a disciplinary consultation from the Unit Director. Proof of disciplinary action was not included in the investigation. Although OIG did not provide a detailed report to the facility, there was no indication that staff had not cooperated with OIG in investigations. OIG was routinely informed of investigations. The Incident Management Coordinator reported that the facility had a cooperative relationship with both DFPS and OIG. The facility self assessment rated this item as being in substantial compliance. The facility had revised its policy to include a mandate that all staff cooperate with outside investigators. A checklist had been developed to	Substantial Compliance

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		ensure timely gathering of requested documents by OIG. The monitoring team found that the facility is in substantial 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, the following was found: • Of the 18 investigations completed by DFPS (Sample #D.1), 12 had been referred to law enforcement agencies. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. Three cases in the sample indicated that DFPS had filed an extension because the DFPS investigator had not interviewed witnesses until OIG had completed its investigation. • OIG found evidence of criminal activity in one case in the sample. • There was no indication that the facility had interfered with any of the investigations by OIG. The facility was found to be in substantial compliance with this provision.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The SASSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video monitoring footage was provided to DFPS as requested and reviewed by facility investigators and photographs were taken of injuries as necessary. The facility was in substantial compliance with this item.	Substantial compliance

#	Provision	Assessment of Status	Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The facility Incident Management policy mandated investigations of serious incidents: • were to commence begin immediately for all unusual incidents; • were to be completed within five working days of the incident; • 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 • were to document results in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. 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: • DFPS reports did not describe substantive investigatory tasks that were undertaken within the first 24 hours in 10 out of 18 investigations (56%) in Sample #D.1. DFPS was in the process of modifying standard operating procedures regarding the conduct and documentation of actions taken to commence an investigation. • Investigations noted the date and time of initial contact with the alleged victim. This contact did not occur within 24 hours in eight of 18 (44%) investigations. This included investigation #393332148, #39414387, #39664587, #39876027, #40014869, #40210945, #40210924, and #39914928. The new DFPS procedure was implemented on 8/1/11; it will require the documentation of actions taken that indicated the commencement of the investigation. • 12 of 18 (67%) were completed within 10 calendar days of the incident. o Extensions were filed in all six cases that were not completed within 10 days. All extensions were filed either due to witnesses not being available or a halt in the investigation so that OIG could complete its investigation first. o It was a concern that the facility did not always receive completed reports from DFPS in a timely manner, thus, could not immediately review and follow up on concerns. Four of 18 completed cases (22%) were not received by the facility within 5 days of completion: Case #39202607, Case #39228307, Case #38991351, and Case #40121067. DADS state office reported that DFPS began delivering completed investigation through secure email on 8/20/11 to expedite the case	Noncompliance

#	Provision	Assessment of Status	Compliance
		delivery process. • All 18 (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 11 of the 18 DFPS investigations reviewed (61%), concerns or recommendations for corrective action were included. These concerns were referred back to the facility to address. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Zero out of five (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). This is a repeat finding from the last monitoring visit. No action had been taken to include this information in the UIR. • Five of five (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Five (100%) of the investigations completed in the sample indicated that the facility director and incident management coordinator had reviewed the report upon completion. • In five investigations reviewed, recommendations for corrective action were included in five of the investigations (100%). UIRs reviewed did not indicate when the investigation commenced. This is a repeat finding from the last monitoring visit. No action had been taken to include this information in the UIR. Investigative activities should commence within 24 hours and activities should be documented. The facility was not in compliance with this provision.	
	(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	SASSLC Incident Management Policy required a UIR to be completed for each serious incident. 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; 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: • UIRs were only completed by the facility investigator for two of the incidents	Noncompliance

#	Provision	Assessment of Status	Compliance

	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.	included in sample #D.1 (DFPS case #39498852 and #39343207).
		• For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following:
		o In 18 (100%), each serious incident or allegations of wrongdoing;
		o In 18 (100%), the name(s) of all witnesses;
		o In 18 (100%), the name(s) of all alleged victims and perpetrators (when known);
		o In 18 (100%), the names of all persons interviewed during the investigation;
		o In 18 (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 18 (100%), all documents reviewed during the investigation;
		o In 18 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS investigations now included a statement indicating that previous investigations were reviewed and either found relevant or not relevant to the case.
		o In 18 (100%), the investigator's findings; and
		o In 18 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of eight facility investigations included in sample #D.2 and #D.3
		• The report utilized a standardized format that set forth explicitly and separately, the following:
		o In five (63%), each serious incident or allegations of wrongdoing;
		o In five (63%), the name(s) of all witnesses;
		o In five (63%), the name(s) of all alleged victims and perpetrators when known;
		o In five (63%), the names of all persons interviewed during the investigation;
		o In five (63%), 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 five (63%), all documents reviewed during the investigation;
		o In five (63%), 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 In five (63%), the investigator's findings; and
		o In five (63%), the investigator's reasons for his/her conclusions.	

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		Facility investigations were not consistently formatted. The facility did not complete UIRs on the three investigations in sample #D.2 referred back to the facility (DFPS cases #39596051, #38866024, and #40210941). The investigation documentation did include a partially completed handwritten UIR for DFPS case #38866024, but required all information required for substantial compliance with this provision was not included. The facility needs to document steps taking to complete investigations referred back for internal investigation. A UIR that includes all relevant information should be completed for each investigation as directed by state policy.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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 a sample of 18 DFPS investigations included in Sample #D.1: • In 18 investigative files reviewed (100%), there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. • DFPS investigation files included a review/approval form to be signed by the Incident Management Coordinator (IMC) and Director of Facility. Eighteen (100%) DFPS investigations were reviewed by the facility director, and IMC following completion. o Eighteen (100%) were reviewed by the Facility Director and Incident Management Coordinator within five days of receipt of the completed investigation. As noted in D.3.e, five of the 18 (28%) of completed reports were not received from DFPS within five days of completion. o None of the completed reviews included additional recommendations or comments by the facility director or IMC. • DFPS noted concerns or made recommendations in 11 (61%) of the cases in sample #D.1. The facility documented follow-up to all recommendations made by DFPS in all four (36%) of the cases (#39343207, #39664587, #40014869, and #40208465). Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u>	Noncompliance

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		• In five out of five (100%) UIRs from sample #D.2 and #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. Recommendations for follow-up were made in five of the five investigations completed by the facility. While the facility rated itself in substantial compliance with this provision, the monitoring team did not find the facility to be meeting this requirement. DFPS needs to provide a copy of completed investigations to the facility in a timely manner to ensure timely follow-up on concerns and recommendations. The facility needs to complete a UIR for all DFPS investigations with documentation of all follow-up action to address concerns and recommendations.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	As noted throughout Section D, a UIR was not completed for each unusual incident in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form but did not include dates and details.	Noncompliance
	(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.	In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included was selected for review. This subsample was comprised of the following investigations: DFPS Case #39343207, DFPS Case #39202607, DFPS Case #39685327, DFPS Case #39596051, and DFPS Case #38866024 Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations. The following summarizes the results of this review: • The facility documented disciplinary action that was taken in regards to confirmed cases of abuse or neglect in the sample, but other action taken to correct the situation and/or prevent recurrence was not appropriately tracked and documented. • DFPS Case #39343207 confirmed two allegations of neglect against two staff members. According to the UIR completed on the incident, immediate action was taken to ensure the health and safety of the two individuals involved in the incident. DFPS completed the investigation on 5/30/11. One of the employees was dismissed on 7/1/11. The other was demoted on 7/1/11. The PST met and made additional recommendations including reassignment of bedrooms in the home and retraining staff in the home. A completion date was given for each action step, but documentation was not available to indicate that all recommendations were completed. • For DFPS Case #39202607, DFPS concluded that the allegation of physical abuse	Noncompliance

#	Provision	Assessment of Status	Compliance
		was unconfirmed. The investigation file did not include a UIR completed by the facility or other documentation regarding immediate action that was taken to safeguard the individual involved from further harm. The DFPS investigator noted two concerns in the conclusion of the case. Follow-up on these concerns was not documented. • DFPS Case #39685327 was referred back to the facility as an administrative and rights issue. Documentation showed that staff involved was removed from contact with individuals the day following the incident. The administrative referral addressed staff not cooperating with the investigation. The UIR completed by the facility noted that the Unit Director would address this issue. Documentation was not included in the investigative report to show this had been completed. A recommendation was made regarding the rights issue, but again follow-up was not documented. • DFPS Case #39596051 was referred back to the facility as an administrative, clinical, and rights issue. The investigation file did not include documentation of steps taken by the facility to further investigate the issues noted. The file did include a memo from the SASSLC Chief Nurse Executive stating that there was no basis for further action, including inservice training, employee counseling, or professional peer review. It was not clear how this determination was reached. • DFPS Case #38866024 was an allegation of neglect referred back to the facility as a clinical issue. There was no documentation showing that the facility took any action to further investigate the allegation of neglect or take corrective action other than a memo sent to nursing staff regarding appropriate documentation. The facility needs to implement a procedure to document recommendations and concerns and track follow-up to completion. The facility was not in compliance with provision D.3.i.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	Files requested during the monitoring visit were readily available for review at the time of request. With regard to DFPS, DFPS investigations were provided by the facility and available as requested by the monitoring team. The team agreed with this facility's self assessment rating of substantial compliance with this item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had a system in place to track data on unusual incidents and investigations. Data were compiled in a numerous logs requested by the monitoring team that included: • Type of incident, • Staff involved in 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 allegations of abuse and neglect, and all injuries. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress. The facility self-assigned a substantial compliance rating to D4. The facility was in substantial compliance with this provision item.	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 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	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility 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 employees confirmed that their	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	background checks were completed. The information obtained about volunteers was also reviewed. According to information provided to the monitoring team, for FYI 11, criminal background checks were submitted for 2181 applicants. The facility did not provide information regarding applicants who were dismissed due to background checks. There were a total of 135 applicants who failed the background check. Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample was requested for 24 employee's acknowledgement to self report criminal activity forms. • All (100%) had a signed acknowledgement on file at the facility. • Additionally, the facility provided examples of where nine of the 24 employees reviewed had submitted a form reporting criminal activity. The facility's POI indicated substantial compliance with this D.5. The monitoring team agreed with this rating.	

Recommendations:

1. The facility needs to complete a UIR for each unusual incident, including abuse and neglect allegations, as described in state policy (D2a).
2. The facility needs to ensure that all serious incidents are reported to the facility director and outside entities as required (D2a).
3. The facility needs to ensure that information regarding protective action taken to ensure the safety of individuals at the facility is clearly documented by the facility in a standardized format for each allegation of abuse or neglect (D2b).
4. The facility needs to ensure that all employees receive annual training as required by the state policies on abuse and neglect and incident management (D2c).

5. All facility investigators should have completed CSI0100, RCA O100, UNU0100, and MEN 0300 (D3a).

6. Investigative activities should commence within 24 hours and activities should be documented (D3e).

7. The facility needs to document steps taking to complete investigations referred back for internal investigation. A UIR that includes all relevant information should be completed for each investigation as directed by state policy (D3f, D3h).

8. DFPS needs to provide a copy of completed investigations to the facility in a timely manner to ensure timely follow-up on concerns and recommendations (D3g).

9. The facility needs to complete a UIR for all DFPS investigations with documentation of all follow-up action to address concerns and recommendations (D3g, D3h).

10. The facility needs to implement a procedure to document and track follow-up to completion all recommendations and concerns noted in investigations of unusual incidents (D3i).

11. Data collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate how data can best be used to evaluate that progress (D4).

12. It is recommended that the facility choose one poster with clear information regarding reporting abuse and neglect and use that poster throughout the facility for easy identification of the information (D1).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003: Quality Enhancement, dated 11/13/09 o DADS Draft revised policy on Quality Enhancement, undated o Organizational chart, undated, but current o SASSLC policy lists, 8/1/11 o List of typical meetings that occurred at SASSLC o SASSLC POI, 8/2/11 o SASSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/15/11 o SASSLC DADS regulatory review reports, through 7/8/11 o QA department staff meeting note 7/7/11 o Detail of duties of QA department nurse an Nursing department QA nurse, 8/18/11 o SASSLC Quality Assurance Plan (six page table/matrix) o Set of blank tools used by QA department staff (eight) o QA Reports, monthly February 2011 through July 2011 (six) o Detailed report of 12 nursing self-monitoring tools, prepared by Robert Zertuche and Mandy Pena o QAQI Council agenda and meeting minutes from February 2011 through June 2011 (7 meetings) o QAQI Council agenda and handouts for 8/17/11 meeting o PIT meeting minutes, one, from 6/21/11 o Corrective Action Plan Tracking Sheet (18 pages) o DADS SASSLC family satisfaction survey online summary, 29 respondents o Self-advocacy meeting minutes and notes, March 2011 through July 2011 <u>Interviews and Meetings Held</u>: o Michelle Rodriguez, Director of Quality Assurance o Laurence Algueseva, Joshua Castro, Mary Sweeney, QA department staff o Mandy Pena, QA department nurse, and Robert Zertuche, QA nurse from the nursing department o Moneke Tyner, Settlement Agreement Coordinator o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors o Family member of one individual o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. <u>Observations Conducted</u>: o QAQI Council Meeting, 8/18/11 o Many residences, day program, and vocational program

	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. In addition, during the onsite review, the QA director reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the QA director wrote a sentence or two about what tasks were completed and/or the status of each provision item. In the POI, the same comments were written for each of the provisions. When the monitoring team conducts its onsite review, the results are 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 POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The QA director self-rated the facility as being in noncompliance with all five provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Only one action step was written; it had to do with the PSP process. The facility will only achieve substantial compliance if a set of actions, such as those described in this monitoring report, are set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: SASSLC had made little progress towards achieving substantial compliance. Improvement will be necessary in the key areas of this provision: QA policy, QA plan, QA data collection and analysis, QAQI Council, and the management of corrective actions. Progress was evident in two areas in particular. First, the QA report improved since the last onsite review. Second, the QAQI Council met regularly and had good attendance and participation. Attendees were most engaged when data were presented and discussed. QA policy was not yet developed and QA plan was not fully in place (a table/matrix existed, but it was inadequate as a QA plan). A QA report was written every month. A system of managing corrective actions

	was not yet in place. All of these components must be in place for the facility to thoroughly review, analyze, and summarize important data. QA staff were competent, hard working, and desirous of providing a valuable and valued service to the facility, department heads, and senior management. QA staff collected a variety of data, and conducted a variety of audits. The two QA nurses had developed, and implemented, an excellent system for the implementation and management of the 12 statewide self-monitoring tools. Corrective actions were not developed or managed as required by this provision. The QA director and the facility's Settlement Agreement Coordinator needed to work more collaboratively, especially regarding incorporation of the SAC's PET information into the QA program.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	SASSLC made little progress towards achieving substantial compliance with the items of this provision since the last onsite review (at that time the facility was making progress). This was due, in part, to the hiring of a new QA director only four months prior to this onsite review. In addition, the new QA director also had primary responsibility for incident management oversight across the entire facility. An incident management coordinator position had been recently approved and the QA director expected to complete the hiring process for this position in the very near future. Then, she expected to be able to devote more time to QA activities. Even so, the new QA director will need more than just additional time, she will need direction and assistance from the facility director and from the state office Quality Assurance coordinator if she and the facility are to successfully create and implement a quality assurance system, including QA policy, a QA plan, QA data collection and analysis, QA reporting, QAQI Council, and the management of corrective actions. Moreover, the QA director should read section E of each of the SASSLC's previous monitoring reports as well as from the monitoring reports of other SSLCs (as suggested in the previous monitoring report). <u>Policies and QA Planning</u> This state policy, #003: Quality Enhancement, dated 11/13/09, was being extensively 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. At the time of the previous review, there were two new facility-specific QA policies. They had not been revised, so the same comments as in the previous monitoring report still applied (i.e., need for revision and detailing, assess what policies are needed after the state policy is disseminated).	Noncompliance

#	Provision	Assessment of Status	Compliance
		Below are comments from the monitoring team regarding SASSLC's status with some important component steps in the development of a QA program. The monitoring team had the opportunity to discuss these at length with the new QA director and with other members of the QA staff. Detail is provided here in hopes that it will be helpful to the QA director. 1. Create a listing of all data collected at the facility that includes the following: a. Data collected by each discipline service department; this includes two categories of data: i. Data the discipline service department uses for its own service and operational purposes ii. Data the discipline service department collects as part of its own self-monitoring and which includes these two categories of self-monitoring tools: • Statewide self-monitoring tools • Facility-specific tools created by the facility service department, if any (e.g., PNMP monitoring, AAC device monitoring) b. Data collected by the QA department staff: i. Data they collect themselves ii. Data that are the result of the QA department's interobserver agreement (reliability) assessments of the service department's own self-monitoring c. Data from the areas listed in the Assistant Commissioner's guidelines for QAQI Council, such as Life Safety Code, ICFMR regulatory activities, and the FSPI. Status: SASSLC had not yet begun to assemble this listing. During the week of the onsite review, following discussion with the monitoring team, the QA director sent a request to each discipline to submit a listing. The development of this listing will take a number of months to complete. It is likely that additional items will be added. Once completed, an annual or semi-annual update will likely be all that will be necessary. 2. Determine which of these data are to be submitted to the QA department for tracking and trending (and to be part of the QA plan table/matrix). Status: The QA department had not made any progress on this activity. The QA plan was a table/matrix of measures and tools, however, it was not useful and contained many errors and duplications. The table/matrix should indicate all the data that the QA department will track, trend, and comment upon. Further, the table/matrix will become part (the primary part) of the QA plan. 3. Determine which of these data are to be included in the QA report. Status: A monthly QA report was being completed. Comments on the	

#	Provision	Assessment of Status	Compliance
		content and quality are in E2 below. 4. Determine which of these data are to be presented regularly to the QAQI Council. QAQI Council should make this determination with suggestions from the service department heads as well as from the QA director. Status: The QAQI Council was reviewing some data, discussing those data, and making recommendations (see below), but again, they were doing so without the benefit of a listing of all types of facility data, the QA table/matrix, or any other guidance from the department heads or QA department. 5. Create and manage corrective actions based upon the data collected and direction from the QAQI Council. Status: A system was not in place (see E2 below). A system of managing corrective actions was not yet in place. QA Department Michelle Rodriguez was the new QA director. The QA department staff who worked for her remained an energetic, thoughtful, and committed group of auditors (three), nurses (two [one from the nursing department]), and data analyst (one). Although the QA program had not progressed, the QA staff were very busy and highly engaged in QA activities; this bodes well for the department as it develops the structure and components required of a QA program. One of the auditors was new and another had just accepted a new job at another SSLC, thus, a great deal of training was also going to be needed for these new staff over the next few months. A QA department meeting was recently initiated and one meeting was held in July 2011. This should continue and should include topics about quality assurance. In other words, the meetings should be used as a staff training-type opportunity so that staff can learn about quality assurance, participate in creating processes for the department and facility, and so forth. Because the QA department at SASSLC also included recordkeeping, incident management, human rights officer, and self-advocacy activities, a separate meeting for the QA auditors, QA nurses, and data analyst should be considered. The QA department's nurse, and the nursing department's QA nurse worked exceptionally well together and developed an outstanding analysis of the 12 nursing self-monitoring tools. This, for example, could be a topic at a QA department meeting, that is, the two nurses could do a 30-minute presentation about their QA system for these tools. The Settlement Agreement Coordinator (SAC) also had responsibilities that were quality assurance related. They were focused solely upon the provisions of the Settlement Agreement. To that end, she had, in June 2011, initiated a meeting to review the status of each provision. It had only had one meeting and none were scheduled so that it could be	

#	Provision	Assessment of Status	Compliance
		observed by the monitoring tem. It did not appear that the SAC and QA director were working together to ensure that the SAC's activities, findings, and data were incorporated appropriately into the QA program (also see E2 below). <u>Quality Assurance Plan</u> SASSLC did not have an adequate or thorough QA plan in place. The QA plan was the same as during the last onsite review except that additional lines had been added. The new lines appeared randomly chosen (i.e., in no systematic or thoughtful manner) and there were numerous errors and duplications. The table/matrix was good to include in the QA plan and can help guide the QA department (and QAQI Council) in understanding what data are being managed by the QA department (some of it collected by QA department staff, some of it submitted by the discipline departments at the facility). Ultimately, the table/matrix should be a component of the QA plan (probably the largest component). All of the data on the table/matrix should be reviewed, analyzed, perhaps graphed and trended, and commented upon, if necessary. The table/matrix will also likely include more detail about how each of these types of data will be obtained (e.g., by whom, how often, what tool, sample size). The new state policy will provide guidance to the facility regarding the content of a QA plan. A QA plan will be a description of the overall QA program at the facility. Therefore, to reiterate, the table/matrix that was created will be a piece of this broader QA plan. In addition, it will include all of the data and activities conducted by the QA department as well as the facility's service and operational department self-monitoring data and other relevant data. <u>QA Activities and Indicators</u> The activities of the QA staff were primarily: • Completion of their eight (or so) data collection tools • Completion of the statewide self-monitoring tools • Infrequent completion of statewide self-monitoring tools for the purpose of interobserver agreement with discipline department • QA assessments of various PSP-related QMRP activities (e.g., PSPs, SPOs, quarterly reviews) • Corrective action plan log (though see E2 below) • Full QA analysis by the QA nurses • Participation on various committees and attendance at various meetings In previous monitoring reports, the monitoring team recommended that a variety of	

#	Provision	Assessment of Status	Compliance
		satisfaction measures be obtained, summarized, and included as part of the QA system at SASSLC. One suggested target was staff satisfaction. The facility had not addressed this yet. Another suggested target was family satisfaction. SASSLC families and LARs had the opportunity to participate in the new statewide online (or paper) questionnaire. Since the last onsite review, 29 families had completed the survey. The facility did not yet appear to be doing anything with this information. Further, SASSLC might explore family input and satisfaction via phone calls or family meetings. Some of the comments made by a family member to the monitoring team might be useful and valuable to the facility. A third suggested target area was satisfaction of individuals. This was not being done in any type of standardized or formal manner. The HRO, however, addressed the recommendations from the previous report regarding including a decision making component to the self-advocacy meetings. A fourth suggested targeting others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. This had not been addressed yet.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	This provision item required the facility to analyze the data collected by the QA processes that were implemented at the facility. SASSLC had made some progress in two aspects of this provision item: further development of the QA report and continuation of the QAQI Council. Overall, to meet the requirements of this provision item, SASSLC needs to (a) analyze data regularly, and (b) act upon the findings of the analysis. <u>QA Data Management and Analysis</u> As the facility moves forward, it will be important for the QA director to review all data that are managed by the QA department (i.e., all of the data on the table/matrix). These data will need to be summarized and trended, such as on a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. Not all of these graphs need to be created by the QA department. It is possible that the facility sets an expectation for the service departments to submit their data and their graphic summaries each month. This will have to be determined at the facility level. Many, if not all, of these graphic presentations should/can appear in the QA report and be presented to QAQI Council. Regarding the statewide trend analysis: for the past few years, every SSLC created an almost identical monthly report on four sets of data: restraint usage, abuse and neglect allegations, injuries, and unusual incidents. These are important topics and the report typical provided a lot of valuable information. Each facility now had data for three or so	Noncompliance

#	Provision	Assessment of Status	Compliance
		years. The document, however, was cumbersome and lengthy. The QA director will need to take the most important parts of this trend analysis document and incorporate them into the facility's QA program (e.g., table/grid, QA report, report to QAQI Council). At SASSLC, these data were summarized in a short paragraph in the QA report, however, the trend analysis itself, surprisingly, was not submitted to the monitoring team for review. One aspect of the trend analysis that the facility (and state) should consider is trending the number of confirmed ANE allegations, not only the number of allegations made. While trend reports for ANE allegations may be useful, it is even more important that trend analyses be developed for confirmed instances of ANE. The work of the two QA nurses deserves special mention. Robert Zertuche and Mandy Pena created an outstanding system to implement and manage the 12 statewide self-monitoring tools for nursing. The monitoring team recommends that the state office look at this as a possible best practice. Their program included the choosing of individuals in the sample, and assignment of implementation of the 12 tools to specific nursing staff. The QA nurses then did interobserver agreement checks of every one of these tools, as much to check reliability as to set the occasion for training and consistency across nursing staff. They then analyzed, tracked, and trended data by tool, by nurse, by home, and so forth. They included a system for tracking any follow-up needed based on the results of use of the tool. The monitoring team and the two QA nurses had a good discussion of their program including suggestions from the monitoring team regarding graphic presentation standards, how to calculate reliability scores, and ways to share their program with the QA director and QA staff. <u>QA Report</u> At the time of the previous onsite review, a monthly QA report had recently been initiated. It was rough and unwieldy, but was a good first start. At this time of this review, the new QA director had, along with lots of assistance from the data analyst, improved the format, appearance, graphs, and content. The format and appearance of the report were the same from month to month, helping readers to become more efficient with reading it. The July 2011 report was presented and reviewed during the QAQI Council meeting. It is likely the new state policy will provide guidance to the QA director as she develops a report further. The monitoring team recommends that each report include the current month's self-monitoring detail (i.e., results on each of the provision items) as well as a second graph showing month-to-month overall self-monitoring results (i.e., a single data point for the month). Other data, as per the QA table/matrix, the QAQI Council's preferences, and any other data deemed noteworthy by the QA director or department heads should be included.	

#	Provision	Assessment of Status	Compliance
		To clarify and perhaps reiterate: the list of data collected at the facility, the QA plan, the QA department's analysis and trending of data in the QA plan, the QA report, QAQI Council agenda and reviews, and CAPs should all line up with each other. <u>QAQI Council</u> The QAQI Council met regularly and its continuation since the previous onsite review was good to see. The QAQI Council appeared to take their responsibility seriously as evidenced by the frequency of meetings, their length, and the attendance and participation of senior management. The monitoring team reviewed meeting minutes and observed conduct of a QAQI Council meeting. Everyone seemed comfortable participating in the meeting, and the facility director was attentive to all comments. The monitoring team noticed that attendee participation was the highest, in fact it was very high, when data were being looked at as part of the QA report or when presented by the unit directors (regarding staff turnover and retention). This was a very good indicator of the QAQI Council's interest in data. Therefore, given the limited time, the monitoring team recommends not taking meeting time to make announcements that could be handled via email or via some other communication vehicle. <u>Performance Improvement Teams</u> Performance Improvement Teams were not used at SASSLC, though they should be created regularly as needed. Once SASSLC begins using PITs, the QAQI Council should have input into the activities of each PIT rather than solely appointing the membership. There was a new committee called the Performance Evaluation Team. Minutes from its first and only meeting on 6/21/11 were reviewed. The meeting was led by the SAC and it appeared that the goal was to review each provision of the Settlement Agreement. A lot of the minutes' template was blank, so it was not clear as to what the exact plan was for the group. A special meeting to review sections of the Settlement Agreement and perhaps the POI makes sense to do, however, to go through all 20 provisions will make for a very long meeting. The SAC should work closely with the QA director. They might consider breaking it up into shorter meetings and only covering a portion of the 20 provisions each time. <u>Corrective Actions</u> A log of corrective action plans was submitted to the monitoring team. It was 18 pages long and had all kinds of information specific to statewide self-monitoring forms for section F. This was not the intention of provision items E2, E3, E4, and E5. The	

#	Provision	Assessment of Status	Compliance
		monitoring team recommends the QA director get guidance from the state office as to how to think about, create, and manage corrective actions. The monitoring team has a number of considerations for the facility as it moves forward with meeting the requirements provision items E2-E5. These considerations were in the previous monitoring report and are repeated here for the convenience of the QA director. These could be included in SASSLC's facility-specific policies regarding QA and the QAQI Council. • How to determine 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 facility's practices for implementing 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 when needed.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

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	the problems originally identified.		
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 state policy (E1).

2. Consider whether facility-specific policies would be helpful to the QA program at the facility, including revision (or deletion) of the two current facility-specific policies (E1).

3. Implement the five component steps numbered and described in E1
    - Create a listing of all data collected at the facility
    - Determine which of these data are to be submitted to the QA department for tracking, trending, and inclusion in the QA plan table/matrix
    - Determine which of these data are to be included in the QA report.
    - Determine which of these data are to be presented regularly to the QAQI Council.
        - QAQI Council should make this determination with suggestions from the department heads as well as from the QA director.
    - Create and manage corrective actions based upon the data, and direction from QAQI Council (also see #14 below, regarding items E2-E5)

4. The statewide trend analysis has four components. One is allegations of abuse and neglect. Add a data set within this component regarding confirmed allegations.

5. Hold regularly occurring QA department staff meetings; consider adding trainings to these meetings (E1).

6. Work in more close collaboration with the SAC; describe (perhaps in the QA plan) the role of what was called the PET and how its work integrates with the QA department and program (E1).

7. Improve the QA plan and the table/matrix of data (E1).

8. Create two graphs per provision per month for the self-assessment date: one that shows the month-to-month overall score (this was already being done), and one that shows the detail for that month's score (E1).

9. Collect, analyze, and then use satisfaction measure results: individuals, staff, family, related community businesses, hospitals, etc. (E1).

10. Review, graph/trend, analyze, and summarize all data managed by the QA department (i.e., the data from the QA plan table/matrix) (E2).

11. Improve the QA report (E2).

12. Share the work of the QA nurses with the QA department and QAQI Council (E2).
13. The QAQI Council should reduce announcements and use the time available for data review and discussion (E2).
14. Create performance improvement teams as needed; QAQI Council should have input into its activities (E2).
15. Implement and manage corrective actions as per items E2-E5 (E2-E5).

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:** Documents Reviewed: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o Supporting Visions Training Curriculum o SASSLC Plan of Improvement o QMRP weekly meetings minutes o A sample of completed monitoring tools to assess the quality of the PSP meeting and the PSP o PSP, PSP Addendums, Assessments, SAPs for the following Individuals: • Individual #73, Individual #18, Individual #10, Individual #78, Individual #57, Individual #275, Individual #342, Individual #170, Individual #39, Individual #45, Individual #284, Individual #310, Individual #110, and Individual #141 o A sample of quarterly reviews for: • Individual #78, Individual #73, Individual #18, Individual #10, Individual #30, Individual #20, and Individual #96. Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Ralph Henry, Facility Director o Michelle Enderle-Rodriguez, Quality Assurance Director o Daisy Ellison, Psychology Coordinator o Audrey Wilson, QMRP Coordinator o Gevona Hicks, Human Rights Officer o Jim Sibley, DADS consultant for PSPs Observations Conducted: o Observations at residences and day programs o Morning Unit Meeting 8/16/11 o Incident Management Review Team Meeting 8/16/11 o Annual PSP meetings for Individual #205 and Individual #286 o PSPA meeting for Individual #218
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. During the onsite review, the QMRP Coordinator reviewed the presentation book for this provision. The facility reported that it was

	focusing on deficits noted in Section F, but acknowledged that many of these efforts were in the beginning stages. Most of the items required by this provision were not yet fully implemented. The QMRP Coordinator was focusing her efforts on evaluating each QMRP's facilitation skills and providing mentoring and feedback where needed. According to the POI, the facility's self-rating was, in part, determined through monitoring of the PSP and PSP process by the QMRP Coordinator. The POI, however, did not include results of that monitoring. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. Thus, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to all provisions in Section F1d, F2a5, F2b, F2f, and F2g. The monitoring team, however, did not find substantial compliance with any of the provisions in Section F. The POI indicated that actions had been taken to address compliance with Section F in the past six months: • A shared folder was created for disciplines to place copies of assessments for review by all team members prior to PST meetings. • All QMRPs had attended Facilitation Skills training. • The QMRP Construction Facilitating for Success Performance Tool was implemented. • The QMRP Coordinator had observed PSP meetings and provided immediate feedback to QMRPs leading the meetings. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style PSPs, assessments were still not completed or updated as needed, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.
	Summary of Monitor's Assessment: The QMRP Coordinator acknowledged that the facility was not yet in substantial compliance with many requirements of this provision. It was evident from conversations with the monitoring team that the facility was considering how to best implement the person centered planning process and ensure consistent implementation and monitoring of services. All staff had also been trained on the new risk identification process and the process had just been implemented for some individuals at the facility. Moreover, DADS had recently initiated a thorough review of the PSP process and hired a set of consultants to help the SSLCs move forward in PSP development and the meeting of this provision's requirements. The monitoring team met with one of the consultants during the week of the onsite review. The consultant's work had not yet begun at SASSLC.

	Two annual PSP meetings were observed by the monitoring team. In meetings observed, the QMRPs were attempting to encourage team participation and ensuring that all necessary information was covered during the PST meeting. Most of the information regarding assessments and supports was presented by a team member and very little discussion took place among team members to integrate information shared. Information regarding supports that the individuals need throughout the day was more clearly stated in some of the newer PSPs. 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 assurance activities with regards to PSPs were in the initial stages of development. Audit tools had been developed to review both meeting facilitation and the PSP development process. Compliance with section F 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 PSPs that were reviewed were chosen from among the list of individuals for whom the new format/process for PSPs had been used. The monitoring team reviewed a sample of 14 of the new plans. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		

#	Provision	Assessment of Status	Compliance
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 were responsible for facilitating PST meetings at the facility. The QMRPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. While onsite, the monitoring team observed a number of PSP meetings, and also met with two teams to discuss the at-risk screening process. All PST meetings observed during the monitoring visit confirmed that QMRPs were facilitating PSP meetings. A sample of 10 PST attendance sheets was reviewed for presence of the QMRP at the annual PST meeting. At all annual meetings, there was a QMRP present. All QMRPs had attended facilitation skills training. While it was too soon to fully evaluate the effectiveness of this training, the QMRP Coordinator was attending annual PST meetings and continuing to mentor QMRPs with regards to meeting facilitation. The QMRP Coordinator reported that QMRPs were at varying stages in learning to competently facilitate meetings. She had identified QMRPs that were better facilitators and had assigned those QMRPS to mentor others that were struggling with the process. For this provision to be in compliance, not only does the PSP process need to be facilitated by one person, but also team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year. This did not always occur. At the June 2011 Monitors' meeting with DADS and DOJ, there was discussion regarding determining the definition and criteria for facilitation, that is, what does it mean for the QMRP to be facilitate the PST in a way that meets this provision item. The facility's POI indicated noncompliance with this requirement. The monitoring team agrees with that assessment.	Noncompliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	A sample of attendance sheets was reviewed with the following results in terms of appropriate team representation at annual PST meetings. The sample included PSPs for the following individuals: Individual #10, Individual #78, Individual #57, Individual #342, Individual #39, Individual #310, Individual #170, Individual #73, Individual #141, and Individual #284. • 6 (60%) of 10 indicated that the individual attended the meeting; o Exceptions included Individual #10, Individual #57, Individual #310 and Individual #170. • 8 (80%) of 10 individuals had a LAR; 7 (88%) participated at the annual PST. o The exception was the LAR for Individual #39. The monitoring team does not expect that all individuals or their LARs will want to	Noncompliance

#	Provision	Assessment of Status	Compliance
		attend their PST meetings. When individuals are not present for meetings, the QMRP should document attempts made to include the individual or LAR and how input was gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contribute to the refusal to attend and brainstorm ways to encourage participation. For example, if the individual does not want to miss work to attend, try holding the meeting outside of work hours, or if the individual does not like crowded rooms, try holding the meeting in a larger space. A review of 10 signature sheets for participation of relevant team members at the annual PST meeting indicated that 0% of the meetings were held with all relevant staff in attendance. There was no documentation included in any of the PSTs that would indicate input was given prior to the meeting by staff who were unable to attend the meeting. Residential staff was only in attendance at one (10%) of the meetings in the sample. These team members can provide important input into how the individual likes to spend his or her day and what supports the individual needs. Inconsistent attendance at PSP meetings by specific team members including OTs, PT, SLPs, and RD was documented. The absence of key members was a significant barrier to integration in the development of PSPs. As a result, the PSPs continued to be discipline specific with excessive reliance on the written assessment. The lack of integration in the PSP negatively impacted the ability to develop the PNMPs in a comprehensive and collaborative manner. It would not be possible to achieve adequate integration with the clear limitations in PNM-related professional participation in the PST meetings when these plans were developed. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. The following are comments regarding participation in PST meetings for this sample. • The signature sheet for the annual PST meeting for Individual #10 indicated that all relevant team members were not in attendance at the annual PST meeting. The signature sheet indicated that the individual did not attend her annual meeting "per LAR request." The CLOIP MRA was not present, though her LAR was adamantly opposed to community placement. Residential staff that possibly knew her best did not attend the meeting. The dietician/nutritionist was not present though she was on a "PKU diet" and eating was listed as a "top priority" for supports needed. • For Individual #78, his physical therapist did not attend the meeting, though positioning was critical for him to actively participate in activities throughout his day and recommendations from the therapist would need to be incorporated in	

#	Provision	Assessment of Status	Compliance
		most of his outcomes. According to the signature sheet, residential staff were also not in attendance at his meeting. • The signature sheet for Individual #342 indicated that residential staff did not attend his annual PST meeting. His occupational therapist did not attend, even though her input would have been beneficial in developing supports strategies. • The signature sheet for Individual #73 indicated that the following PST members did not participate in the annual PST meeting: dietician/nutritionist, residential staff, occupational therapist, psychiatrist, and vocational staff.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	The monitoring team found the quality of some assessments continued to be an area of needed improvement. In order for adequate protections, supports, and services to be included in an individual's PSP, it is essential that adequate assessments be completed that identify the individual's preferences, strengths, and supports needed (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, section R regarding communication assessments, and section T regarding most integrated setting practices). For example, the functional assessments were not being completed (K5), psychological assessments had not been completed for all individual (K5) and the PALS was not effective for assessing training needs (see S1). The facility had begun using the new Personal Focus Assessment (PFA). The PFA was an assessment screening tool used to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. In the PSPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual PSP. This list was individualized to some extent, and offered a good starting point for plan development. For some individuals, the preferences/priorities developed from the PFA process were too general to facilitate individualized planning. The list of preferences developed from the PFA process was reviewed for the 14 individuals whose PSPs were reviewed (listed above in Documents Reviewed). Ten (71%) of the 14 PSPs included one or more generic statements in the list of preferences that would not help the team in individualizing supports and services. For example, the PSP for Individual #141 included the following preferences: enjoys maintaining safety, enjoys maintaining appropriate behavior, enjoys developing self-help skills, and enjoys eating and sleeping well. Individual #78's PSP, however, included a good example of a more individualized list of preferences that would be a basis for person centered planning. Her list included sensory activities (i.e., holding items that vibrate – massagers, large hand bells, large stuffed animals), being outdoors, relaxing to music, and coffee.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Additional comments from PFAs reviewed: • PFAs can be difficult to complete for individuals with barriers to expressing their preferences. It will be necessary for staff who know the individual the best to complete the assessment based on observation of that individual in a variety of settings and situations. • The PFAs for Individual #18 and Individual #284 were good examples of how staff used their knowledge of how the individual typically communicated likes and dislikes to complete information regarding preferences. • The PFA for Individual #78 stated "unknown" for the question of what makes you happy, most content, or really enjoy in your life. He had lived at SASSLC for nine years. There should have been at least one person involved in completing his PFA that knew him well enough to answer this question. Information gathered from the PFA was discussed in the PST meetings observed. Each QMRP reviewed the individual's list of preferences and members of the team engaged in limited discussion on how this might be supported. Attempts were made to integrate these preferences into outcomes developed by the team. Since most individuals at the facility had limited exposure to options outside of what was offered at the facility, teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. An assessment geared towards identifying activities not typically offered at the facility would broaden the spectrum of activities that individuals may want to be involved in during his or her day. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community. The Active Treatment Coordinator reported that attempts were being made to gather this information, but no formal process was in place to share the information gathered during team meetings. This information should be discussed at the PST meeting and the team should plan for opportunities that might lead to discovering new activities that the individual might enjoy for recreation, leisure, and work. The Positive Assessment of Living Skills (PALS) was used by the facility to assess adaptive living skills. It appeared that staff were routinely completing the checklist, but not developing individualized recommendations from assessment results. It had become a rote check off that was not useful for planning. None of the assessments described specific supports needed by the individual. Section III of the PALS was a summary section that should have been used to develop a list of priorities for training objectives. Completed PALS were reviewed for Individual #310, Individual #73, Individual #284, Individual #78, Individual #10, Individual #18, Individual #284, Individual #39, Individual #342, and Individual #57. The summary section was completed for only 3	

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		(30%) of the assessments in the sample. Some examples where adequate assessments were not completed for the individual prior to the annual PST meeting, or updated in response to significant changes included: • Individual #10's PFA indicated that relaxation, leisure time, and work were important to her. The PFA listed limited activities in each of these areas that she regularly participated in and enjoyed. In Section III of the PFA, the checklist for assessments needed, based on her preferences, did not include a need for additional assessment in the areas of retirement/life skills, recreation, community awareness, sensory, or occupational interests, though all areas related to her stated preferences. • Individual #78's psychological assessment was completed on the same date that his PST met to develop his annual PSP. The summary section identifying his priority needs was not completed on his PALS assessment. • Individual #18 had a diagnosis of severe osteoporosis with eight fractures since 1993 according to his OT/PT assessment. He had not had a recent DEXA scan. His risk assessment dated 2/2/11 indicated that one would be ordered. This information would have been useful to the team in determining his actual risk level for osteoporosis and fractures prior to the PST meeting. • Individual #110 did not have a neurology assessment prior to her annual team meeting. The previous year, a new antiepileptic medication had been started and she was weaned off of a medication. Her nursing assessment indicated that she had seven seizures over the past year. There was no indication that she had a communication assessment prior to her annual PST meeting, though her PFA indicated that she had limited communication skills. • Individual #73's PFA indicated that working and earning money were priorities for him. His vocational assessment did not assess areas of work interest outside of his present job or describe supports that he needed to complete his job at the sheltered workshop. • Individual #284 did not have an annual neurological assessment. Her PSP indicated that she had 28 seizures over the past year and was taking three antiepileptic medications. An x ray from March 2011 indicated that she had osteoporosis. At the time of her annual PST meeting on 6/8/11, she had not had a bone density scan. All team members will need to ensure assessments are completed updated when necessary and accessible to all team members prior to the PST meeting to facilitate adequate planning.	

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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. 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 QMRPs were at varying stages of integrating information into a more meaningful plan that identified needed supports in relation to the individual's preferences and needs. PSPs should be a guide to providing supports that all staff can understand and follow. As was expected at this early stage in the new process, some QMRPs were doing a better job than others at integrating assessment information into a meaningful plan. Plans that were not good examples of an integrated discussion included: • The PSP for Individual #170 included a summary of each assessment completed prior to the PSP meeting. There was no integrated discussion of assessment results and how this information would be used to provide supports to the individual throughout his day. Information was "cut and pasted" from assessments into the PSP document without edits. This led to a disjointed support plan that did not offer staff a clear guide for staff providing supports. • The PSP for Individual #342 included findings and recommendations from assessment and a discussion of some of his preferences, but did not use the information to describe supports that he needed to engage in his preferred activities. One of his priorities was "consistent schedule." His PSP did not describe specifically what needed to remain consistent in his schedule or how staff might need to support him to maintain this consistency. • The PSP for Individual #78 included a list of some of his adaptive equipment that he needed, but not all. The plan did not describe when or how the equipment should be used. • Individual #310's PST included a summary of each assessment, but did not integrate that information into a plan for supports throughout her day. Plans that were good examples included: • The PSP for Individual #18 was a better example of integrating assessment information into a description of supports needed during the day. There was evidence that the team discussed recommendations from assessments and made additional recommendations when warranted. His nutrition assessment indicated that he was in his ideal weight range. Team members raised questions regarding whether or not this was an ideal weight range for him, resulting in the team's request a new assessment. The assessment was completed and the team met for follow-up. • The PSP for Individual #284 was another good example of integrating	Noncompliance

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		assessment information into the discussion of her preferences and supports that she needed throughout her day. The information was clearly written and offered clear direction to support staff. There was a description of how she liked to spend her day, preferred activities, and important relationships. Her PSP included her chronic medical issues and gave a brief description of how she should be supported to minimize her risks. Consideration was given to her independence in each area. As evidenced by the following examples, assessments often included important information that should have been used as the basis for planning for individuals, however, this information was not used to develop and implement protections, services, and supports for the individual. ▪ Individual #310's vocational assessment indicated that she had displayed regression in her work skills and an increase in refusing to attend work. The assessment noted that regression occurred following a change in her medication regimen. Her PSP included a general statement regarding her refusal to work and noted that there was a suggestion to consider movement to the senior's program if she continued to refuse work. There was no evidence that the team had discussed the possible correlation between the change in medication and refusal to attend work. ▪ Individual #78's communication assessment described living preferences that should have contributed to the optimal living discussion held by the PST. The assessment noted that he disliked loud or crowded environments, and enjoyed quiet environments and having personal space. These were all good observations that would have contributed to the discussion about optimal placement. The assessment also included a good description of his communication style. This information was not included in the PSP, but would be useful for staff providing daily supports. Assessments indicated that he was legally blind. His PST did not note any type of visual impairment or what supports he might need in regards to this diagnosis. Plans offered little indication of how each individual spent a majority of the day. A description of each individual's day along with needed supports identified by assessment should be included in PSPs. The facility was in the beginning stage of ensuring assessment information was used to develop plans that outlined all supports and services. The QMRP Coordinator recognized the challenges in achieving compliance with this provision and was working with QMRPs to ensure progress in this area.	

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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).	Observation throughout the facility's day and residential programs revealed that individuals were involved in minimal programming that would provide meaningful learning opportunities to develop new skills and increase opportunities for community integration. A sample of 10 PSPs (see list above in Documents Reviewed) was reviewed for indication that individuals and/or their LARs were offered information regarding community placement as required. All 10 (100%) indicated that this discussion took place at the annual PST meeting. In 10 of 10 (100%) instances, the team concluded that the individual should continue to reside at SASSLC. As evidenced by the summary below, this discussion, however, was not always adequate (also see section T of this report). • Individual #16's PST members agreed that they were not able to determine his awareness of alternative living options due to his inability to hear and speak. His family was present at this meeting and indicated that they were aware of living options, but pleased with his care at SASSLC, so did not want to pursue alternate placement. The only barriers noted to placement were that he enjoyed running in open spaces and did not have pedestrian skills. The team did not develop outcomes to address expanding his communication skills, other than to learn the sign for medicine. He had an outcome to attend "off campus" activities, but strategies did not include teaching pedestrian skills. • Individual #78's PSP indicated that his living preferences were unknown. He had the opportunity to tour a group home prior to the meeting, but the PSP indicated that he was "unresponsive." According to the PSP, his father informed the CLOIP representative that community living may be a good idea for certain individuals, but not for his son. Obstacles to living in a less restrictive environment were identified as two staff always present, on duty, and awake, space for a modified wheelchair, and proximity to family. These should have been discussed as supports rather than barriers to community placement. • The PSP for Individual #57 indicated that he had toured a group home and appeared to like it. The team agreed that he would benefit from placement in a smaller home if protections were in place to keep him safe, particularly in terms of his pica behaviors. His mother/LAR preferred that he remain at SASSLC. She was "not convinced that there is a home for people with kinds of challenging behaviors that her son possesses." The team concluded that he should remain at SASSLC. • The Optimistic Living Vision section of the PSP for Individual #39 noted, "After extensive conversations with Individual #39, she has not given any indication that she would prefer any other location than the SASSLC. Therefore the team will not be pursuing an alternate location at this time. The team noted that she is knowledgeable of her options, but has not made a request for alternate	Noncompliance

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		placement." Optimal living options were not discussed, nor were supports for living in less restrictive environment. • The PSP for Individual #45 stated that there were no plans for her to visit the community this year because she had "experienced some medical obstacles over the year. She was diagnosed with a hiatal hernia which has severe medical concerns." The team concluded that SASSLC was optimal placement for her at the time of her PST meeting. There were some common themes among the discussion and determination of optimal living placement in the PSPs reviewed: • Teams were not able to determine the preferences of individuals due to lack of exposure to other living options or inability to communicate choices and preferences. • Some of the individuals in the sample had prior unsuccessful placements in the community so family members were reluctant to consider community placement. • SASSLC was determined to be the safest environment for all of the individuals in the sample. PSTs need to give consideration to the following: • The primary focus of all PSTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • Communication skills, decision-making skills, and increased exposure to life outside of the facility should not be considered barriers to living in a less restrictive setting. These skills, however, are likely to support greater success and independence in less restrictive settings. • Team members need to be provided with updated training on services and supports that are now available in the community. • As evidenced throughout this report by the number of confirmed abuse and neglect allegations, injuries, incidents of substandard or compromised care, and lack of appropriate services available, SASSLC may not be the safest or optimal living environment for all individuals. The team needs to review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual. Plans still included limited opportunities for community based training. Opportunities to develop relationships and gain membership in the community were not addressed in any of the plans in the sample. Although the facility reported that some training was occurring in the community, it was not evident in PSP outcome documentation. Plans	

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		will need to include community based teaching strategies to ensure that training is consistent and measurable. There was no indication that employment outside of the facility had been actively pursued for any of the individuals in the sample. 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. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The facility's POI indicated that no new initiatives had been implemented at the facility to address this provision. The PSPs reviewed continued to include a list of the individual's preferences and interests. For individuals in the sample, this list was used as the basis for outcome development. Limited exposure to new activities meant that this list was often limited. As noted in F1c, the facility was not identifying a comprehensive list of individualized preferences. In order to meet compliance requirements with F2a1, PSTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. PSPs reviewed were reflective of the lack of options and programming available at SASSLC. . As noted in F1e, outcomes were not functionally implemented in the community. There was very little focus on priority skills such as communication, socialization, and community integration The PSTs should have developed action steps that would facilitate community participation while providing learning opportunities for skills that could be utilized for positive community integration. The PSTs should have developed action steps that would facilitate community participation while learning valuable skills needed in the community for most individuals in the sample. Currently, little structured training was occurring in the community.	Noncompliance

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		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. Progress made on each vocational outcome should move the individual closer to community employment. It did not appear that community employment was a real consideration for the individuals in the vocational program. Work outcomes tended to be just a continuation to work in the same job without any measurable outcomes to learn new work skills. While all 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. Observation of activities occurring in the day programs and homes revealed that many individuals at the facility were still engaged in nonfunctional isolated activities with very little social interaction, such as working puzzles, watching TV, and completing workbook pages during the evening hours. Active treatment occurring in small groups did not generally address individual preferences as stated in the PSP. The facility's POI indicated noncompliance with this requirement. No new initiatives had been taken to address compliance with F2a1. The monitoring team agrees with that assessment. DADS had recently contracted with a set of consultants to help bring about change in the overall PSP process, including development and implementation. During the week of the onsite review, the monitoring team had the opportunity to meet with one of the consultants and learn about the plan that he and the other consultants had for SASSLC.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. For example, rarely was the focus of the PNMP identified as a measurable outcome in the PSP actions. PSPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs. Outcomes were not written to address all preferences and were not written in a way that progress or lack of progress could be consistently measured. For example: • The PSP for Individual #141 included an outcome to correctly identify a quarter with hand over hand assistance. This outcome did not clearly relate to any of his	Noncompliance

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		stated preferences. It was also not clear what would constitute a successful attempt since hand over hand assistance would be used to make the selection. One of his stated preferences was developing vocational skills. The PSP did not identify what type of work he enjoyed, so it was not known how his vocational outcome to pick up an object related to his preference to work. He had a communication outcome "to produce one message using voice output device." Again, the skill acquisition plan (SAP) did not identify what would constitute a successful attempt for recording data. The SAP instructed staff to use the various switches around the home, for example, the "I'm hungry" switch in the dining room, "I want to go outside" by the door, or "time for medication" by the nurse's station. He needed staff assistance to propel his wheelchair to the desired switch, so without the ability to communicate his preferences, it was unknown how staff would know which switch he wanted to use at any particular time. o Having a switch on his lap tray that offered a variety of choices based on his known preferences would have been more functional. • Individual #275 had been referred for community placement. He had an outcome to participate in money management. Steps to achieve this outcome included (1) understand the terms banking and saving, (2) understand why we save money, (3)understand what a bank is for, (4)understand how saving money works, and (5) understand where we save money. Strategies did not include what would be considered a correct response to any of these steps. o A more functional outcome would have been to support him to do his banking in the community or actually save money from his paycheck and review his balance as funds were added. He had another outcome to learn the different medications that he was taking. It was not clear how this related to his preferences. One of the action steps stated "will gain better control over what medications he is taking and why". This was not measurable and it was not clear how this outcome would lead to "better control" over what medications he is taking. His only outcome related to community integration stated that he would have the opportunity to attend at least one off campus activity weekly. There was no outcome for functional learning in the community. • Individual #310's outcomes included an outcome to maintain appropriate behavior. A step to achieve that outcome was stated as "decrease frequency of tantrums to 0 episodes." There was no definition of "tantrum" so that staff could accurately report the occurrence. Additionally, she had limited communication skills, so it was likely that her "tantrums" were her only effective means of communicating frustration. The PST did not address teaching functional communication skills other than to continue skills that she already exhibited.	

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		Teams were not consistently identifying measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. See section F1e and T1b for additional comments related to this requirement.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted in F1d, recommendations for assessments were not integrated into supports for individuals. Teaching strategies in the SAPs reviewed did not integrate recommendations from PNMPs, BSPs, and other assessments. 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.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	For the goals and objectives identified, PSPs generally described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement. The following provide some additional examples: • Individual #310 had a service objective to have the opportunity to participate in an off campus activity. The method stated that she would be given a choice of which activity she would like to attend and that staff should ensure that she is dressed appropriately and has on the appropriate shoes for the activity. Her communication assessment noted that she communicated through body movement, eye contact, facial expressions, and gestures, but communication strategies were not integrated into her plan for choosing the activity. Methods were not specific enough to ensure consistent implementation. • Individual #39 had a training objective to wash her laundry. The strategies were generic and did not include specific supports that she would need to complete the task. For example, her PNMP stated that she was to use a gait belt or wheel chair to move around the house. Teaching strategies stated to assist her as needed with taking her dirty clothes to the laundry. Recommendations from her PNMP should have been incorporated into teaching strategies. She also had an outcome to use the bathroom at night. The task analysis stated that she would go to the bathroom independently. The teaching strategy noted "this training is important to assist her not to urinate in the bed. If staff walk in her room and she has already urinated, she should get up and clean the urine (replace bedding, clean floors, etc.). If she completes a step independently, place a (+) in the corresponding box." It was not clear if staff were collecting data on when she	Noncompliance

#	Provision	Assessment of Status	Compliance
		went to the bathroom or when she cleaned her bed or floor. • Individual #10 had service objectives to purchase a personal item and participate in cooking class. The team had not developed methods that described supports needed for her to successfully complete these outcomes. The facility POI indicated that the facility was in compliance with F2a4. It noted that the team process addressed methods of implementation at least quarterly/annually. It further noted that data were collected and reviewed. The monitoring team did not agree with the facility's self rating. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The facility had made little progress towards compliance with this item. As noted throughout the report, outcomes in the PSPs reviewed did not always adequately address supports needed by the individual to achieve the outcomes. Strategies to support functional learning were not included in the PSPs in the sample. As noted throughout other sections of this report, there is need for improvement in the development of plans to address risk for individuals, psychiatric treatment, healthcare issues, PNM needs, and behavioral support needs. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Little training was completed in a natural setting, such as the home or community. Individuals attended group sessions during the day and in each group worked on training that was a focus of that group rather than a priority for that individual identified by the PST. There were certain constraints due to the fact that individuals were living at the facility rather than in the community that limited functional training opportunities. For instance, individuals did not participate in meal preparation and service. They did not bank in the community, or go to the pharmacy to get their medication. They did not have routine access to stores, libraries, and other facilities. They were not able to choose, join, or regularly participate in group and social activities such as church, art, and gym classes. The facility's self rating for F2a5 was substantial compliance. The POI noted that the PST addressed the individual's needs for services and supports to include goals which were functional, practical, and data driven. The monitoring team, as noted above, was not in agreement.	Noncompliance
	6. Identifies the data to be collected and/or	PSPs identified the person responsible for implementing service and training objectives and the frequency of implementation. PSPs also included a column to note where	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	information should be recorded. Data collection sheets were generated for some service objectives, but not all. A person was assigned to collect data, but it was not clear what happened with the information gathered from this process in terms of making changes when an outcome was completed or when there was no progress made outside of the quarterly reviews. Training program/data collection sheets were generated for training objectives. This form included what data would be collected, the frequency of data collection, who would collect data and who would monitor data. Again, it was not clear what would happen with the information gathered from the data sheets in terms of modifying plans when needed outside of the quarterly reviews. Outcomes developed as part of a risk action plans were not included in PSP outcomes. The risk action plan indicated the frequency of data collection and the person responsible for monitoring the plan, but did not indicate what data should be collected or who would collect the data. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
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. Please refer to these sections of the report regarding the coordination of services as well as section G regarding the coordination and integration of clinical 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 fully developed quality assurance system in place to effectively monitor the quality of PSPs. The monitoring team found a lack of coordinated supports and services throughout the facility. Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. As discussed with the facility during the monitoring visit, PSTs will need to work together to develop PSPs that coordinate all services and supports. The facility's POI indicated that it was in substantial compliance with this item, however,	Noncompliance

#	Provision	Assessment of Status	Compliance
		the facility did not have a process to ensure coordination of all components of the PSP. The monitoring team did not agree with this self-rating.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current PSPs were not available in eight of 31 (26%) of the records, indicating that support staff did not have the PSPs and, therefore, the information necessary to fully implement the PSP. This was noted to be a problem during the last monitoring visit. The facility had implemented a plan to monitor individual records for the presence of a current plan. Although, this was an improvement from the last monitoring visit, there were still a significant number of plans not available to staff providing supports. The facility needs to revise the monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility. The PSP is a document that is integral to overall service provision, and ensuring it is available in the record seems to be a relatively easy clerical task. As noted throughout this report, plans were not always written to ensure that staff would know how to consistently provide all necessary supports. The facility remained out of compliance with this requirement.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	A review of records indicated that the PST routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. For example, • The PST met outside of the quarterly review meetings for Individual #18 when concerns were noted regarding the use of his BIPAP mask. The team developed recommendations to address the concerns. His team also met outside of the quarterly review meeting when monthly assessment showed that he was gaining weight. A consultation with the dietician was requested and the team met again to follow up on new recommendations. It was not evident, however, that teams had a process in place to revise PSPs when there was lack of progress towards PSP outcomes or when outcomes were completed or no longer appropriate outside of schedule quarterly review meetings. The facility POI indicated that a process to address this item was in development, and assigned a self-rating of noncompliance for F2d The facility had a quarterly review process in place to look at progress towards outcomes, changes in health and behavioral status, therapy recommendations, level of	Noncompliance

#	Provision	Assessment of Status	Compliance
		supervision, injuries and restraints, family, and participation in community and social activities. The facility will need to implement a system to monitor services and supports monthly and ensure that plans are revised and updated as necessary. When plans are revised, there needs to be a system in place to ensure that all support staff are aware of changes and new plans are being implemented as written. A sample of quarterly reviews was reviewed for compliance with this provision. The sample included quarterly reviews for Individual #78, Individual #73, Individual #18, Individual #10, Individual #30, Individual #20, and Individual #96. The form included a section to note progress or regression on all service and training objectives monthly and a place for QMRPs to comment quarterly on the progress or lack of progress. Comments regarding the quarterly review process are below. • The quarterly review for Individual #30 dated 6/29/11 noted "maintained – continue with no change" for a majority of the service objectives reviewed. No further comments were made as to the status of the objective. For other objectives, comments were made as to the status, but it was not clear if follow-up was completed when warranted. For example, he had an outcome addressing seizure activity. The QMRP noted that the neurologist had ordered an EEG, but the results were not documented. There was no action taken to address this. • The quarterly review dated 7/1/11 for Individual #20, also documented "maintained" for a majority of the service objectives reviewed. The April 2011 monthly comment for her service objective addressing infections noted 4/2/11-4/6/11 pneumonia. There was no further comment regarding her status or the team's efforts to address this. • The monthly review dated 6/29/11 for Individual #96 noted that he had regressed on his outcome to "remain free of eye infections." Comments for March 2011 and May 2011 indicated that he had an eye infection both months. There were no additional comments regarding treatment or prevention strategies implemented. The quarterly review of medication indicated that an order clarification was needed for the indication for Ergocalciferol. There was no further comment regarding follow-up to this recommendation. There was also a note that he had experienced a breakthrough seizure on 10/30/10 with a recommendation to consider obtaining a neurology consult. Follow-up was not documented on this recommendation. • For Individual #78, the quarterly review dated 2/25/11 documented follow-up on his service objectives for respiration and skin breakdown when regression was noted. He had a service objective to maintain his ideal weight range that stated he would not gain or lose more than 5% of his body range over a quarter. Data recorded for the months during the quarter noted that he went from	

#	Provision	Assessment of Status	Compliance
		weighing 96 pounds in November 2010 to 89 pounds in January 2011. The quarterly comment stated "maintained. Continue without change." The monthly data recorded for operating a switch showed regression. The quarterly comment for this outcome stated, "Regressed. Continue without change." There was no further comment regarding what might have caused the regression or how the team would address it. • Similar findings were noted for the other quarterly reviews in the sample. Quarterly reviews should address the lack of implementation, lack of progress, or need for revised supports. Follow-up on issues occurring during the quarter should be documented. As the facility continues to progress toward developing person centered plans for all individuals, 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. QMRPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow up on issues.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive	In order to meet the Settlement Agreement requirements with regard to competency based training, QMRPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive PSP document. A review of training transcripts for 23 employees indicated that 23 (100%) of the 23 had completed the new training on PSP process entitled Supporting Visions. As evidenced by findings throughout this report, training on the implementation of plans was not ensuring that plans were being implemented as written The facility's POI indicated noncompliance with this requirement. The monitoring team agreed with that assessment. The QMRP Coordinator was aware of deficits in the implementation of the PSP and was providing additional training to QMRPs in monitoring for this requirement. The monitoring team understands that additional consultative support, training, mentoring, and coaching were going to be provided by the state office over the next few months.	Noncompliance

#	Provision	Assessment of Status	Compliance
	updated competency- based training when the plans are revised.		
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, all (100%) had been developed within the past 365 days. As noted in F2c, a sample of 31 plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 26% of the plans in the sample were not current. Some plans were over a year old indicating that in some cases, PSPs may never have been distributed, if developed. This is concerning for a number of reasons. The PSP should be the plan that ensures all support staff have information regarding services, risks, and supports for individuals in the home. Without it, staff did not have the tools that they. Additionally, as noted in F2d, plans were not always revised as needed. The facility was rated as being out of compliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility had 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 still in the initial stages of development and implementation (also see section E above). The QMRP Coordinator was both attending and monitoring a sample of PSP meetings and reviewing a sample of PSPs using new monitoring tools. She reported that she was providing immediate feedback and training to QMRPs. These appeared to be good steps towards developing a QA process as required by this provision item, however, the QMRP Coordinator should work with the QA director to create a thorough and comprehensive process to address this provision item. QMRPs should be held responsible for not distributing 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.	Noncompliance

Recommendations:

1. Team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year (F1).

2. When individuals are not present for meetings, the QMRP should document attempts made to include the individual or LAR and how input was

gathered to contribute to planning if the individual did not attend the meeting. When individuals consistently refuse to attend meetings, the team should look at what factors contribute to the refusal to attend and brainstorm ways to encourage participation (F1b).

3. All team members will need to ensure assessments are completed updated when necessary and accessible to all team members prior to the PST meeting to facilitate adequate planning. Consideration should be given to capturing and sharing information regarding possible areas of interests while individuals are in the community (F1c).

4. A description of each individual's day along with needed supports identified by assessment should be included in PSPs (F1d).

5. Provide additional training to PST members on developing and implementing plans that focus on community integration (F1e, F2a).

6. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility when these are identified as barriers to living in a less restrictive setting (F1e).

7. Team members need to be provided with updated training on services and supports that are now available in the community (F1e).

8. PSTs should review each individual's history of incidents and injuries, any decline in health status, or regression in skills and hold an integrated discussion regarding whether or not the facility is able to provide the best care possible for each individual (F1e).

9. PSTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day (F2a1).

10. Meaningful supports and services should be put into place to encourage individuals to try new things in the community. The PSTs should develop action steps that will facilitate community participation while learning skills needed in the community (F2a1).

11. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs (F2a2).

12. PSTs 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 (F2a3).

13. The facility should ensure that plans are developed and implemented in a timely manner. (F2a3, F2c, F2f, F2g)

14. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress (F2a4).

15. PSTs should develop outcomes that are practical and functional at the Facility and in community settings (F2a5).

16. Outcomes should identify the data to be collected and/or documentation to be maintained, the frequency of data collection, the person(s) responsible for the data collection, and the person(s) responsible for the data review (F2a6).

17. Implement a monitoring system to assure PSPs are accessible to all staff providing supports to individuals at the facility (F2c).

18. Develop a process in place to revise PSPs when there is lack of progress towards PSP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings (F2d).

19. QMRPs should ensure that direct care staff has current information needed to support each individual safely and consistently, and that all plans are being implemented as written (F1, F2a3, F2c).

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, undated, but current o SASSLC policy lists, 8/1/11 o List of typical meetings that occurred at SASSLC o SASSLC POI, 8/2/11 o SASSLC Sections G and H Settlement Agreement Presentation Book, which included: • Variety of documentation examples for a number of different activities related to the way services were integrated, such as trainings provided by clinical pharmacist and psychologist, ADRs, DUEs, polypharmacy and chemical restraint information, medication error data, psychiatry clinic notes, and PNMT and P&T Committee minutes. o Presentation materials from opening remarks made to the monitoring team, 8/15/11 o QAQI Council meeting minutes listed in section E above o Review of records listed in other sections of this report o New facility-specific policy detailing activities related to the provision of integrated clinical services, 7/28/11 o Samples of daily morning clinical meeting minutes, 6/15/11, 6/16/11, 7/18/11 Interviews and Meetings Held: o Dr. Carmen Mascarenhas, M.D., Medical Director, Dr. Lilani Muthali, DADS medical services coordinator, Jodie Bailey, Medical Department Program Compliance Nurse o Ralph Henry, Facility Director o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors 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 QAQI Council Meeting, 8/18/11 o Three Medical Director's daily morning clinical meetings o Four psychiatry clinics
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11.

	The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the medical director wrote a sentence or two about what tasks were completed and/or the status of each provision item. The facility reported that the medical audits being used to self-assess section L would also apply to sections G and H. This, however, did not appear to be sufficient because sections G and H refer to all clinical services, not only medical services. Regarding the POI for item G2, the review of home 673 appeared to be a type of self-assessment, but it needs to be incorporated into a broader system of self-assessment for section G in order to be useful to the facility. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item, however, the medical director self-rated the facility as being in noncompliance with both provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team. The SASSLC action steps were only for G2. The steps appeared reasonable and appropriate for meeting G2, however, there were no action steps for G1. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: SASSLC continued to make progress with this important provision and was taking action to address it. The medical director was the lead for this provision and was knowledgeable about the provision and steps that would bring the facility towards substantial compliance. The facility had recently created a new position, a medical program compliance nurse. This will likely greatly assist the facility towards meeting this provision's requirements. 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. 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. Even so, the medical director developed a facility-specific policy that described how 13 activities should be conducted to support and demonstrate that clinical services were being provided in an integrated manner. The policy defined these activities in a way that could possibly be used to self-assess whether or not the activities are occurring in the integrated manner intended.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	SASSLC made continued progress towards meeting the items of this provision. Integration of clinical services was taken seriously by senior clinical and management staff. They were very aware of this provision and had taken actions towards achieving substantial compliance. The medical director was the facility's lead manager for this provision (as well as for provision H). To assist all of the facilities in achieving substantial compliance with this provision, the monitoring teams recently presented to DADS and DOJ a listing of activities in which the SSLCs might engage that would indicate the occurrence of the provision of integrated clinical services. This list (i.e., criteria) was being reviewed by DADS and it is expected that over the next several months, this list will be finalized and can be used by each facility. The medical director recently wrote and implemented a facility-specific policy and procedure. It described 13 activities and the way these activities should be conducted to promote (and demonstrate) the provision of integrated clinical services. Some of these meetings and committees had been occurring at SASSLC for some time. What was new was that the activities were now to specifically operate in a way to promote integrated clinical services. Thus, the policy/procedure was an excellent step towards substantial compliance and, moreover, the definitions/descriptions in the policy can provide the detail needed for the facility to self-assess whether or not the activities are occurring as intended by this new policy (i.e., in a way such that clinical services are provided in an integrated manner). The policy had not yet been through the full process of approval as required (see section V2 below), including review by DADS central office. The monitoring team believes that DADS might find this policy to be a good model for the other SSLCs. Thus, the combination of this SASSLC policy plus the suggestions made by the monitoring teams to DADS and DOJ might lead to a set of criteria to be use by all SSLCs as minimum requirements for the demonstration of the provision of integrated clinical services. A draft DADS statewide policy had also been available for a number of months. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		clinical services were occurring. Monitoring team examples: Examples of integration of clinical services were observed by the monitoring team, or that were planned to occur, are listed below (in no particular order of importance). • The medical director's daily morning clinical meeting was observed throughout the week of the onsite review. This morning review was led by the medical director and attended by all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, and the psychologist on call (or designee). The events of the past 24 hours were discussed including hospital admissions, transfers, use of emergency drugs and restraints. At Friday's meeting, there were 12 attendees. In addition to the typical department updates, the group discussed the problem of consultation notes not accompanying the individual to the consulting physician. After a brief, but focused discussion, the group came up with a plan to address the problem (the medical compliance nurse was to attend the next meeting of nurse casemanagers to discuss and solve). • PCPs attended PST and PNMT meetings more frequently than they had been. • Nurse case managers were attending psychiatric clinic. • Neurology appointments held on campus were attended by the medical director, treating physician, and psychiatrists. Consultation notes generated from the clinic were a collaborative effort. • The dental clinic was involved in many collaborative efforts across the facility: o The dental director, psychiatrist, and PCP worked together to ensure that pretreatment sedation for dental clinic was utilized appropriately. Documentation of recommendations occurred on the consultation form. o The dental director and PCP worked together to identify individuals at high risk for aspiration in order to provide the appropriate special supports. o The dental director shared valuable information related to oral hygiene and failed appointments with psychology staff in order to develop strategies to overcome barriers to treatment. o The clinical pharmacists attended neurology and psychiatry clinics and made recommendations to the treating physicians. Additionally, the pharmacists were involved in training staff about side effects of psychotropic medications. • The QDRRs were completed by the clinical pharmacist and forwarded to the PCP and psychiatrist when appropriate. The PCPs and psychiatrists indicated consideration or non-consideration of the recommendations provided. Compliance with this requirement was excellent. Compliance with	

#	Provision	Assessment of Status	Compliance
		documentation in the IPN of this decision was less consistent. • 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. • PSTs and additional clinicians came together when the challenges presented by specific individuals were extraordinary challenging (e.g., Individual #170, Individual #83, Individual #276). • This was also noted by the unit directors. • Unit directors were aware of the need and importance of integrated clinical services. The unit directors acknowledged the way the monitoring team members modeled the way to have integrated, cross discipline participation in team discussion and case review. • The facility director was aware of the need and importance of integrated clinical services. He also told the monitoring team about the types of integration that were occurring at the facility. • Integrated progress notes were being used. Other examples indicated that more work needed to be done: • 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 integration of clinical care was to occur during the upcoming year. • The PSPs of over half of the 20 individuals reviewed (in section M below) failed to integrate their health needs and risks and ensure that they received the clinical services they needed. For example, Individual #39 was prescribed a weight reduction diet, but she lost weight at a much higher rate than what was desired. • Consultation and case collaboration between psychiatry and psychology remained limited and needed improvement. To that end, during this onsite review, a meeting was arranged with leadership from psychology and psychiatry. Per the discussion during this meeting, regular weekly contact between these two disciplines was planned. • Psychology was not involved in helping program developers with writing SPOs. • There was limited collaboration of the development of communication plans between psychology, speech therapists, and home staff. • 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 programming.	

#	Provision	Assessment of Status	Compliance
		• The PNMT tended to identify interventions without a clear rationale to guide what they needed to track to determine efficacy. • Some of the participants in the PNMT process did not all come well prepared for the meeting, and did not take initiative to get key information, but rather waited for someone else to get it or give it to them.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	As noted in the previous monitoring report, the facility appeared to be responsive to recommendations from non-facility clinicians. There was, however, sufficient evidence that the PCPs reviewed consultation reports. Most reports included the initials of the PCP and the date of review. Documentation in the IPN was frequently not done. The facility's internal audits completed by the medical program compliance nurse found compliance with this requirement to be relatively low. Therefore, recently, the medical director initiated procedures, and conducted training with medical staff for: • Physicians to promptly review consultations from non-SASSLC clinicians • Physicians to document acceptance or rejection of the recommendations in the integrated progress notes. • The recommendations to be forwarded to the QMRP (PST) for incorporation into the PSP. The effect of these changes was recently self-assessed by the facility for one home. Its ongoing implementation will be reviewed at the next onsite review. The facility's Hospital Liaison regularly visited individuals who were hospitalized. During her visits, she met with the individuals' non-facility clinicians to both obtain and offer information to improve the coordination of care and ensure safe and smooth discharge/transfer back to SASSLC. The Hospital Liaison's hospital reports were comprehensive and documented the individuals' receipt of care and treatment, response to and effectiveness of care/treatment, and outcomes of non-facility clinicians' interventions/consultations/recommendations. The Hospital Liaison's reports were distributed to the SASSLC Medical Director and individual's PST and filed in the individuals' records. Finally, the medical department should maintain a report log that lists all non-facility consultations and tracked them from the date received until the final report was obtained. This listing might be useful to the recordkeeping department for their conduct of quality assurance reviews of the active record (see section V3 below).	Noncompliance

Recommendations:

1. DADS should develop and implement policy (G1 G2).
    a. The policy should include items agreed upon by the monitoring teams, DADS, and DOJ.
    b. The policy should consider including items (and possibly definitions) in the SASSLC facility-specific policy.

2. Put the facility-specific policy through the required approval process (G1).

3. Develop a system to assess whether or not integration of clinical services is occurring (i.e., self-monitoring). This will require creating measurable actions and outcomes (G1).

4. Address the items above in G1 under "Other examples indicated that more work needed to be done" (G1).

5. Consider the inclusion of a statement regarding the integration of clinical services in each individual's PSP document (G1).

6. Develop and maintain a list of all non-facility consultations, per individual (G2).

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o Organizational chart, undated, but current o SASSLC policy lists, 8/1/11 o List of typical meetings that occurred at SASSLC o SASSLC POI, 8/2/11 o SASSLC Sections G and H Settlement Agreement Presentation Book, which included: o Presentation materials from opening remarks made to the monitoring team, 8/15/11 o QAQI Council meeting minutes listed in section E above o Review of records listed in other sections of this report Interviews and Meetings Held: o Dr. Carmen Mascarenhas, M.D., Medical Director, Dr. Lilani Muthali, DADS medical services coordinator, Jodie Bailey, Medical Department Program Compliance Nurse o Ralph Henry, Facility Director o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors 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 QAQI Council Meeting, 8/18/11 o Three Medical Director's daily morning clinical meetings o Four psychiatry clinics
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 7/1/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the medical director wrote a sentence or two about what tasks were completed and/or the status of each provision item. These provided some useful information to the monitoring team regarding some of the activities conducted since the last onsite review. The POI did not indicate how the findings from any activities of self-assessment were used to determine the

	self-rating of each provision item. The medical director self-rated the facility as being in noncompliance with all seven provision items. The monitoring team agreed with these self-ratings. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). There was only one action step, it was for H1, and it was only for medical assessments. The facility will benefit from the eventual development of a self-monitoring tool for this provision of the Settlement Agreement. Perhaps this can occur after the state policy is finalized.
	Summary of Monitor's Assessment: During the week of the onsite visit, the monitoring team had the opportunity to meet with the DADS central office medical coordinator and the SASSLC medical director regarding section H. Based on that discussion, it appeared clear that the state and the facilities need to determine how to proceed regarding section H across all of the SSLCs, including the determination of the detail, definition, expectations, and criteria for all of the items of this provision. Because much work needed to be done, overall, it was not surprising that little progress had been made regarding all of the items of provision H. As was the case with provision G, the medical director and facility management were very aware of the importance of this provision and its components, however, they had not yet focused their attention on how to address all of the contents of the provision. Guidance from state office will be necessary. A draft state policy was disseminated. 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 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. It is recommended that the facility's QA department play a role in addressing this provision.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular	During the week of the onsite visit, the monitoring team had the opportunity to meet with the DADS central office medical coordinator and the SASSLC medical director regarding section H. Based on that discussion, it appeared clear that the state and the facilities need to determine how to proceed regarding section H across all of the SSLCs, including the determination of the detail, definition, expectations, and criteria for all of	Noncompliance

#	Provision	Assessment of Status	Compliance
	basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	the items of this provision. Because much work needed to be done, overall, it was not surprising that little progress had been made regarding all of the items of provision H. As was the case with provision G, the medical director and facility management were very aware of the importance of this provision and its components, however, they had not yet focused their attention on how to address all of the contents of the provision. Guidance from state office will be necessary. At SASSLC, regarding provision H1, some work had been done to develop a new annual medical summary and problem list, but provision H requires that all clinical assessments be managed. Therefore, a plan, implementation, and review of outcomes will need to occur across all areas of clinical service. For this provision item, H1, the state 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). At SASSLC, the medical staff conducted sick call daily based on the assigned caseload. Assessments were usually in response to acute changes or hospital returns. Quarterly assessments were completed. The quarterly assessments were forwarded to the treating psychiatrist for review. These assessments were not consistently found in the record sample reviewed. Further, individuals' nurses had not consistently notified the individuals' physicians in a timely manner of significant changes in the individuals' health status and needs. There was a pattern of failure by the nursing department to ensure that emergent changes in individuals' health status, risks, and needs were identified, assessed, and addressed in a timely manner, reported to physicians, and closely monitored and evaluated until resolution. There was also evidence of failure to ensure that ACPs were developed and implemented in a timely manner, and/or HMPs were reviewed and revised as significant changes occurred. There were many lapses in follow-up to ensure that individuals who suffered significant changes in their health status were monitored and/or evaluated by nursing until resolution of their health changes/problems. The psychiatrists, due to time constraints, were slowly completing comprehensive psychiatric evaluations as time allowed. A total of 23 individuals had undergone	

#	Provision	Assessment of Status	Compliance
		evaluations using the required Appendix B format. Of these 23, only 14 were complete and followed the Appendix B format. On the other hand, psychiatrists had, over the previous six months, revised the diagnosis and justification for prescription of psychotropic medication for 79 individuals. Psychology assessments were not consistently complete. Functional assessments were not adequate for the majority of individuals with PBSPs. OT/PT assessments were generally conducted on an annual basis, and issue-specific consults were completed upon referral or change in status.	
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, however, it was a priority of the new medical program compliance nurse. She described what she was doing and her plan for moving forward to look at whether the diagnoses fit the indications and at indications compared to diagnoses and medications. Integrated records and other documents reviewed demonstrated that, generally, the appropriate ICD-9 nomenclature was used. In psychiatry, many of the diagnostic revisions gave comprehensive reviews of the diagnostic criteria/symptoms that an individual was experiencing, such that a specific diagnosis was assigned. Many more assessments and evaluations, and the assignment of corresponding DSM diagnoses, however, still needed to be completed. The majority of nursing assessments consistently failed to accurately reference complete lists of the individuals' active medical problems.	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. Facility self-monitoring might include an item indicating whether there were any examples of interventions being clinically inappropriate and/or provided later than clinically appropriate. The medical staff responded to changes in status by conducting assessments and providing treatment. For the most part, the responses appeared to be timely. Across the majority of the 20 sample individuals (listed in section M), their physician prescribed treatments and interventions were based upon timely assessments, diagnoses, and medical plans of care. In addition, they conducted follow-up until the medical problem was resolved.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Psychiatry was an area where increased collaboration with psychology would be appropriate, specifically with increased attention to non-pharmacological treatment interventions. Many of the intellectual assessments in the psychological assessments were over five years old.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The 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, as well as the other, items of provision H. The medical director reported that the following databases were developed at SASSLC. Further, it was the monitoring team's understanding that clinical protocols for a variety of medical disorders and conditions were being developed at the state central office, but had not yet been disseminated for implementation. • Seizure database • Bowel management program • Tracking of ER visits/hospitalizations • Database for tracking preventive services, such as colon cancer screening and mammograms was completed. • Information regarding any overdue items was forwarded to the nursing department so that tests could be scheduled and performed. At the individual level, there was no evidence that the goals/desired outcomes of individuals' HMPs (i.e., the indicators of efficacy of treatments and interventions) were established with input from the individuals and their caregivers, in accordance with evidence based practice, or revised to reflect the changing needs/desires of the individual and their progress/lack of progress toward the achievement of their health goals. The psychiatrists had begun to indicate the time period for expected pharmacological benefit, however, as discussed in sections J and K below, there were numerous problems with the utilization of clinical indicators (i.e., reliable data). There were only a few intervention plans developed by PT and speech, and none were developed by OT.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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, as it develops procedures for provision item H4.	
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. Recently, the way in which the facilities determined and managed risk was overhauled. The health status team system was discontinued and managing risk was incorporated into the PSP process (see section I below). 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 medical director reported that data collection was beginning. It was to look at all healthcare services provided. The information was to be entered into a database. She reported that home 673 was going to be the first home to which this would be implemented. Overall, at SASSLC, although members of nursing leadership (nurse managers and charge nurses) reported that they conducted regular monitoring of individuals' health status, there was no evidence that nurse managers and/or charge nurses made rounds on a regular basis and no evidence that observations were consistently reported, recorded, and/or acted upon in a timely manner. As health status had 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.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	No work had been done for this provision item, that is, 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. A comprehensive set of clinical indicators had not been established. Numerous clinical guidelines were being reviewed at the state level. In nursing, despite changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes, the majority of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		individuals' HMPs and ACPs were not revised, and they did not reflect the most current conditions and intervention strategies. In psychology, there was no evidence that PBSPs were modified based on individual indicators (i.e., behavioral occurrences).	
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.	Noncompliance

Recommendations:

1. State office and the facilities should work together to determine how they are going to address all of the seven items of this provision. Therefore, specific recommendations for each of the seven provision items are not presented here (H1 – H7).

2. Develop and implement policy. Specifically indicate in the policy how it addresses each of the seven provision items of provision H (H1 – H7).

3. Ensure that all clinical services are addressed by the facility, not only medical activities (H1 – H7).

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 (H1 – H7).

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o At Risk/Aspiration Pneumonia Initiative Frequently Asked Questions o DADS Integrated Risk Rating Form dated 12/20/10 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 Aspiration Pneumonia/Enteral Nutrition Evaluation Form 12/29/10 o Aspiration Triggers Data Sheet o SASSLC POI for Section I o List of individuals seen in the ER or hospitalized since 8/1/10 o List of individuals with fractures or sutures since 8/1/10 o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individuals at risk for choking o List of individuals at risk for GERD o List of individuals at risk for aspiration o List of individuals at risk for weight issues o List of individuals at risk for falls o List of individuals at risk for dehydration o List of individuals at risk for osteoporosis o List of individuals at risk for constipation o List of individuals with choking incident since the last review o List of individuals diagnosed with pica o List of individuals who are non-ambulatory or require assistance with ambulation o List of individuals requiring mealtime assistance o List of individuals requiring enteral feeding o List of individuals who have pain, including chronic and acute o List of individuals with poor oral hygiene o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o List of top ten individuals causing peer injuries for the past six months. o List of Incidents and Injuries since 2/1/11 o PSPs and relevant assessments for determining risk: • Individual #73, Individual #18, Individual #10, Individual #78, Individual #57, Individual

	#275, Individual #342, Individual #170, Individual #39, Individual #45, Individual #284, Individual #310, Individual #110, and Individual #141 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QMRPs in homes and day programs o Carmen Mascarenhas, MD, Medical Director o Daisy Ellison, Psychology Coordinator o Audrey Wilson, QMRP Coordinator Observations Conducted: o Observations at residences and day programs o Annual PSP meetings for Individual #205 and Individual #286 o PST Integrated Risk Rating demonstrations/discussions for Individual #108 and #170
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding how the facility carried out the mandate (e.g., when an Individual identified as At Risk during the PSP, the discipline in attendance makes recommendations). The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to each of the three provision items in section I. 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. The monitoring team was in agreement with these self-ratings. It was unclear from a review of the POI how SASSLC came to this self-rating.
	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 risk, and a risk action plan had been developed. • Risk Guidelines had been developed to be used by PSTs in rating risk factors. • A new initiative had been implemented to address aspiration pneumonia. A tool had been

	developed to identify individuals at risk for aspiration. 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. SASSLC had taken minimal steps towards compliance with this provision including: • Employees had attended webinar training on the at risk policy in January 2011. • Implementation had begun of the new risk action plan for individuals determined to be at risk. Health care plans were being developed from the risk action plans. As noted throughout Section I, the monitoring team did not find that PSTs were accurately identifying risk for individuals, even with the new process. 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.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy, At Risk Individuals 006.1, required 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 beginning in February 2011. 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. Each was to be rated according to how many risk indicators applied to the individual's case. A risk level of high, moderate, or low was to be assigned for each category. The facility captured data in a number of ways that should have been useful to identify risks for particular individuals, but it was not evident that the data was always being used to identify risks. For instance, Individual #209, Individual #159, Individual #127, Individual #41, and Individual #106 each had three or more falls since 1/1/11. None of these individuals were identified as being at risk for falls on the facility master list of risks.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility had identified a target list of individuals at risk for aspiration. Twelve individuals at the facility had been identified as high risk for aspiration and 44 were rated as medium risk. A list of all individuals diagnosed with pneumonia at the facility indicated that 23 individuals had been hospitalized due to pneumonia/aspiration pneumonia since 8/1/10. With the exception of Individual #259 (diagnosed with aspiration pneumonia on 5/2/11), individuals who had incidence of pneumonia were assigned a high or medium risk rating. As noted in I3, not all individuals at risk had a plan in place to address that risk. The monitoring team met with the PSTs for Individual #108 and Individual #170 during the review week to observe and discuss how the teams assigned risk ratings, as well as to demonstrate the type of interdisciplinary discussion that could occur during PST meetings. The monitoring team appreciated the PST's willingness to conduct this type of discussion with the monitoring team. In the meeting for Individual #108, the team reviewed the list of risk areas that had been developed by the state office and assigned risk ratings to each area. Comments from the monitoring team are summarized below: • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. • The interrelatedness of risk factors should be considered and discussed in an interdisciplinary fashion. • Teams should be thinking about characteristics that put an individual at risk (i.e., statistical at risk) rather than just reviewing their personal history of experiencing the identified problem (e.g., someone might be at high risk for aspiration even if he or she has never had the problem). This was especially evident during the annual PSP meeting for Individual #205 (see below). The meeting regarding risk for Individual #170 was not a scheduled risk review meeting, but rather an opportunity for the monitoring team to observe and contribute to PST discussion regarding his complex health and behavioral needs. It was evident that the team had focused on addressing his immediate health care issues. For both short and long range planning, the team will need to: • Ensure integrated discussion continues to focus on his interrelated health, communication, and behavioral needs. • Consistently gather and analyze data regarding health and behavioral indicators (changes in medication, results from lab work, incidents of SIB, engagement levels, etc.) • Develop both short and long term outcomes and specific action step for achieving those outcomes.	

#	Provision	Assessment of Status	Compliance
		• Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. Observation of annual PST 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. QMRPs were responsible for attending meetings and facilitating the risk discussion. At meetings observed, the process appeared to be similar to the process that Health Status Teams were using during previous onsite reviews. The team briefly read over the indicators for each risk and corresponding disciplines assigned the rating based on the state guidelines. Clinical indicators were not considered when determining health risk ratings. There was little integrated discussion from the team and few factors were considered outside of documented symptoms and diagnoses. For example, at the annual PST meeting for Individual #205, the team determined that she was at low risk for diabetes and arthritis because she exhibited no symptoms of either. Her mother stated that both sides of her family had a history of arthritis and her father had diabetes. Consideration should have been given to family history when determining risk level. The team determined that she was low risk for weight concerns because she had lost 10 pounds over the past year and was now only 15% over her IBW. State guidelines noted risk level to be 20% over IBW. Due to her history, she actually was at risk. The team did not discuss supports that were needed to address risk that were identified. A sample of PSPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by PSTs. The following are examples where risks were not appropriately identified in documents reviewed. • Risk ratings were not identified in the PSP narrative for Individual #310. Her PSP did note that she was at risk for choking due to PICA and briefly commented on her reflux (GERD). Her Risk Rating Form indicated that she was at medium risk for seizures and osteoporosis. Neither of these diagnoses was discussed in her PSP. • The PSP for Individual #45 included a summary of the PSTs discussion of risk levels and supports needed to address risks. It was not evident that the team correctly identified all health risk and assigned appropriate ratings. For instance, she was rated as low risk for skin integrity though her PSP noted that she relied on staff for mobility and remained either in her wheelchair or bed all day. • The PSP for Individual #18 summarized the PST's risk rating discussion. Again, it was not evident that risk ratings were assigned according to actual risk. His	

#	Provision	Assessment of Status	Compliance
		PSP noted that he received all nutrition, hydration, and medications via his gastrostomy tube; he relied on staff for repositioning; and he had a history of recurrent pneumonia. He was rated as medium risk for aspiration. These combined factors placed him at high risk for aspiration. Although he had a plan in place to address skin integrity, he had seven episodes of skin issues, including skin breakdown, in the year prior to his PST meeting and relied on staff for repositioning. The team rated him as medium risk for skin breakdown. • The risk rating form for Individual #275 did not include the rationale for risk ratings. According to the form, he was low risk in all areas except cardiac disease. He was assigned a medium risk rating for cardiac concerns. He was rated as low risk for challenging behaviors, though he had five outcomes addressing behaviors. Additional examples are listed in section M5. The facility's POI indicated that the facility had given itself a noncompliance rating for this provision. The facility was not yet in compliance with this provision of the Settlement Agreement. The facility needs to ensure that present risk assignments are reviewed for accuracy, adequate plans are in place to address all risks, and all staff are trained on plans to minimize and monitor risks.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The new At Risk policy required that when an individual was identified at high risk, or if referred by the PST, the PNMT or BSC was to begin an assessment within five working days if applicable to the risk category. 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. Additionally, as noted in section F of this report, the facility did not have an effective plan for monitoring and revising supports as needed. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces 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.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>I3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.</td><td>The 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. The new policy required 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.

According to data provided to the monitoring team, of the 12 individuals rated at high risk for aspiration, five (42%) did not have a care plan in place to address the risk: Individual #311, Individual #227, Individual #143, Individual #319, and Individual #302.

There were similar findings in data provided to the monitoring team regarding the lack of care plans for individuals identified as being at risk in a number of areas as evidenced by the chart below.

<table>
<tr><th>High Risk Category</th><th>Number of Individuals Rated as High Risk</th><th>Individuals with Plan in Place to Address Risk/Percentage of Total</th></tr>
<tr><td>Respiratory</td><td>18</td><td>13/72%</td></tr>
<tr><td>GERD</td><td>4</td><td>1/25%</td></tr>
<tr><td>Choking</td><td>4</td><td>2/50%</td></tr>
<tr><td>Falls</td><td>3</td><td>1/33%</td></tr>
<tr><td>Weight</td><td>21</td><td>15/71%</td></tr>
<tr><td>Skin Integrity</td><td>7</td><td>5/71%</td></tr>
<tr><td>Constipation</td><td>3</td><td>3/100%</td></tr>
<tr><td>Seizures</td><td>11</td><td>9/82%</td></tr>
<tr><td>Osteoporosis</td><td>8</td><td>8/50%</td></tr>
<tr><td>Dental</td><td>21</td><td>17/81%</td></tr>
</table>

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 health care risk for the individuals who they were supporting. As noted throughout this report, intervention plans were often not carried out as written, therefore, individuals remained at risk.

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 or not accessible, so direct support staff did not have current information regarding risks available to them. If there is not a current PSP in the</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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. See additional comments throughout this report regarding the monitoring of healthcare risks. The facility POI indicated that the facility was not in compliance with this provision. The monitoring team agrees with that assessment.	

Recommendations:

1. 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 (I1).

2. Ensure that risk rating accurately reflect risks identified through the assessment process (I1).

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 (I1, I2, I3).

4. Ensure PSTs are monitoring progress on health and behavioral outcomes and plans are revised when necessary (12).

5. Ensure that plans to address risks are individualized to address specific supports needed by each individual identified as at risk (I2).

6. 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 (I2 and I3).

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Any policies, procedures and/or other documents addressing the use of pretreatment sedation medication o For the past six months, a list of individuals who have received pretreatment sedation medication or TIVA for medical or dental procedures o For the last 10 individuals participating in psychiatry clinic who required medical/dental pretreatment sedation, a copy of the doctor's order, nurses notes, psychiatry notes associated with the incident, documentation of any PST meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Ten examples of desensitization plans (five for dental and five for medical) o Any auditing/monitoring data and/or reports addressing the pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation are evaluated for any needed mental health services beyond desensitization protocols o Individuals prescribed psychotropic/psychiatric medication, and for each individual: name of individual; name of prescribing psychiatrist; residence/home; psychiatric Diagnoses inclusive of Axis I, Axis II, and Axis III; medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration); frequency of clinical contact (note the dates the individual was seen in the psychiatric clinic for the past six months and the purpose of this contact, for example: comprehensive psychiatric assessment, quarterly medication review, or emergency psychiatric assessment); date of the last annual BSP review; date of the last annual PSP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use o A list of individuals diagnosed with tardive dyskinesia, including the name of the physician who is monitoring this condition, and the date and result of the most recent monitoring scale utilized o Spreadsheet of individuals who have been evaluated with the MOSES and DISCUS scores, with dates of completion for the last six months o Documentation of in-service training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Ten examples of MOSES and DISCUS examination for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations o A separate list of individuals being prescribed each of the following: anti-epileptic medication

	being used as a psychotropic medication in the absence of a seizure disorder; lithium; tricyclic antidepressants; trazadone; beta blockers being used as a psychotropic medication; clozaril/Clozapine; mellaril; reglan o List of new facility admissions for the previous six months and whether a REISS screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who have had a REISS screen completed in the previous 12 months. o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: individual Information Sheet; Consent Section for psychotropic medication; personal Support Plan, and PSP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the PST, PSP, PSPA, and BSP meetings. o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that relate to the role of psychiatrists o A list of all psychiatrists including board status; with indication who has been designated as the facility's lead psychiatrist o CVs of all psychiatrists who work in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and in-service training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who have a diagnosis of seizure disorder o For the past six months, minutes from the committee that addresses polypharmacy o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy

	o Facility-wide data regarding polypharmacy, including intra-class polypharmacy. o For the last 10 newly prescribed psychotropic medications, Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; Signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger who are receiving psychotropic medication. o Name of every individual assigned to psychiatry clinic who has had a psychiatric assessment per Appendix B with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Ten comprehensive psychiatric evaluations per Appendix B performed in the previous six months o Documentation of psychiatry attendance at PSP, PSPA, BSP, or PST meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months Documents requested onsite: o Quarterly clinic update for direct care staff o New Employee Orientation medication handout o Flier regarding serotonin syndrome and neuroleptic malignant syndrome. o List of all individuals requiring chemical restraint in the previous six months. o All data presented, physician consents, progress notes and orders from Dr. Howland's clinics dated 8/17/11 regarding the following individuals: Individual #57, Individual #177, Individual #304, Individual #87, and Individual #3. o Copy of the presentation book for section J. o Five examples of specific learning objectives for dental desensitization. o All data presented, doctor's progress notes and doctor's orders from Dr. Vale's clinic 8/15/11 regarding the following individuals: Individual #332, Individual #149, Individual #193, Individual #224. o All data presented, doctor's progress notes and doctor's orders from Dr. Vale's clinic 8/16/11 regarding the following individuals: Individual #298, Individual #315, Individual #94, and Individual #111. o Ten dental desensitization plans regarding: Individual #284, Individual #88, Individual #127, Individual #108, Individual #41, Individual #288, Individual #43, Individual #330, Individual #240, and Individual #90. o These documents: • Demographic Data Sheet • Consent Section (last six months) • Personal Support Plan and addendums (last six months) • Behavioral Support Plan • Human Rights Committee review of Behavioral Support Plan • Restraint Checklists for the previous six months.

	• Annual Medical Summary • Quarterly Medical Review (last six months) • 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 #94, Individual #278, Individual #67, Individual #111, Individual #198, Individual #83, Individual #98, Individual #216, Individual #95, Individual #250, Individual #132, Individual #268, Individual #128, Individual #277, Individual #19, Individual #6, Individual #170, Individual #204. <u>Individual Interviews and Meetings Held</u>: o Sandra Vale, M.D., facility lead psychiatrist o Sandra Vale, M.D., facility lead psychiatrist and George Howland, M.D., facility psychiatrist o Daisy Ellison, M.A., Director of Psychology o Daisy Ellison, M.A., Sandra Vale, M.D., and other monitoring team members o Jodie Bailey, R.N., medical program compliance nurse o Carmen Mascarenhas, M.D., Medical Director o Marla Lanni, R.N., J.D., Chief Nursing Executive o J.P. Fancher, D.D.S., Ph.D., facility dentist with Russell Riddell, D.D.S., Dental Coordinator o Ashley Smith, Pharm.D., clinical pharmacist and Sharon Tramonte, Pharm.D., clinical pharmacist <u>Observations Conducted</u>: o PST at-risk and case reviews regarding Individual #170 and Individual #108 o Pharmacy and Therapeutics Committee meeting o Clinical Services Meeting 8/16/11, 8/17/11, 8/18/11 o Dr. Vale's clinic 8/15/11 regarding the following individuals: Individual #332, Individual #149, Individual #193, and Individual #224. o Dr. Vale's clinic 8/16/11 regarding the following individuals: Individual #298, Individual #315, Individual #94, and Individual #111. o Dr. Howland's clinics dated 8/17/11 regarding the following individuals: Individual #57, Individual #177, Individual #304, Individual #87, and Individual #3

	Facility Self-Assessment: SASSLC submitted its self-assessment, the Plan of Improvement on 8/2/11. In addition, during the onsite review, the monitor reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the lead psychiatrist wrote a sentence or two about what tasks were completed and/or the status of each provision item. The monitoring team's review was based on observation, staff interview and document review. The facility will need to engage in similar activities in order to conduct an adequate self-assessment. The lead psychiatrist self-rated the facility as being in compliance with two provision items J1 and J2, which were found in substantial compliance during the previous monitoring period. The monitoring team continued to agree with these self-ratings. Following the comprehensive monitoring process outlined above, the facility was also found to be in substantial compliance with one additional item, J12. With regard to other provisions, the need for improved integration was noted. Some provisions in this section require collaboration with other disciplines. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Some of the actions were relevant towards achieving substantial compliance, but the facility will only achieve substantial compliance if a set of actions, such as those described in this monitoring report, are set out en banc as a system. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation, but a timeline that will indicate the stable and regular implementation of each of these actions. In several provisions (e.g., J7, J10, J11, J13) the facility was approaching substantial compliance. In other areas improvement was apparent, however, additional systems must be developed. The facility will benefit from the eventual development of a self-monitoring tool or a peer review process for this provision of the Settlement Agreement.
	Summary of Monitor's Assessment: SASSLC was found to be in substantial compliance with three of the items in this section of the Settlement Agreement. The facility 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. The new documentation and multidisciplinary clinic practice was expanded to include all facility homes. The last home was folded into this process during this onsite visit. There remained challenges with respect to this enhanced clinic that related to both increased time

	commitment for 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. As discussed below, the facility clinical staff has appropriately placed much emphasis on the development of appropriate diagnoses and pharmacological regimens. As this task was becoming more manageable, it was time to expand the focus to include identification and implementation of non-pharmacological regimens. Challenges remain, 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 data in order for them to make data informed decisions regarding pharmacology in an objective manner. In order for psychiatric services to improve, strong leadership and integration among all the necessary disciplines will need to occur.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	SASSLC had a lead psychiatrist designated, and had 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 13 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 second 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. One issue is that while this second psychiatrist has some child and adolescent experience, he was not board eligible or board certified to provide psychiatric services to children and adolescents. At the time of this monitoring review, there were two individuals under the age of 16 currently prescribed psychotropic medications. In an effort to address this, the facility could consider providing access to a psychiatrist at a sister facility who is either board certified or eligible to treat children and adolescents below the age of 16 for the purposes of clinical case consultation.	Substantial Compliance

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		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, informed consent, movement disorders, medical ethics, epilepsy, posttraumatic stress disorder and autism within the previous year. 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 will be necessary for psychiatry services to meet generally accepted professional standards. As stated in the previous monitoring report, and in this report, psychiatry will need administrative and interdisciplinary support in order to move forward.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Per interviews with the 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 previously performed monthly medication reviews, however, due to a lack of psychiatric resources, the frequency of clinical contacts was reduced to quarterly during this monitoring review. Psychiatrists indicated that they would continue to see individuals more frequently, according to need. Additionally, they were creating a schedule to allow for five open emergency slots per week so that other disciplines (e.g., psychology or nursing) can request a rapid clinic visit for an individual. There were currently 188 individuals (of a total facility population 279) participating in psychiatry clinic. As such, concerns remained regarding the adequacy of psychiatric clinical availability. For further discussion regarding this, please see section J5 below. 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 23 individuals had undergone evaluations using this format. Of these, 14 were complete and followed the Appendix B format. The others were performed by prior treatment providers and were not of the same quality. For further discussion regarding this, please see section J6. 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" and the "Quarterly Clinic Addendum-Treatment Plan Review." Examples of this	Substantial Compliance

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		documentation will be included in the discussion regarding paragraphs J13 and J10. A review of documentation revealed that the current psychiatric providers were making attempts to review the diagnosis and regimens of individuals assigned to their caseload due to the resignation of two previous providers. Per documentation provided, between the dates of 1/4/11 and 6/29/11 the diagnoses of 79 individuals had been reviewed. For example: • Individual #104 – This individual's prior diagnoses included Intermittent Explosive Disorder and rule out Pica. His diagnoses were revised to include mood disorder secondary to Angelman's syndrome. There was documentation of hyperactivity, aggression, and property destruction (tearing shirts with his teeth). Given these mood symptoms and the previous diagnosis of Angelman's syndrome, this diagnosis was substituted. • Individual #244 - "Remove Bipolar diagnosis. Chart review and discussions with team have not been congruent with symptoms. Symptoms are more consistent with intermittent explosive disorder in that she has significant bouts of agitation hat are fleeting and somewhat unpredictable and definitely out of context with a typical response to the situation at hand." • Individual #82 – "Remove intermittent explosive disorder diagnosis. Symptoms can be better explained by autistic disorder, as evidenced by poor social engagement and no verbal skills along with very restricted stereotyped movements (finger tapping) and non-functional routines (constantly going up and down on the halls). Change generalized anxiety disorder to social anxiety disorder as she has been observed over time to avoid social settings and large crowds along with new staff." The above, and the examples contained in the ensuing items below, are illustrative of the marked improvements in documentation. Psychiatry clinic had evolved into a multidisciplinary clinical encounter, allowing for the ability to have a PST meeting during clinic. This was a good opportunity for the team to begin to review/document objective rating scales and specific target symptoms for monitoring. Regardless, given the continued improvements, this section will be assigned a compliance rating of substantial compliance. There were also examples included that were not as complete as those above. These were attributable to the newer physician. Admittedly, documentation from this practitioner had improved dramatically since the prior monitoring review. Per an interview with both psychiatric providers, this improvement was due to ongoing close clinical supervision. This newer psychiatrist was encouraged as improvements were apparent. The practice of psychiatry within the SSLC environment is challenging, and	

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		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" 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. All individuals prescribed medication had diagnoses noted in the record. As noted above in the discussion regarding provision J2, psychiatric practitioners were making good effort to justify diagnoses and were focusing on the description of appropriate pharmacological interventions in detail. Given the team approach to psychiatry clinic that was piloted and expanded throughout the facility, psychology representatives and other staff disciplines were present at clinic. Given the documentation reviewed and observations of psychiatry clinic performed during the course of this monitoring period, there were collaborative efforts with regard to the justification of diagnosis and pharmacological interventions. An expansion to include a review of non-pharmacological interventions either occurring or proposed for a specific individual would be a natural outgrowth of this process. Given the lack of appropriate data presentation observed during psychiatry clinics and included in the documents available for review, it will be imperative that psychiatry and psychology staff meet to formulate a cohesive diagnostic summary inclusive of behavioral data and in the process generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and to discuss strategies to reduce the use of emergency medications. Again, given the current team process and collaborative efforts, this expansion of the clinical discussion would be a natural outgrowth of the process that had been diligently implemented across the facility. <u>Emergency use of psychotropic medications</u> During the onsite monitoring review and per the record review, it appeared that the facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had remained increased. During the prior monitoring period, there	Noncompliance

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		were a total of 10 incidents involving seven different individuals. During this monitoring period, there were a total of 35 incidents involving 10 individuals. While this was an increase, review of documentation and discussions with psychiatric providers and other facility staff revealed that 45% of these incidents were attributable to two individuals (Individual #268 and Individual #83). • Individual #268 required an alteration in medication regimen due to electrocardiogram abnormalities attributed to treatment with psychotropic medication. This change in medication regimen proved difficult for this individual, who experienced an increase in behavioral challenges. • Individual #83 was a more recent admission to the facility with a diagnosis of Bipolar Mood Disorder, who engaged in multiple unauthorized departures and acts of physical aggression. A review of the PST meeting notes and Behavior Support Planning for these two individuals revealed multiple intervention attempts for Individual #268. Unfortunately, a review of the PST meeting notes regarding Individual #83 did not reveal intensive behavioral management strategies other than chemical or physical restraint. A review of the documentation regarding the last 10 individuals who required chemical restraint revealed that in all instances, a psychiatrist's clinic note regarding the incident was included. A review of the documentation provided revealed documentation from psychiatry regarding the justification for the utilization of additional medication. There was not, however, consistent documentation of the PST or BSP response to the individual's experience of behavioral challenges and the need for additional medications. During the monitoring review, the simultaneous use of multiple psychotropic medications as a chemical restraint was discussed. A review of the chemical restraint episodes over the last six months revealed seven instances where three medications were used simultaneously. It was discussed that a more parsimonious approach to chemical restraint would be preferable, especially in light of the potential for negative side effects with medication polypharmacy.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for	Per staff interviews, the facility planned to open a full clinic in February 2012. At the present time, the dentist and his staff were performing dental assessments and encouraging routine oral care. In order to promote routine oral care, all dental staff (the full time dentist, one full time hygienist and one part time hygienist) began work daily at 6:30 am so that they could be present in the facility homes during morning oral hygiene in order to model and supervise the provision of this care. Initially, the dentist had suspended the use of pretreatment sedation for dental pending increased contact with the individual patients. Since 12/8/10, pretreatment sedation	Noncompliance

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	pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	had been reinstated. In the period between 12/8/10 and 6/3/11, there were 47 dental pretreatment sedations performed. Of these: • 25 instances were for individuals also treated via psychiatry clinic. A review of data regarding these episodes revealed that the date of an implemented dental desensitization plan for all 47 instances (comprising 32 individuals) was "unavailable." There were 10 examples provided of multidisciplinary consultation regarding the utilization of pretreatment sedation for individuals. This process was evident during the previous monitoring review, and had continued. Examples regarding Individual #45, Individual #42, Individual #156, Individual #17, Individual #57, Individual #14, Individual#193, Individual #333, Individual #244, and Individual #241 were reviewed. These were comprehensive and included representatives from dentistry, primary care, psychiatry and clinical pharmacy. In addition, nursing monitored individuals appropriately following the administration of pretreatment sedation per facility policy and procedure entitled "Dental/Medical Sedation and Restraint" dated 9/15/10. 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 avoid the need for additional medication. Per staff interview, it was apparent that there were challenges in the collaborative development of individualized desensitization plans with psychology. A list of individuals with dental desensitization plans was provided that included six individuals. Interestingly, none of these individuals were included in the list of 32 individuals who required pretreatment sedation mentioned above. Five examples of dental desensitization plans were provided for review (regarding Individual #88, Individual #127, Individual #108, Individual #41, and Individual #43). These plans were templates and essentially identical. They did not include an assessment of the individual's abilities, they were not individualized in order to address specific challenges the individual experienced with dental treatment, and they did not describe particular reinforcers that would be useful with the individual. 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 plan of improvement revealed plans to begin an individualized desensitization process via psychology, however, it should be noted that this was the case during the prior monitoring period as well.	

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		While the facility had made great strides regarding to the multidisciplinary review of pretreatment sedation for dental care, there was no documentation available regarding a review of medical pretreatment sedation. Given the lack of individualized desensitization and the lack of comprehensive consultation regarding medical pretreatment sedation, this provision will remain in noncompliance, which was in agreement with the facility plan of improvement.	
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.	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. The 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 thirteen months prior to this monitoring review. This physician was full time, and had been designated facility lead psychiatrist. Per interviews, 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. The lead psychiatrist was energetic, organized, and ambitious with regard to meeting the requirements of provision J. As in the prior reviews, the facility medical director was supportive of the psychiatric staff and invested in their success. It was questionable, however, whether the current allotment of psychiatric clinical services will be sufficient to provide clinical services at the facility. At the time of the 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. In contrast to the prior monitoring review, where psychiatrists were performing monthly medication reviews, the psychiatry clinic was moving to quarterly medication reviews and follow-up for medication adjustments and psychiatric crisis more frequently or as indicated. SASSLC should engage in an activity to determine the amount of psychiatry service FTEs required. This computation should consider hours for clinical consultation, 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,	Noncompliance

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		pharmacy, and psychology. During this monitoring review, the use of psychiatric nurses and nurse practitioners was discussed. The addition of personnel from either of these disciplines to the psychiatry clinic would assist with workload.	
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, 23 individuals had undergone evaluations using this format. Of these 23, 14 were complete and followed the Appendix B format. The others were performed by prior treatment providers and were not of an acceptable quality. It was apparent that the psychiatrists had not been able to focus attention on the completion of the comprehensive psychiatric evaluations in the Appendix B format. They were, however, making valiant efforts to provide services in other areas (e.g., justification of psychotropic medication and determination of diagnoses). The facility had a draft facility-specific policy and procedure authored by the facility lead psychiatrist. It 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 slowly introduced to all homes at the facility during the intervening period since the last monitoring visit. The final home was integrated into this process during the current monitoring review. Given the changes in psychiatry clinic required by the new draft policy (e.g., increased number of clinics, longer clinics, need for increased information provided for clinic, increased documentation requirements for all clinic attendees), the implementation had not been without challenges. As the 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 is poised for a change in provision of mental health treatment that appropriately includes a combined collaborative approach to treatment with both pharmacological and behavioral interventions in order to comply with generally accepted professional standards of care. Ten completed examples of Appendix B evaluations were provided for review. Those performed by the current psychiatric physicians were complete in that they followed the recommended outline and included pertinent information. The examples reviewed did a good job with respect to documenting information provided by other team sources. All of the examples included a five-axis diagnosis and documented a detailed discussion	Noncompliance

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		regarding the justification/rule out of each diagnosis. For example, a portion of the diagnostic assessment in the evaluation of Individual #184 stated, "she has a mixed receptive-expressive language disorder…scores obtained form individually administered measures of receptive and expressive language are substantially below those obtained from measures of non verbal intellectual capacity, given the individual…developmental age and previous education…with regard to psychosis, she has not been observed on the home displaying any psychotic like behavior such as responding to internal stimuli. She does not have the history for this behavior. She denied it in her interview. She did, however, show paranoia on her Reiss screen. This will need to be followed over time." The completed evaluations also included comprehensive bio-psycho-social-spiritual formulations. For example, a portion of the case formulation included in the evaluation of Individual #184 stated, "mother had toxemia of pregnancy which could have caused her current mental retardation…in the hospital for one week after delivery…could have been a contributing factor to her current mood instability, aggression, and impulsivity…current psychologist contributed to this assessment…had sexual abuse reportedly by her father…could have affected her future relationships with others…could have fostered her social inadequacies…could have contributed to her depression and negative self image…could have been the precipitant for the establishment of her borderline personality disorder…" The completed evaluations provided detailed treatment recommendations regarding pharmacological interventions. For example with regard to Individual #184, "Zyprexa for mood control...continued to have self abuse…dose of the Zyprexa has been increased to 10 mg in the morning and 20 mg at bedtime …to help control her aggression and unstable mood…Reiss screed showed some paranoia which could be treated by the Zyprexa…formulation was changed to the regular tablet…was getting her meds in pudding…unclear if this would affect the bioavailability of the Zydis, so she was switched to regular Zyprexa…" The completed evaluations, however, did not provide any detail with regard to non-pharmacological interventions. The evaluation outlined above did discuss a consideration for dialectical behavioral therapy, however, the document then referred the reader to the individual's positive behavioral support plan for other information. Seven of the 10 evaluations available for review documented the names of additional staff members who contributed to the completion of the comprehensive assessment. It was surmised that a discussion of non-pharmacological interventions would have occurred (given the observations of psychiatry clinic performed during this and prior monitoring visits), however, this must be documented. It is imperative that psychiatric treatment providers are involved in the identification of non-pharmacological interventions. As stated elsewhere in this report, these was concern that the facility over	

#	Provision	Assessment of Status	Compliance
		relied on pharmacological interventions due to the lack of a strong psychology department and presence. Although the completed evaluations were generally of high quality, the small percentage of those completed required that this provision remain in noncompliance. The facility also gave a noncompliance rating in their plan of improvement, however, the monitoring team wishes to acknowledge the continued progress made by the psychiatrists in regard to diagnosis and review of treatments.	
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 five Reiss Screens on new facility admissions in the previous six months. All five of these individuals were referred for a complete psychiatric evaluation. A review of the dates of admission, the dates of completed Reiss screening and the dates of psychiatric evaluation revealed that on average, the Reiss screen was performed 24 days following admission (range 2 – 76 days). The psychiatric evaluation, on average, was performed 15 days following admission (range 5 – 23 days). On three occasions, the psychiatric evaluation was performed prior to the Reiss screen, making this screening irrelevant. In the case of the assessments above that predated the Reiss screening, these individuals were admitted to the facility prescribed psychotropic medications and, therefore, required evaluation, with or without the Reiss screen results. Given questions regarding the procedure for the referral of individuals for a psychiatric evaluation following a determination of need based on Reiss screen results, the lead psychiatrist had developed a written description of this process entitled "psychiatry consult note procedure." The form for this procedure included a space for data obtained via the Reiss screen, that per the procedure, "must be completed…before psychiatric consultation." Following review of this procedure, the addition of timelines (i.e., maximum allowable time between the referral for consultation and the scheduling of the consultation) should be considered. The timeline was, however, included in the draft Psychiatry Clinical Services Policy indicating that the comprehensive psychiatric evaluation in the form of Appendix B "will follow within 30 calendar days." While this policy was designated as draft, all interviews and observations performed during this monitoring period revealed that it was for all intents and purposes, implemented across campus. Psychiatry was also working to ensure that all individuals who were not currently participating in psychiatry clinic had undergone Reiss screening and that the Reiss screen was implemented for those individuals who were experiencing behavioral exacerbations or changes in status who were not currently enrolled in psychiatry clinic.	Noncompliance

#	Provision	Assessment of Status	Compliance
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Per the SASSLC draft facility-specific policy entitled "Psychiatry Clinical Services," psychiatry clinics were far more comprehensive than they had been, including staff from various disciplines, to ensure appropriate discussion and treatment planning for individuals. This was observed during the current and most recent monitoring reviews. The more comprehensive clinic process had slowly been implemented at the facility, with the final home transitioning to this model during this onsite monitoring review. Review of the documentation generated during psychiatry clinic revealed increased participation by other staff disciplines. This was particularly evident in that psychiatry was able to develop the ability for a PST within psychiatry clinic that was then documented in the psychiatry clinic note. A review of the more recent Appendix B assessments performed that seven out of 10 evaluations documented the participation of other team members in the diagnosis and case formulation. This process was relatively new, with the comprehensive clinic format only just implemented across all homes at the facility. There were several areas that required attention, specifically the presentation of data and the identification/implementation of non-pharmacological interventions. Data presented during psychiatry clinic were provided in a tabular format with data clumped in monthly intervals. Data should be graphed for each individual's target symptomatology. Graphs should include notations for start/stop/dosage change of medication. It should also include other potential antecedents for changes in target behavior frequency, such as changes in the individual's life (e.g., change in preferred staff, death of a family member), social and situational factors (e.g., move to a new home, begin a new job), or health-related variables (e.g., illnesses, allergies). Please also see section K of this report for additional discussion regarding data. 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 little evidence that these modalities were being implemented. Overall, both observation and document review revealed that the focus was primarily on medication management and diagnostic clarification. While this was understandable given the number of individuals with polypharmacy, and the number of individuals lacking appropriate diagnostic case conceptualizations, because these have been	Noncompliance

#	Provision	Assessment of Status	Compliance
		addressed, the focus must now expand to address non-pharmacological interventions. Medication decisions made during clinic observations conducted during this onsite monitoring review were based on lengthy (minimum 35 minute) observations and interactions with the individuals, as well as the review of information provided during the time of the clinic. In the four clinic observations observed 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 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	Per interviews of both psychiatrists and psychology staff, the psychiatrists were making efforts to attend annual PSP meetings, time permitting, for individuals deemed high risk with frequent behavioral challenges. Currently, psychiatry staff reported attending a minimum of three PSP meetings per month. A review of data provided regarding the psychiatrists attendance at PSP or PSPA meetings revealed that since 2/3/11, psychiatrists had participated in 36 PSP or PSPA meetings. Given the revisions to the psychiatry clinic process with representatives from multiple disciplines, the psychiatry clinic had the ability to hold a PSP meeting during the clinical encounter. This was a positive step in the conservation of staff resources. A review of provided documentation revealed sign in sheets/clinical documentation for 30 of the 36 meetings noted above. Of these, 13 meetings were conducted during psychiatry clinic. A review of the listing of meetings attended by psychiatry did not include meetings regarding behavioral support planning. Other than the interaction during psychiatry clinic where behaviors were discussed, the psychiatrists were not regularly involved in the development of the plans. Therefore, this provision item was rated as being in noncompliance, which concurred with the facility plan of improvement. To meet the requirements of this provision item, there needs to be indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this item. Psychiatrists verbalized a willingness to become more involved, but indicated that a lack	Noncompliance

#	Provision	Assessment of Status	Compliance
	psychotropic medication to the degree possible.	of clinical contact time had made this challenging. 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. 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 these documents. Specifically, as stated in other areas of this section J, psychiatry and psychology must learn to work together regarding how they can assist each other toward the common goal of identifying and implementing appropriate treatment interventions, both pharmacological and non-pharmacological.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	A review of DADS policy and procedure entitled "Psychiatry Services" dated 2/16/11 revealed requirements for the development of a risk benefit analysis by psychiatry. Review of the draft "SASSLC Psychiatry Clinical Services Policy" revealed that prior to the initiation of a medication, the "New Psychotropic Medication Initiation Form" must be completed. This document allowed for documentation regarding the risk vs. benefit of treatment with a particular medication. 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 initiated 11/1/10 in order to document the risk/benefit 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 examples typical of the documentation included on the "New Psychotropic Medication Justification Form." • Individual #99 – On 5/19/11 Propranolol 20 mg twice daily was prescribed emergently for "Intermittent Explosive Disorder…anxiety secondary to Autistic Disorder…in speaking with the team and family this may be related to underlying anxiety component. Team also notes he has worsened since discontinuation of Risperdal due to SIADH. His EKG when on Risperdal reflected QTC 448 so for this reason and the increased risk of side effects inherent with second generation antipsychotics in general, Propranolol appears to have a better safety profile and can target underlying anxiety that may be manifesting	Noncompliance

#	Provision	Assessment of Status	Compliance
		as aggression towards self (SIB) and others…symptoms to be monitored: reduction in aggression towards self (SIB) and towards others; improvement in anxiety symptoms, not appearing as 'keyed up' or 'on edge' and pacing around. Expected timeline…effects may be seen within one to two weeks." • Individual #104 – ON 6/3/11 Depakote ER 500 mg in the morning was prescribed emergently for "Mood disorder secondary to a general medical condition (Angelman's syndrome) aggression associated with Angelman's syndrome…currently on Seroquel to help with mood control, aggression. His QTC has increased with increase in Seroquel. Need to get him off Seroquel. Need to replace Seroquel with another drug to treat aggression…symptoms to be monitored: aggression…expected timeline…four weeks." As noted above, the new form will address newly prescribed agents, but does not address previously prescribed agents, or the interaction between medications in the total regimen. Revisions to the form made since the prior monitoring review included signatures for the prescribing psychiatrist, psychologist, PST members present in clinic, the review of the primary care provider, behavioral therapy committee members, and human rights committee. At the time of the review, the form was included in draft policy and procedure. While the above noted innovations were a good start, and indicated the involvement of 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 to the issues included in the Settlement Agreement.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	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 observation of this meeting during this monitoring visit, the review of polypharmacy was limited to a review of the data regarding polypharmacy (e.g., numbers of individuals meeting criteria for polypharmacy, and trends over time). There was no monthly meeting specifically geared toward a review of the justification of polypharmacy on a case-by-case basis. The facility had clinical pharmacists who were excellent additions to the psychiatry clinic. The clinical pharmacists 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. It was recognized by the monitoring team that the current psychiatric providers had assumed the psychiatric care of individuals from other physicians where documentation	Noncompliance

#	Provision	Assessment of Status	Compliance
		of the rationale for a particular medication regimen was either non-existent or insufficient. A review of the records revealed ongoing improvements in the documentation regarding rationale for a particular medication in association with justification of a particular diagnosis. Please also see J13. The following is a good example of the justification for polypharmacy typically authored by psychiatry at SASSLC: • Individual #191 – "Trazodone began to be reduced because, at doses as high as 200 mg at hs, it appeared ineffective for primary insomnia. Melatonin had been started the previous quarter in hopes of better addressing this; the plan remains to titrate Melatonin as necessary while tapering and eventually discontinuing Trazodone. As well the use of Trazodone and Clozapine (being used to target bipolar disorder) can increase the risk of QTC prolongation, though no evidence of this at this time (6/8/11 EKG NSR with QTC 380). He is on phenytoin for seizure disorder and this med in combination with Trazodone can lead to increased risk for phenytoin toxicity. Because his Depakote is being reduced…reduction of Trazodone will have to be very cautious and separate from Depakote reduction so that breakthrough seizures are not exhibited. The times that Clonidine was administered were changed to hopefully better target continued symptoms of ADHD. Of note, the concurrent use of Trazodone, Clonidine and Clozapine greatly increases the risk of hypotension, pointing to another reason to reduce and discontinue Trazodone. This is being monitoring through vital sign monitoring and monitoring for signs of hypotension like dizziness and syncope, which have not been noted to date. The main focus has centered around a rapidly fluctuating WBC/ANC that is presumed to be an underlying benign cyclic neutropenia, though it may never be able to be confirmed due to being on Clozapine (we would likely have to discontinue for confounding reasons in order to really find out). I was collaborating with PCP to reduce his Depakote, used for seizure disorder, to see if that would improve readings. Improvements were noted but not sustained. For this reason, along with the idea that behaviorally he is still not stable, low dose Lithium (150 mg po every morning) was initiated. It should be noted, that he has had Lithium toxicity before, but when much higher doses of Lithium were used. As a result, there was no intention of using high doses of Lithium; the goal is to use lower doses of Lithium as an augment to his current medication regimen. When he was on two antipsychotics (Zyprexa and Clozapine) there was a question of oculogyric symptoms; he has not exhibited these further or any other notable EPS, though does continue with significant drooling, likely from Clozapine, for which Cogentin is being utilized. There has been good evidence and clinical success of use of iprapratropium or atropine specifically for drooling, so discontinue of Cogentin and initiation of one of these agents is a possible future step. He is on phenytoin for seizure disorder. The combination of this with	

#	Provision	Assessment of Status	Compliance
		Clozapine may lead to reduced Clozapine levels which has been noted, but titrations have not been made due to a low ANC. Using Depakote and Clozapine can lead to altered levels of both meds." The above notes the medical rationale for the use of a particular medication, a respect for specific side effects and acknowledgement of specific medication interactions to monitor when polypharmacy is implemented. Per the most recent Pharmacy and Therapeutics Committee notes dated 6/29/11 "longitudinal data…demonstrates that since the new psychiatry team has been coordinating psychiatric care, the total numbers of psychotropic polypharmacy has decreased. Since December 2010 the number of individuals with two or more medications in the same general class has been reduced from 49 to 37. This represents a 24% decrease. The number of individuals with three or more psychotropic medications has been reduced from 105 to 96. This represents a 9% reduction. The reduction in total number of psychotropic medications has not been as dramatic as other psychotropic medications must be initiated in order to wean medications involved in intra-class polypharmacy. There have been four recent admissions. All four came to the facility on psychotropic medications. Two of the new admissions came to the facility on polypharmacy…the formation of the polypharmacy committee has been put on hold…due to limited psychiatric resources across the state…the psychiatrist and the team discuss polypharmacy on each individual every quarter." 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 38	

#	Provision	Assessment of Status	Compliance
		individuals at the facility meeting criteria for polypharmacy due to the prescription of two medications from a single class (reduced from 47 during the prior monitoring review) and 98 individuals meeting criteria for polypharmacy due to the prescription of three or more psychotropic medications (decreased from 108 during the prior monitoring review). 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 SSLCs.	
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 16 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). A review of the spreadsheet indicating completion of MOSES and DISCUS revealed that all were up to date. There were some instances where monitoring had been performed prior to the due date. Per records, this was due to the individual having been scheduled for a quarterly psychiatry clinic and the need for updated assessments during that clinical encounter. Per the facility self-assessment, an inservice training was held for all nursing case managers on 6/22/11. Per the signature page, 21 nurses attended. Per interviews with psychiatry staff, observation of psychiatric clinic, and review of 16 records, psychiatric physicians were reviewing the MOSES and DISCUS rating scales, and tallying the final rating scale scores for inclusion into clinic documentation. A review of MOSES and DISCUS forms provided for review revealed that 100% of these documents had been signed off by the psychiatrists and the prescriber review section of the document was completed. 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 which would serve to document the inclusion of this information in clinical decision making. This revised form had been piloted in selected homes, and during this monitoring review, the final home was transitioned to the use of the psychiatric clinic form. Additionally, a listing of 13 individuals diagnosed with Tardive Dyskinesia had been compiled. This listing included the individual's name, psychiatrist's name, and prior	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		DISCUS scores including a listing of those symptoms scored and the ratings. This reportedly assisted treatment providers and nursing case managers with follow-up of these individuals. Issues reviewed in the prior monitoring report with respect to the presence of nursing case mangers attendance at psychiatry clinic were resolved since the prior monitoring review. Interviews with psychiatry and nursing leadership revealed a good working relationship with focus on the provision of generally acceptable standards of care.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	Currently, the facility did not have an approved facility based policy and procedure governing psychiatric treatment. There was draft policy entitled, "SASSLC Psychiatry Clinical Services Policy" that the facility psychiatrists were informally following pending full approval and implementation. The psychiatry clinic note procedure had been piloted in November 2010 and slowly implemented in each home. The final implementation of this procedure was performed during this monitoring review. Formerly, individuals were seen in psychiatry clinic monthly, with more frequent review by psychiatry as needed. Due the lack of psychiatry resources, the lead psychiatrist determined that individuals would be seen quarterly, or more frequently as indicated. This change to quarterly clinical reviews was occurring during this monitoring review. During this monitoring review, four psychiatry clinics (for a total of 13 individuals) were observed. In all instances, the individual was present for clinic. All treatment team disciplines were represented during the clinical encounter. The team did not rush clinic, spending an appropriate amount of time (often 35-45 minutes) with the individual and discussing the individual's treatment. Prior to clinic, the various disciplines (e.g., psychology, nursing, and psychiatry) documented information into the clinic note format in preparation for the clinical encounter. During clinic, the psychiatrist made attempts to review behavioral data. In general, the data were up to date, however, the data were not graphed, but rather provided in table format (e.g., the number of target behaviors occurring during a particular period was reported). This made data based decision making difficult for the psychiatrist, as medication changes and other events that may affect behavior or psychiatric symptoms were not noted. In all observed clinical encounters (and in all documentation reviewed) the individual's weights and vital signs were documented and reviewed. There were two instances where up to date vital signs were not available. With the psychiatrist's insistence, this information was obtained and provided during clinic. The individual's record and laboratory examinations were reviewed during the clinical encounter and documented in	Noncompliance

#	Provision	Assessment of Status	Compliance
		clinic notes. In an effort to utilize staff resources most effectively, the revised forms utilized in psychiatry clinic allowed for the documentation of a PST meeting. These were frequently held during psychiatry clinic, as given the new clinic format, all staff disciplines required for a PST were also in attendance. This integration of the PST into psychiatry clinic allowed for improvements in overall team cohesion, information sharing, and collaborative case conceptualization and management. Documentation generated in preparation for and during psychiatry clinic was reflective of the improved clinic process inclusive of a more comprehensive review of diagnoses and treatments. For example: • Individual #111- Quarterly Clinic Addendum-Treatment Plan Review dated 7/20/11. This document included a thorough review of this individual's medication regimen and the rationale for treatment with each medication as well as a review of specific side effects that this individual had experienced. Additionally, this document included a diagnostic formulation reviewing each current and prior diagnosis with information included regarding the presence or absence of required target symptoms. For example, "Schizoaffective disorder-Bipolar type…clearly meets criteria as evidenced by longstanding history of distinct mood episodes that would meet criteria for major depression and/or mania along with psychosis that would not resolve despite resolution of mood episodes. In looking over records it appears he may have had his first psychotic break somewhere in his early teens. In accordance with the DM-ID there is no adaptation for schizophrenia or schizoaffective disorders in those with mild mental retardation. Manic episodes were characterized by hypersexual behavior, increased aggression/irritability, lack of sleep, flight of ideas. His most recent episode was a manic episode that consisted of significant increased irritability, flight of ideas, hyper-sexuality, disrupted sleep. He has a long-standing history of hallucinations, mostly auditory type along with disorganized speech, very perseverative, and negative symptoms of affective flattening. He has a long-standing history of disturbance and deficits with interpersonal relations…" • Individual #82-Quarterly Clinic Addendum-Treatment Plan Review dated 5/5/11. This document included a thorough review of this individual's medication regimen and the rationale for treatment with each medication as well as a review of specific side effects that this individual had experienced. Additionally, this document included a diagnostic formulation reviewing each current and prior diagnosis with information included regarding the presence or absence of required target symptoms. For example, "Autistic Disorder…after	

#	Provision	Assessment of Status	Compliance
		many months of discussion it appears…meets DSM-IV criteria for this…qualitative impairment in social interaction as manifested by marked impairment in nonverbal behaviors such as eye to eye gaze, failure to develop peer relationships…lack of spontaneous seeking to share enjoyment, interests or achievements with other people, and a lack of social/emotional reciprocity. She has a diagnosis of social anxiety disorder that was added in before recognition of autistic disorder. It is possible that these social phobic patterns could be more related to a previously undiagnosed autistic disorder. She has qualitative impairments in communication as manifested by total lack of development of spoken language; and she has restricted repetitive and stereotyped patterns of behavior, interests, and activities as manifested by apparently inflexible adherence to specific nonfunctional routines or rituals. This constant movement in her wheelchair appears to be a restricted repetitive pattern of behavior (when she was more ambulatory, it was incessant walking)." As discussed in J14 below, 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. A review of completed "New Psychotropic Medication Justification Form" documents revealed improvements in documentation over the prior monitoring period. For example: • Individual #75 – "Oxcarbazepine…indication aggression, self injurious behavior…current dose of Oxcarbazepine not sufficient to treat aggression... previously just used for seizures…trying to utilize current med regimen without increasing polypharmacy." • Individual #204- "Quetiapine…indication Bipolar I Disorder, most recent episode mixed with psychotic features…has failed Abilify at max recommended dose…previously was on Risperdal and failed that- unable to maximize Depakote ER due to thrombocytopenia at higher doses. Seroquel has been shown to be helpful for depressive episodes and since in mixed episode it may help." • Individual #298- "Risperidone…indication irritability associated with autistic disorder…has been on Thorazine for a number of years and has had significant side effects likely associated with Thorazine including rare side effect of skin discoloration (bluish hue). A taper was initiated for Thorazine reduction but he has become aggressive. Propranolol was initiated to target this aggression but it	

#	Provision	Assessment of Status	Compliance
		has been minimally helpful at its current dose. Thorazine could be titrated back up, but risks appear to outweigh benefit. He has not been on a second generation antipsychotic like Risperdal so plan to start this." As evidenced by the above, the facility psychiatry staff are making strides with regard to developing a treatment plan for psychotropic medication that identifies a clinically 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 have also initiated a psychiatric treatment planning process. What was notable was the documentation of a thoughtful, planned approach to psychopharmacological interventions. These practices have continued over the intervening period. Per a review of the facility POI, this provision was rated in noncompliance. In order to improve the compliance rating, the current procedures must be codified in approved policy and procedure, and data presented to the psychiatrist must be in a form that is useful for them to make data based decisions (e.g., graphed with indications of medication changes or significant events).	
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 continued with positive changes with respect to the manner of obtaining informed consent for treatment with psychotropic medications. These changes included psychiatry obtaining informed consent for newly prescribed psychotropic medication. This procedure was outlined in the draft policy entitled "SASSLC Psychiatry Clinical Services Policy." Per this draft policy, "Initiation of a new psychotropic medication on an emergency basis: 'New Psychotropic Medication Justification Form' will be filled out by the psychiatry provider…if there is a LAR the psychiatry provider will make attempts during clinic to reach the LAR for verbal consent. If unable to reach the LAR, the psychiatry provider will continue to make attempts outside of clinic hours…for at least five working days thereafter…attempts to reach the LAR need to be documented in the integrated progress notes…" Per the draft policy, the process for the initiation of a new psychotropic medication on a non-emergency basis was similar, however, the psychiatric provider was to make continued attempts to reach the LAR for ten working days. The draft policy did not address the procedure for annual psychotropic medication consent reviews.	Noncompliance

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		This draft policy had been revised since the prior monitoring period. At that time, if the psychiatric physician was unable to reach the LAR during clinic, the responsibility for ongoing consent attempts were delegated to other PST members. With the current edits, the responsibility for consent remained appropriately with the prescribing practitioner. Other edits to the "New Psychotropic Medication Justification Form" included signature lines for the individual's primary care physician, PST members present at psychiatry clinic, Behavior Therapy Committee members, and Human Rights Committee members. Per interviews with team members and psychiatry staff, there had been increased contact with LAR's over the past several months. Anecdotes of multiple telephone conversations with the LARs of several individuals were discussed. A review of the completed "New Psychotropic Medication Justification Form" for seven individuals (Individual #99, Individual #155, Individual #34, Individual #111, Individual #104, Individual #5, Individual #191) revealed that these were in general complete, including the name of the medication, indication for the medication, a review of the risk/benefit, a listing of target symptoms, expected timelines for therapeutic effects of medication to occur, and signatures of all involved parties. 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 with consent documented via the nursing case manager. Additionally, annual medication consent reviews remained the responsibility of the assigned psychologist, as did medication consents approved by the facility director. A review of the documentation available for review revealed that documentation of potential medication side effects remained in behavior support plans. This information was, however, improved, as psychiatry in conjunction with pharmacy had developed a document entitled "SASSLC-Potential Medication Adverse Drug Reactions." This document was a comprehensive review of potential deleterious side effects associated with a wide range of psychotropic medication. Per a review of individual records, this information was being utilized in psychology documentation. While the efforts of the psychiatry staff with regard to completion of the "New Psychotropic Medication Justification Form" and contact with the individual's LAR were laudable, and indicative of a transition toward appropriate practice, the current informed consent policy and procedure and the informed consent practices at the facility were not consistent with generally accepted professional standards of care that require that the	

#	Provision	Assessment of Status	Compliance
		prescribing practitioner disclose to the individual the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the individual's record. While this was being done for newly prescribed medication, the requirement of annual consent review cannot be delegated to a non-prescribing practitioner. Currently, the lack of available psychiatric resources had reportedly made this ongoing practice necessary. A review of the facility plan of improvement revealed that this item had been rated in non-compliance. Although some improvements have been noted, given the deficits outline above, a non-compliance rating was appropriate. In an effort to address the deficits in informed consent practices, it was recommended that the facility consult with the state office who, in turn, should consider a state wide policy and procedure outlining appropriate informed consent practices that comply with Texas state law and generally accepted medical practice.	
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 DADS policy entitled "Psychiatry Services" number 007.1 dated 2/16/11, " the neurologist and psychiatrist must coordinate the use of medications, through the PST process, when the medication is prescribed to treat both seizures and a mental health disorder." A review of documents requested, including facility based draft policy and procedure regarding psychiatric treatment at the facility did not reveal additional policy and procedure regarding this issue. Per interviews with the two facility psychiatrists and the facility medical director, attempts to coordinate treatment efforts between primary care, neurology, and psychiatry had resumed. During the prior monitoring period, there had been a hiatus of neurology clinic due to staff illness. During this monitoring period, clinics had resumed as of February 2011 and were reportedly held monthly. In an effort to increase neurology services on campus, SASSLC had reportedly "submitted a contract for on-campus services from the Comprehensive Epilepsy Center…awaiting approval by the University of Texas Health Science Center at San Antonio." A listing of individuals treated in psychiatry clinic with a concomitant seizure disorder diagnosis revealed a listing of 67 individuals. In addition, the date that the individual was most recently seen by neurology was included. The information revealed that of the 67 individuals, there was "no data" for 22 individuals (indicating no recent neurology clinic evaluations). Two individuals were last seen in 2007, three individuals were last seen in 2008, two individuals were last seen in 2009, 18 individuals were last seen in 2010, and 20 individuals had been seen thus far in 2011. Given these data, it was	Noncompliance

#	Provision	Assessment of Status	Compliance
		apparent that there was an increase in services provided in the past six months. It was also evident, however, of the need for additional clinical neurology consultation, as 32% of the individuals had not been seen in neurology clinic. Given the above, 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 pursuit 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 available for review, four had a diagnosis of seizure disorder. A review of these four records revealed two individuals who received neurology consultations dated within the previous six months. • Individual #94- This individual was evaluated in neurology clinic 2/22/11 and 4/12/11. There was documentation available regarding a third clinical encounter, however, this document was not dated. All three documents were signed by both the neurologist and treating psychiatrist, and two out of three documents were signed by the primary care physician. A review of psychiatric progress notes dated 3/16/11 and 5/17/11 revealed documentation of the psychiatrist's attendance at neurology clinic and a review of neurology recommendations with the PST members present in psychiatry clinic. • Individual #198- A review of the medical record available for review did not reveal documentation of the neurology consultation. A review of psychiatric documentation dated 2/15/11 did reveal a report of the psychiatrist's attendance at neurology clinic as well as a discussion of the neurological recommendations during psychiatry clinic including those PST members present in psychiatry clinic. Given the above, it was apparent that there had been increased efforts to integrate psychiatric clinicians into neurology clinic, as well as for psychiatric clinicians to be the conduit of information from neurology clinic to the PST. As SASSLC psychiatry had developed a clinic protocol where psychiatry clinics were integrated, requiring the participation of various PST members, and allowing for a meeting of the PST during psychiatry clinic, clinical coordination between neurology, psychiatry and the PST had improved. Unfortunately, the neurologist was not available for interview during this monitoring review, and therefore, there was no opportunity to observe neurology clinic. A review of	

#	Provision	Assessment of Status	Compliance
		the facility plan of improvement revealed that a noncompliance rating was designated for this paragraph. While the return of monthly neurology clinical consultation was positive, the present neurology resources were inadequate to provide needed consultation and follow-up.	

Recommendations:

1. Provide the facility psychiatrists with access to child and adolescent psychiatrists for clinical case consultation (J1).
2. Develop quality assurance monitoring (e.g., chart reviews, peer review process) for psychiatry (J2, J4, J6, J8, J9, J10, J11, J12, J13, J14).
3. 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, non-pharmacological interventions, and behavioral support planning (J3, J8).
4. Reduce the use of multi-agent chemical restraints. If the use of multiple agents is absolutely necessary, documentation and practice must reveal attempts/failures of single agent interventions. Additionally, when multiple agent chemical restraints are required, this should prompt a review of both the individuals current psychotropic medication regimen to determine adequacy in light of breakthrough symptoms, as well as the individuals behavioral support plan (J3).
5. Individualize the desensitization plans for dental and medical clinic. Continue cross discipline consultation regarding pre treatment sedation options. This must be expanded to include medical pre treatment sedation (J4).
6. 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. Do an adequate assessment of the amount of psychiatry FTE needed at the facility (J5).
7. 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 (J5).
8. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B (J6).
9. Consider the inclusion of timelines for completion of psychiatry consultation to the referral protocol for individuals with Reiss screen results indicating the need for psychiatric intervention (J7).
10. 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, the monitoring of the response to treatment with psychotropic medications, and the identification/implementation of non-pharmacological interventions (J8, J9).

11. Include psychiatry in the development of behavioral support plans. This would include collaborative identification of non-pharmacological interventions to address symptoms and behavioral challenges exhibited by individuals (J9).

12. Expand the current review of the risk vs. benefit analysis for newly prescribed psychotropic medication to include medications in the total regimen (J10).

13. Institute a monthly psychiatric polypharmacy committee meeting (J11).

14. 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 (J11).

15. Continue current psychiatric documentation to include a diagnostic formulation and justification for each specific diagnosis (J13).

16. 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) (J8, J13).

17. Finalize and implement policy and procedure regarding psychiatric services at the facility (J14, J13, J6, J8, J10, J13).

18. Ensure that weight and vital sign monitoring is performed in a timely manner and that up to date results are available for psychiatry clinic (J13).

19. Individualize the process for Informed Consent, ensuring that the prescribing practitioner obtains consent for all prescribed psychotropic medications, both newly prescribed and annual reviews (J14).

20. Consult with DADS administration regarding a statewide policy and procedure for Informed Consent (J14).

21. Explore options to increase the availability of neurology consultation (J15).

22. Include the process for psychiatric participation in neurology clinic and report to the PST during psychiatry clinic in policy and procedure (J15).

23. Continue clinical consultation clinic for psychiatry and neurology. Documentation for both psychiatry and neurology participation should be included in the individual's medical record (J15).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Functional Assessments for: • Individual #3 (7/21/11), Individual #35 (7/07/11), Individual #168 (7/1/11), Individual #159 (6/30/11), Individual #125 (6/22/11), Individual #138 (6/30/11), Individual #164 (6/8/11), Individual #271 (6/6/11), Individual #284 (6/3/11), Individual #173 (5/26/11), Individual #272 (5/11/11) o Positive Behavior Support Plans (PBSPs) for: • Individual #141 (3/15/11), Individual #125 (5/25/11), Individual #272 (5/3/11), Individual #164 (6/14/11), Individual #284 (6/13/11), Individual #173 (5/2/11), Individual #159 (6/30/11), Individual #138 (11/30/11), Individual #306 (2/15/11), Individual #177 (4/18/11), Individual #101 (7/13/11), Individual #271 (6/10/11), Individual #168 (7/5/11), Individual #10 (5/19/11) o Annual Psychological updates for: • Individual #165 (4/20/11), Individual #35 (7/11/11), Individual #8 (5/11/11), Individual #62 (7/12/11), Individual #23 (5/10/11), Individual #95 (5/10/11), Individual #248 (6/10/11), Individual #181 (6/2/11), Individual #256 (6/13/11), Individual #38 (5/18/11), Individual #170(5/10/11), Individual #151(5/25/11) o Full Psychological Assessments for: • Individual #128, Individual #173, Individual #283, Individual #130, Individual #138, Individual #71, Individual #122, Individual #196, Individual #15, Individual #235 o A list of individuals who have PBSPs, dated 7/27/11 o A list of SASSLC Consumers with PBSPs who also have functional assessments, dated 8/17/11 o A list of all individuals for whom an functional assessment has been completed, undated o A list individuals receiving counseling/psychotherapy, undated o Names of all psychology department staff, including status of enrollment in BCBA coursework, undated o Minutes for peer review meeting for the past 6 months o Individual #170 ear scratching and mouth biting data o Psychology Department Reduction Behavior Data Sheet, undated o Graphs for: • Individual #349, Individual #96, Individual #259, Individual #35, Individual #298, Individual #188, Individual #263, Individual #17, Individual #299 o SASSLC Psychological Services Referral Form, dated 5/24/11 o An alphabetical list of all individuals served, including age and date of admission, undated o Positive Behavior Support Plan format, undated o Section K Presentation Book

	o SASSLC Plan of Improvement, dated 8/2/11 Interviews and Meetings Held: o Daisy Ellison, Director of Psychology o Charlotte Fisher, Associate Psychologist V o Charles Obi, Associate Psychologist V o Mark Boozer, 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; Miguel Phillips Associate Psychologist, Bill McCarthy, QMRP; Laura Lewis, Associate Psychologist; Barbara Smith, Psychology Technician; Linda Francis, Psychology Technician; Daisy Ellison, Psychology Director • Individuals presented: Individual #Individual #271, Individual #51, Individual #145, Individual #18, Individual #10, Individual #101 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; Miguel Phillips, Associate Psychology; Gary Sarli, Associate Psychology; Steven Boncek; Melanie Rodgers, Associate Psychology; Rosalia Rodriguez, Associate Psychology; Melissa Steerman, Associate Psychologist; Barbara Hayes, Psychology Assistant; Tiffany Nash, Psychology Assistant; Connie Ramos, Psychology Assistant; Brandon Bailey, Psychology Assistant; Justin Lizcano, Psychology Assistant; Ashley Pleasant, Psychology Assistant; Barbara Smith, Psychology Technician; Linda Francis, Psychology Technician o Psychiatry Clinic: • Staff present: Dr. Vale, Psychiatrist; Ashley Smith, Pharm.D.; Charles Obi, Associate Psychologist; Eric Saenz, QMRP; Michelle Green, DCP; Cynthia McLaughlin, Home Supervisor • Individuals presented: Individual #298, Individual #315 o Personal Support Team Meeting: • Staff present: Dr. Mascarenhas; Dr. Vale, Psychiatry Director; Dr. Fancher, Dental Director; Dr. Howland, Psychiatrist; Sharon Tramonte, Pharmacy; Joe Sainz, QMRP; Audrey Wilson, QMRP coordinator; Melissa Steerman, Associate Psychologist; Rose Ward, DCP; Roland Hoffmann, SLP • Individual discussed: Individual #170 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 submitted its Plan of Improvement (POI), dated 8/2/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. In the comments section of each item of the provision, the Director of Psychology identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. SASSLC's POI indicated noncompliance for all the items 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 self-assessment. 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, the monitoring team suggests that the facility establish, and focus their activities, on short-term goals. The specific provision items that the monitoring team suggests that the facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: The monitoring team was able to identify only minimal progress toward compliance with this provision since the last review. These improvements included: • The implementation of the new simplified data system across all homes and day programming sites (K4). • Increase in the number of individuals with annual Psychological Assessments (K5). • Improvements in the quality of the Positive Behavior Support Plans (K9). Some specific activities toward compliance with this provision of the settlement agreement that the facility is encouraged to focus on over the next six months are: • Ensuring that peer review is occurring weekly (K3). • The establishment of external peer review (K3). • The establishment 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). • 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). As noted in the last report, seven of the department's 10 psychologists were enrolled in coursework toward becoming BCBAs. It is recommended that all psychologists writing PBSPs either possess a BCBA or be enrolled in a program to receive the BCBA. Two of the seven psychologists enrolled in the program 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 who is responsible for maintaining a consistent level of psychological care throughout the Facility.	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 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.	Noncompliance
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	SASSLC had introduced internal peer review meetings prior to the last review. At the time of this onsite review, however, there was not documentation that this meeting was occurring weekly and, in addition, there was no evidence of monthly external peer review. Therefore, this item continues to be rated as being in noncompliance.	Noncompliance

#	Provision	Assessment of Status	Compliance
	of PBSPs.	The newly established internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. During the BTC/peer review meeting observed by the monitoring team, there was active discussion and several examples of staff sharing strategies and suggestions to better identify the variables affecting Individuals undesired behaviors. Review of minutes from internal peer review meetings indicated that peer review meetings were attended by the majority of psychologists in the psychology department. The minutes also indicated, however, that the peer review meetings did not consistently occur weekly. It is recommended that peer review meetings be scheduled and occur weekly. The facility began to have the BCBA consultants (see K1) attend BTC/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 PBSPs, however, the monitoring team does 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 other Texas DADS psychologists 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 of SASSLC. 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	The monitoring team noted some 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 implemented the simplify data collection system for target behaviors across all homes and vocational sites. The new data system was designed to document target behaviors in 30-minute intervals. Additionally, in the new data system, direct care professionals (DCPs) were 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 ensured 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 also allows the psychologists to review data sheets and determine if DCPs were recording data at the intervals specified. It was not apparent, however, that replacement behaviors were included in this data system. It is	Noncompliance

#	Provision	Assessment of Status	Compliance
	and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	recommended that the facility add the collection of replacement behaviors to their simplified data collection system. The monitoring team did their own data collection reliability by sampling individual data books across all homes, and noting if data were recorded up to the previous shift for target behaviors. The results for target behaviors were disappointing. • The target behaviors for only one the seven data sheets reviewed (14%) were completed up to the previous shift. • Most disturbing was the finding of one data sheet (Individual #349's in home 673) where the data were already filled out until 10 pm; the observation, however, was conducted at approximately 8 pm of the same day. These observations indicated that DCPs were not consistently recording target behaviors. This was a serious problem because if the DCPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. 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 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 was 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 review, that the majority of data books continued to be in locked rooms. 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. 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.	

#	Provision	Assessment of Status	Compliance
		As discussed in the last report, SASSLC had begun to increase the flexibility of their data system by beginning to use Antecedent-Behavior-Consequences (ABC) data to better understand and track individuals target behavior. During this onsite review, the monitoring team noted several more examples of the use of ABC data (e.g., Individual #138, Individual #159), and one example of the use of a functional analysis (i.e., Individual #3) to better understand the variable or variables maintaining a target behavior (see K5). All target behaviors, however, collected by DCPs appeared to be collected with the use of a 30 minute time sample. Some target behaviors may require other measures such as frequency (when it is important to note multiple occurrence of a target behavior in an interval). It is recommended that the facility expand the flexibility of the collection of target behaviors to ensure that all measures are sensitive to individual need. As discussed 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). For example the monitoring team reviewed several figures that were graphed in weekly increments (e.g., Individual #259, Individual #35). The monitoring team, however, found no examples of replacement behaviors graphed. It is recommended that the facility begin to graph replacement behaviors. Although several examples of target behaviors graphed in varying increments were available and shown to the monitoring team, these graphs (and therefore opportunities for data-based decisions) were often absent at interdisciplinary meetings. For example: • In a psychiatric clinic, observed by the monitoring team, the psychiatrist wanted to evaluate the effects of a recent medication change. Monthly data were available, but they were not graphed. Weekly graphed data that indicated when medication changes occurred would have better lent themselves to data-based decisions about the effects of the medications. • In a team meeting for Individual #170, variables potentially affecting his self-injurious behavior were discussed. Although monthly data averages were presented, the data were not as useful for identifying the effects of potentially important environmental variables (e.g., his medical status) because the increment (monthly averages) was too large and the data were not graphed so as to clearly show how these variables affected his SIB. In order to achieve substantial compliance with this provision item, the psychology department needs to ensure that all treatment decisions are data-based. Specifically, they need to demonstrate the value of data by consistently graphing and presenting data in increments that encourage data-based treatment decisions. SASSLC had improved the process of documenting PBSP modifications prior to last review. The facility had added a box to each PBSP indicating if this report was new, an	

#	Provision	Assessment of Status	Compliance
		annual review, or a revision due to lack of progress. In reviewing at least six months of PBSP data of severe behavior (i.e., aggression or SIB) for eight individuals, however, five (Individual #159, Individual #306, Individual #271, Individual #168, and Individual #101), or 62%, indicated no obvious improvement in severe behavior and no indication of a change in the PBSP prior to the annual review. Clearly the lack of treatment progress in all of these individuals was not likely to be solely the result of an ineffective PBSP, however the monitoring team does expect that the progress note or PBSP would indicate that some activity (e.g., retraining of staff, additional functional assessment) had occurred if an individual was not making expected progress. Nevertheless, the monitoring team will continue to monitor the progress of target behaviors as one measure of the effectiveness of PBSPs, and behavior systems in general, at the facility.	
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 initial (full) psychological assessments for each individual, the lack of comprehensiveness of the majority of the psychological assessments and functional assessments reviewed, and the absence of functional assessments for each individual with a PBSP. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had initial psychological assessments. Ten initial psychological assessments were reviewed: • One (Individual #173) of 10 initial psychological assessments reviewed (10%) was considered complete and included a standardized assessment of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric and medical status • Nine (90%) contained a standardized assessment of intellectual and adaptive ability, and a review of personal history • Six (60%) contained a review of behavioral/psychiatric status • One (10%) contained a review of medical status Each individual's record should contain an initial 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. <u>Functional Assessments</u> A spreadsheet of individuals with PBSPs and functional assessments indicated that of the 206 individuals at SASSLC with a PBSP, 112 (54%) had functional assessments. All individuals with a PBSP should have a functional assessment of the variable or variables	Noncompliance

#	Provision	Assessment of Status	Compliance
		affecting the individual's target behaviors. Another spreadsheet indicated that 23 functional assessments were completed since the last review. Eleven of those functional assessments (48%) were reviewed to assess compliance with this item of the Settlement Agreement. As discussed in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be. All functional assessments should include direct and indirect assessment procedures. A direct assessment consists of direct observations of the individual and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect assessments help to understand why a target behavior occurred by conducting/administrating questionnaires, interviews, or rating scales. All 11 of the functional assessments reviewed indicated that direct and indirect assessments occurred. As discussed in the last report, however, many of the functional assessments reviewed did not present data from those assessments. The direct functional assessments for seven (i.e., Individual #125, Individual #138, Individual #272, Individual #164, Individual #168, Individual #284, and Individual #35) of the 11 assessments reviewed (64%), were rated as incomplete because they did not specify antecedents prior to the target behavior(s) and/or consequences after it occurred. In other words they were not helpful in understanding the potential variables affecting undesired behavior. For example: • Individual #35 and Individual #125's direct functional assessments 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. As discussed in the last report, one potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of both antecedent and consequent behavior) data (see K4). In order to be useful, however, ABC data needs to be collected for a duration long enough to observe several examples of the of the target behavior, so that patterns of antecedents and consequences could be identified. • Individual #284's direct functional assessment consisted of one observation of her self-propelling her wheelchair, with no mention of target behaviors. On the other hand, the following direct functional assessment appeared to be particularly useful for identifying potential variables affecting the target behavior:	

#	Provision	Assessment of Status	Compliance
		• Individual #3's direct functional assessments included an experimental observation (i.e., functional analysis) where the psychologist manipulated various conditions and noted the differential occurrence of the target behavior in each condition. This analysis clearly revealed that Individual #3's undesired behavior was related to the presence of staff demands. All functional assessments should include the measures and results of indirect and direct assessments used. All functional assessments should identify potential antecedents and consequences of the undesired behavior. Two functional assessments (e.g., Individual #125 and Individual #271), however, did not include potential antecedents, and three functional assessments (e.g., Individual #168, Individual #125, and Individual #164) reviewed did not clearly identify potential consequences. As discussed in the last report, when comprehensive functional assessments are conducted there are going to be some variables identified 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. Two functional assessments did not include a summary statement (i.e., Individual #272 and Individual #168). Seven of the remaining nine functional assessments reviewed (78%) did include a clear summary statement. This represented an improvement from the last review when 58% of all summary statements were rated as acceptable. 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. 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 #3 and Individual #173) of the 11 functional assessments reviewed (18%) were evaluated to be comprehensive and clear. This is comparable to the percentage of functional assessments rated as comprehensive and clear in the last review (14%), and indicates that there is much room for improvement.	

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K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	SASSLC's initial (full) psychological assessments were not complete (see K5) and, therefore, this provision item was rated as being in noncompliance. Additionally, four of 10 initial intellectual assessments that were reviewed were more than five years old. Psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the initial or full psychological assessment, an annual update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should contain the elements identified in K5 and 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. Annual psychological assessments (updates) were completed for 109 of the 279 individuals at SASSLC. This represented an improvement from the last review when only 60 individuals had annual psychological assessments. The monitoring team reviewed 12 annual psychological assessments completed since the last review to assess their comprehensiveness: • One (Individual #165) of 12 annual psychological assessments reviewed (8%) was considered complete and included an assessment or review of intellectual and adaptive ability, a review of personal history, and a review of behavioral/psychiatric and medical status • 12 (100%) contained a standardized assessment of adaptive ability, and a review of personal history • Seven (58%) contained a review of behavioral/psychiatric status • Five (42%) contained a review of medical status • Four (33%) contained an assessment or review of intellectual ability In order to achieve compliance with this item of the settlement agreement all individuals at the facility will need to have annual psychological assessments and they need to contain all of the elements described in K5. Psychological assessments should be conducted within 30 days for newly admitted individuals. A review of a recent admission (Individual #170) 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

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K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	There were no changes in this area since the last review, therefore, it continues to be rated as in noncompliance. During the last review, the facility had developed a referral form to improve documentation of psychological services for individuals referred for these services. During the current onsite review, the monitoring team found one example of a PBSP (i.e., Individual #101) reviewed that documented the need for psychological services. It is recommended that needed psychological services (other than PBSPs) be documented in the each individual's psychological assessment or PBSP. A list of individuals receiving counseling indicated that six individuals were receiving counseling services by SASSLC psychologists, and 10 additional individuals were receiving counseling from a therapist outside of the facility. As reported in the last report, some of these therapies had specific measurable objectives and treatment expectations. They also included documentation and review of progress reflecting evidence-based practices. None of the service plans, however, included 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. No new treatment plans were available to the monitors during the current review. 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	Noncompliance
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting	This item was rated as being in noncompliance because not all PBSPs reviewed contained adequate use of all of the components necessary for an effective plan, and many of the interventions were not clearly based on functional assessment results. A list of individuals with PBSPs indicated that 76 PBSPs were completed since the last review. Fourteen (18%) of these PBSPs were reviewed to evaluate compliance with this	Noncompliance

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	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.	provision item. All 14 of the PBSPs reviewed had the necessary consent and approvals. The monitoring team was pleased to find that all of the PBSPs reviewed included operational definitions of target behaviors. This represented an improvement from the last review when 20% of the PBSPs included descriptions of target behaviors that were not operational. All 14 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but four (i.e., Individual #272, Individual #271, Individual #164, and Individual #173) of the 14 reviewed (29%) identified antecedents and consequences that did not appear to be consistent with the stated function of the behavior, and therefore were not likely to be useful for weakening an undesired behavior. This does, however, represent and improvement from the last review when 55% of PBSPs reviewed antecedent or consequence interventions were rated to not be useful for decreasing target behaviors. Examples of interventions not related to the hypothesized function were: • Individual #173's PBSP hypothesized that his physical aggression may have been maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). His intervention, however, following target behaviors included offering him a change in environment (e.g., his bedroom). If his aggression was maintained by negative reinforcement, then this intervention would likely encourage, rather than discourage, his physical aggression because it allowed him to escape unpleasant activities by engaging in the target behavior. On the other hand, removing the hypothesized source of the aggression BEFORE the target behavior occurred would represent a good antecedent procedure. Unfortunately, the antecedent procedures in Individual #173's PBSP did not include encouraging him to escape and/or avoid (whenever practical) undesired activities by using desirable forms of communication. Ideally, after the aggression occurs, Individual #173 should not be allowed to escape the undesired activity until he appropriately requests it. If the nature of the aggression is such that it is dangerous to maintain him in the activity following aggression, however, then the PBSP should specify his return to the activity when he calm, and again encourage him to escape or avoid the demand by using desired forms of communication. The point is that the PBSP should clearly state that staff should be encouraging and prompting Individual #173 to use desired forms of communication to tell us when he wants to terminate, or have a break from, an activity. Once the target behavior occurs, it may be necessary to remove the source (i.e., the undesired activity) for safety reasons. The PBSP, however, needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future aggressive behavior. • Individual #271's PBSP hypothesized that his physical aggression was	

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		maintained by attention and access to tangible preferred activities. The intervention following aggression, however, included redirecting her by attempting to get her to do something new, like take a walk, watch TV, etc. If her aggression was maintained by attention, this intervention would likely result in an increase in the target behavior. An alternative procedure, that would be more consistent with the hypothesized function, would be to attempt to redirect her, but minimize the attention and access to preferred activities until the physical aggression ends. Once the aggressive episode has ended, then staff would be directed to do engage her in a preferred activity. • Individual #164's PBSP hypothesize that his aggressive behavior was functioning to gain staff attention. The antecedent procedure, however, did not specify that he should receive staff attention for desired behavior or during prescribed intervals. If one assumes that a target behavior occurs to gain attention, then one could decrease the likelihood of that behavior occurring if staff attention is consistently provided for desirable behaviors. Example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior was: • Individual #168's PBSP hypothesized that his physical aggression functioned to gain attention and escape undesired activities. Antecedent interventions included providing "…lavish social and verbal praise for appropriately utilizing coping skills..." His intervention following physical aggression included attempts at redirection, but specified that staff minimize the conversation during redirection (to decrease the possibility of reinforcing the target behavior), and that Individual #168 be required to return to the previous activity once the aggression had stopped (to decrease the likelihood that aggression would result in escaping or avoiding an undesired activity). 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. Replacement behaviors were included in all 14 PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified and providing that reinforcer for alternative behavior is practical. The monitoring team found that six of 11 (55%) of the replacement behaviors that practically could be functional, were functional. This represents an improvement over the last report when 33% of replacement behaviors were judged to be functional. Examples of replacement behaviors that were not functional included:	

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		• Individual #306's targeted behaviors were hypothesized to be primarily maintained by negative reinforcement. Her replacement behavior consisted of manipulating scarves without engaging in SIB. These may an important skill for Individual #306, however, it is not functionally equivalent to the purposed function of her target behaviors, that is, escaping or avoiding undesired activities. An example of a more functional replacement behavior would be to teach her an appropriate way to postpone or terminate an undesirable activity. If practical, this would represent a good example of a functionally equivalent replacement behavior because it provides the same reinforcer (i.e., a way to escape non-preferred activities) as hypothesized to be maintaining her SIB. Only one (i.e., Individual #101) of the 14 PBSPs reviewed included specific instructions for how to train replacement behaviors. As discussed in the last report, it is recommended that all replacement behaviors include specific skill acquisition plans for training. Moreover, these plans should be included into the current methodology, data system (when appropriate), and schedule of implementation for other skill acquisition plans at SASSLC. 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). Overall, seven (Individual #141, Individual #306, Individual #177, Individual #159, Individual #168, Individual #10, and Individual #101) of the 14 PBSPs reviewed (50%) represented an example of a complete plan that contained operational definitions of target behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represents an improvement over the last review when 40% of the PBSPs reviewed were judged to be acceptable. The monitoring team is encouraged by this improvement in the quality of the PBSPs and looks forward to continued progress in this provision item.	
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	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 achieving substantial compliance of this provision item. Target behavior data were consistently graphed monthly at SASSLC. At the time of the onsite review, replacement behaviors were not graphed. It is recommended that the facility begin to graph replacement behavior. As discussed in K4, 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), however, it was not obvious that these graphs	Noncompliance

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	review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	were used to make data-based decisions. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines and label, data points, and a data path. It is recommended that all graphs contain clear demarcation of changes in medication, health status, or other relevant events.	
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 #168 and Individual #101's PBSPs had seven target behaviors each. Additionally many of the PBSPs reviewed were very long (e.g., Individual #101's PBSP was 19 pages and Individual #272's was 16 pages). The facility had recently decided to adapt a new briefer version on the PBSP for future use. The monitoring team looks forward to reading these new briefer PBSPs in the next review. In the meantime, it is recommended that SASSLC review each PBSP and eliminate unnecessary target behaviors and ensure that all plans are written concisely. The only way to ensure that PBSPs are understood and implemented as written is to implement a system to monitor treatment integrity. Although a treatment integrity system was discussed in the last report, SASSLC did not present any integrity data for review. It is recommended that an effective treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established.	Noncompliance
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 last review, each psychologist at SASSLC maintained logs documenting DCP training on each individual's PBSP. The trainings were conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. The facility has reported working on standardizing these trainings, but no data or training forms were made available to the monitoring team. Additionally, there was no system in place to ensure that all staff (including relief staff) had been trained. Finally, there was no systematic way to identify all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. In order to meet the requirements of this provision item, the facility will need to provide documentation that all staff assigned to work with an individual have been trained (including a competency-based training component) in the implementation of the 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	Noncompliance

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		retrained, and subsequently demonstrated competence in the implementation of each individual's PBSP.	
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 279 individuals and employed 10 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. All psychologists writing PBSPs should either possess a BCBA, or be enrolled in a program to receive the BCBA (K1).
2. Peer review meetings should occur weekly (K3).
3. Monthly external peer review meeting need to be established (K3).
4. Operating procedures for both internal and external peer review committees need to be established (K3).
5. It is recommended that the facility collect and graph replacement behaviors (K4).
6. 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 (K4).
7. 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 (K4).
8. The facility should 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 (K4, K10).
9. It is recommended that the facility expand the flexibility of the collection of target behaviors to ensure that all measures are sensitive to individual need (K4).
10. Data should be graphed in increments that allow data-based treatment decisions. Additionally these graphs should be consistently available when treatment/medication decisions are made (K4, K10).

11. If an individual is not making expected progress, the facility should ensure that their progress note or PBSP indicate that some activity to address the lack of progress (e.g., retraining of staff, additional functional assessment, modification of the PPBSP, etc.) had occurred (K4).

12. Each individual's record should contain an initial 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 (K5).

13. All individuals at the facility will need to have annual psychological assessments and they need to contain all of the elements described for initial psychological assessments (K7).

14. All individuals with a PBSP should have a functional assessment of the variable or variables affecting the individual's target behaviors (K5).

15. All functional assessments should include the measures and results of indirect and direct assessment measures used (K5).

16. Ensure that all functional assessments identify potential antecedents and consequences of the undesired behavior (K5).

17. 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 (K5).

18. It is recommended that needed psychological services (other than PBSPs) be documented in the each individual's psychological assessment or PBSP (K8).

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 (K8).

20. 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 (K9).

21. Replacement behaviors should be functional when possible and practical (K9).

22. All replacement behaviors should include specific skill acquisition plans for training (K9).

23. It is recommended that SASSLC review each PBSP and eliminate unnecessary target behaviors and ensure that all plans are written concisely (K11).

24. It is recommended that a treatment integrity system be used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established (K11).

25. The facility should provide 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. This training should include a competency-based component. 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 (K12).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009: Medical Care, 2/16/11 o DADS Policy#006.2: At Risk Individuals, 12/29/10 o DADS Policy#09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044: Medical Emergency Response, 7/21/10 o SASSLC Policy and Procedure: Seizure Management Guidelines, 12/1/10 o SASSLC Policy and Procedure: Medical Services Policy and Procedure, 11/22/10 o Mortality Reviews for individuals who died in 2011 o Listing, Individuals with seizure disorder o Listing, Individuals with pneumonia o Listing, Individuals with a diagnosis of osteopenia and osteoporosis o Listing, Individuals over age 50 with dates of last colonoscopy o Listing, Females over age 40 with dates of last mammogram o Listing, Females over age 18 with dates of last cervical cancer screening o Listing, Individuals with DNR Orders o Listing, Individuals hospitalized and sent to emergency department o Report of external medical review conducted in March 2011 o Report of internal medical reviews conducted June 2011 o Infection Control Committee Meeting Minutes, 1/26/11 and 3/9/11 o Daily clinical services meting minutes, June 2011 o Medical caseload data o Medical Compliance Nurse chart audit data o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, psychiatric assessments, MOSES/DISCUS forms, quarterly drug regimen reviews, quarterly medical summaries, 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 #213, Individual #311, Individual #148, Individual #42, Individual #146, Individual #238, Individual #108, Individual #19, Individual #170 , Individual #288, Individual #, o DNR documentation for Individual #314

	Interviews and Meetings Held: o Carmen Mascarenhas, MD, Medical Director o Liesl Schott, MD, Primary Care Physician o Sandra Vale, MD, Psychiatry Director o George Howland, MD, Psychiatrist o Lilani Muthali, MD, DADS Medical Services Coordinator o Jodie Bailey, RN, Medical Program Compliance Nurse o Marla Lanni, RN, Chief Nurse Executive o Meeting with medical director, chief nurse executive and state office to discuss mortality management and DNRs Observations Conducted: o Opening meeting with facility management o Risk Management meeting with PST
	Facility Self-Assessment: The facility's self-assessment, known as the POI, was updated on 8/2/11. It did not include a description of activities the facility engaged in to conduct the self assessment. The monitor also reviewed the presentation book with the medical director during the onsite review. The POI did not indicate how the self-assessment was used in determining the self-rating. The action plan included in the POI listed seven steps that were being taken to move towards compliance with provision L1. There were no action steps related to provisions L2, L3 and L4. Clearly, the facility will need to address each provision item in order to achieve substantial compliance for Provision L. The monitoring team's review was based on observations, staff interviews, and document review. The facility will need to engage in similar activities in order to conduct an adequate self-assessment. The facility rated itself noncompliant with all provisions. The monitoring team concurred with this finding.
	Summary of Monitor's Assessment: The provision of medical services had made continued progress towards achieving substantial compliance. The medical department was in a state of transition due to a medical staff team that had undergone many changes. A series of locum tenens physicians provided coverage in the months prior to the onsite review. A database for tracking preventive services was implemented and this represented a significant improvement in the ability to assess the quality of care provided and compliance with preventive care guidelines. Newly implemented internal reviews and chart audits provided valuable information to the medical staff.

	There was no noteworthy improvement in the actual provision of care. While basic preventive care was provided, deficits were evident in some aspects of preventive care, such as cancer screenings. Problems were also identified with follow-up of chronic issues as well as laboratory monitoring for chronic diseases and medication use. The current DNR system allowed execution of DNR orders for conditions that were not terminal. Individuals could and did maintain this status indefinitely. The mortality reviews were completed in a timely manner, but the reviews failed to generate any recommendations other than those related to documentation. The external review was completed in March 2011 and showed high rates of compliance with essential and nonessential elements. These results were a striking contrast to the findings of the facility's internal audits. Although continued efforts were seen in the area of medical quality, an organized and systematic medical quality program was lacking. There was also no progress made in the area of development of clinical pathways.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	**Overview** The medical department had undergone several staffing changes since the February 2011 onsite review. Two long-term staff physicians had retired. At the time of the onsite review, the medical staff was comprised of a full time medical director, one full time primary care physician, and one full time locum tenens physician. The medical director also maintained a caseload. Staffing had increased with the addition of a medical program compliance nurse who reported directly to the medical director. Two full time psychiatrists provided psychiatric services. Medical care was provided in the sick call format. Each PCP visited his or her assigned homes on a daily basis. 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. EKGs were done at the facility and a computer generated interpretation provided. There was no over-read done by a cardiologist. The facility conducted onsite neurology, dental, eye, podiatry, dermatology, gynecology, orthopedic, and psychiatry clinics. Other specialty services were provided in the community. A local pulmonary group admitted individuals to Methodist Hospital. This informal agreement had been in place for almost 20 years and provided continuity of	Noncompliance

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		care. The daily clinical services meetings, initiated in August 2010, continued to serve as one forum for an integrated discussion of care. This morning review was attended by the medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, and the psychologist on call (or designee). The events of the past 24 hours were discussed including hospital admissions, transfers, use of emergency drugs and restraints. Minutes were recorded when possible. The monitoring team attended several of these meetings and observed that valuable information was exchanged during this collaborative process. **General Medical Care and Documentation** The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. Several of the requirements of the Health Care Guidelines are discussed below. Examples of findings related to the requirements are provided in the case reviews documented later in this section. <u>Annual Medical Assessments</u> Annual Medical Assessments were contained within the integrated record. The medical director had recently introduced a new format for completion of these assessments. There was some improvement in the AMAs with removal of the underscoring of every sentence. The assessments continued to list all past findings, such as tinea pedis diagnosed 15 years ago, but did not document immunization status. The preventive care flowsheet referred the reader to the annual nursing assessment. A review of the records contained in the sample showed that the annual nursing summary's documentation of immunization was not always consistent with the actual immunization records. Moreover, when individuals had community appointments, the annual nursing assessment was not included in the transfer packet. For these reasons, the monitoring team recommends that the annual medical assessment include a summary of the key immunizations.. There was no one format for completion of the annual assessment, however some key issues should be addressed: • An interval history is needed - Inserting an interval history (what has occurred since the last annual assessment) provides one way of linking all relevant information. Discussion of 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, etc. – 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	

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		discussed together. • Immunizations should be noted in the assessment. • The active problems should be listed along with a plan of care that addresses each problem. <u>Active Problem List</u> All of the records contained an active problem list. With few exceptions, the APLs were not updated in an ongoing manner. <u>Integrated Progress Notes</u> Medical providers documented in the integrated progress notes. The notes were usually timed, dated, and signed although some signatures and credentials were illegible. Pre-hospital transfer notes were inconsistently found, even when transfers occurred during normal business hours. Post-hospital transfer notes were found more consistently. Documentation of consult summaries was often lacking as were notes related to quarterly drug regimen reviews. <u>Quarterly Medical Summaries</u> The medical staff completed quarterly summaries that provided information on current medications and diagnostics completed during the quarter. These summaries were not consistently done and did not provide an adequate snapshot of the health occurrences of the quarter. <u>Physician Orders</u> Physician orders were usually timed and dated. Incomplete orders were not infrequent. Indications were not noted for every medication order. The health care guidelines required "All medication orders will be rewritten when the individual returns to the Center. Medication changes should be noted." This was not evident in the records reviewed since readmit orders usually stated resume or continue previous medications, treatments, and diet orders. **Routine and Preventive Care** Individuals received routine and preventive care. Some areas achieved high rates of compliance, such as vision and hearing screenings. Yearly influenza and pneumococcal vaccinations were provided with high rates of compliance, as well. Hepatitis B vaccinations and varicella vaccinations were also provided appropriately. The facility was in the process of implementing a database to track preventive care. Preventive care flowsheets were found in the records audited. Unfortunately, these documents were frequently noted to be incomplete and lacked the most recent data.	

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		The observations below are based on review of 10 comprehensive records. Several sections also include data provided by the facility. Specific examples of these findings are included in the case reviews. <u>Screenings</u> • 10 of 10 records contained documentation of appropriate vision and hearing screenings <u>Prostate Cancer Screening</u> • 4 of 7 males met criteria for PSA testing • 4 of 4 (100%) males had appropriate PSA testing <u>Breast Cancer Screening</u> • 1 of 3 females met criteria for breast cancer screening • 0 of 1 females had current breast cancer screenings A list of females over the age of 40, date of last mammogram, and reasons for noncompliance was provided. The list contained 79 individuals. • 40 of 79 (51%) individuals had current breast cancer screenings • 22 of 79 (28%) were scheduled for screening o 21 of 22 were within 90 days of due date o 1 of 22 was 2 years past due date • 12 of 79 (15%) individuals had MD orders to stop screening • 3 of 79 (4%) individuals had no documentation of screening • 2 of 79 (2%) individuals had no current screening due to refusal and mastectomy <u>Cervical Cancer Screening</u> • 3 of 3 females met criteria for cervical cancer screening • 2 of 3 (66%) females completed cervical cancer screening A list of all females age 18 and older was provided. The list contained 104 individuals, dates of birth and dates of last pap smears. • 34 of 104 (33%) had cervical cancer screenings completed in 2011 • 33 of 104 (32%) completed screenings within the past 3 years o 2 of 33 were age 70 or greater • 33 of 104 (33%) had not completed screenings within the past 3 years • 2 of 104 (2%) refused • 1 of 104 (1%): blank date	

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		Colorectal Cancer Screening • 5 of 10 individuals met criteria for colorectal cancer screening • 0 of 5 individuals had undergone colonoscopy for colorectal cancer screening A list of all individuals over the age of 50 was provided. The list contained 120 individuals. • 7 of 120 (6%) had completed colonoscopies • 83 of 120 (69%) individuals had completed fecal occult blood testing • 14 of 120 (12%) individuals had no current FOB • 5 of 120 (4%)individuals had no documented FOB • 11 of 120 (9%) individuals were due for testing in August Immunizations • 10 of 10 individuals received pneumococcal and yearly influenza vaccinations • 9 of 10 individuals received vaccination against Hepatitis B Additional Discussion Data provided by the facility revealed relatively low compliance rates with current recommendations for breast, cervical, and colorectal cancer screening. The facility had adopted the USPSTF guidelines for colorectal cancer screening. Annual fecal occult blood testing was performed yearly for individuals age 50 and older. Even with adoption of this minimal requirement, compliance was only 69%. The medical director should review these data to determine how to improve compliance with these screenings. It is also imperative that the USPSTF guidelines for colorectal cancer screening be applied to the appropriate population. This requires a through assessment of risk. The USPSTF recommends shared decision making between clinicians and patients in deciding on the screening strategy. **Case Reviews** Individual #146 • Preventive care including vision/hearing and appropriate cancer screenings were current. • The APL was not dated and, therefore, did not include the diagnoses of osteopenia and atypical neuroleptic malignant syndrome. Individual #19 • Preventive care was current. • There was no physician note related to a low vitamin D level on 6/14/11. There was an order for ergocalciferol written o 6/24/11.	

#	Provision	Assessment of Status	Compliance
		• There was no note for sodium of 131 on 6/13/11 <u>Individual #42</u> • The IPN contained a physician entry dated 1/18/11 related to an abnormal Vitamin D level, but no plan was documented in the IPN. • The IPN contained an entry dated 2/15/11 related to a discussion with the mother about the Vitamin D level. • The MOSES dated 5/19/11 had no MD conclusion. • APL did not contain the diagnoses of constipation and Vitamin D deficiency. • ENT consult was not dated and not initialed by PCP. <u>Individual #108</u> • Preventive care was current. • The QDRR listed edema as the indication for Lasix. The APL listed CHF as the indication. • The AMA stated the individual had a history of CHF and MI and was treated with ASA and beta-blockers. The ASA was discontinued, but there was no rational documented for discontinuing the beta-blocker. • The individual had CHF, but did not receive an ace inhibitor (ACE) or angiotensin receptor blocker (ARB) which are usually prescribed for this condition. The individual received laspropazole for esophagitis, but the diagnosis was not in the APL. <u>Individual #213</u> • Preventive care was current. • On 11/16/10, the individual had an incomplete mammogram. There was no physician documentation in the IPN and no follow-up mammogram. • The TSH level was low and there was no documentation of this in the IPN and no follow-up TSH. The QDRR noted this on 7/14/11. <u>Individual #311</u> • Preventive care was current. • The IPN did not contain a note regarding GI consult and neurosurgery consult. • The preventive care flowsheet stated "NA" for diabetes screening. This 58 year old individual had Down Syndrome making diabetes screening applicable. • The last recorded TD booster was in 2000. • Physician orders, 5/7/11, stated, "resume previous orders." • There was no indication for medication order on 7/20/11. • There was no pre-hospital transfer note on 6/20/11. • There was a post hospital note on 6/29/11.	

#	Provision	Assessment of Status	Compliance
		• The records contained a DNR signed in 2005. No current form was available in the record. • The neurology clinic 1/10 requested follow-up in one year. That consult was not found in records. **Do Not Resuscitate** The monitoring team requested a list of individuals with current DNR orders as well as the reason for the DNR orders. A list of 28 individuals was submitted. The qualifying conditions were listed. The dates of implementation of the DNR orders were not included. The qualifying conditions cited below caused particular concern on the part of the monitoring team as none of the diagnoses were necessarily considered terminal: • Individual #311: Down Syndrome and heart disease • Individual #90: Severe degenerative joint disease and seizure disorder • Individual #10: PKU • Individual #325: Hypertension and diastolic dysfunction A meeting with the medical director, chief nurse executive and representative from state office was held to discuss the DNR process. The monitoring team inquired about qualifying conditions, length of DNRs, and the process for making decisions on DNR implementation. It was reported that the majority of the DNR orders were due to family requests. The facility had an Ethics Committee whose members included the medical director, chief nurse executive, and chaplain. There were two outside members with medical school affiliations and experience in ethical decision making. The longevity of the individual was not a criteria for determining DNR status. The committee met with families and carefully educated them on the implications of DNRs. It was believed that families had enough knowledge to make informed decisions. The medical director reported that the Ethics Committee did not review the most recent DNR decision as the outside members were becoming uncomfortable with participation due to the inquires being made by the monitoring team. During the past six months, one individual had a newly implemented DNR order. Individual #314 had multiple medical diagnoses. The DNR order was signed on 5/31/11 indicating that the individual's father did not desire any type of resuscitative procedures. The integrated progress notes contained a physician entry dated 5/31/11 at 10:00 am "signed DNR request." There was no other entry regarding the medical history, rationale for DNR order, or the procedure for ensuring the decision was appropriate.	

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		Seizure Management Neurology clinic was held onsite. During the February 2011 onsite review, it was reported that no clinics were conducted during December 2010 and January 2011, but clinics were scheduled to resume twice a month in February 2011. Individuals with intractable epilepsy were going to be referred to the epileptologist at the University Medical Center. Data provided indicated that from January 2011 through June 2011, there were six onsite neurology clinics that resulted in a total of 47 clinic visits. There were nine off campus neurology appointments involving seven individuals. A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 135 individuals with a diagnosis of seizure disorder. With regards to drug use: • 19 of 135 (14%) individuals received 0 AEDs • 58 of 135 (43%) individuals received 1 AED • 31 of 135 (23%) individuals received two AEDs • 17 of 135 (12%) individuals received three AED • 6 of 135 (4%) individuals received 4 AEDs • 4 of 135 (3%) of individuals received 5 AEDs • 50 of 135 (37%) individuals received at least one older drug, such as Pb and dilantin Seizure management notes were requested for five individuals. Four sets of notes were provided. The fifth individual did not have a diagnosis of seizure disorder and was seen for management of Parkinson Disease. <u>Individual #94</u> • 2/22/11- The individual was seen in clinic due to gait difficulty. A CT of the head showed mild diffuse atrophy. The physician exam documented a shuffling gait, which was considered to be possibly an extrapyramidal manifestation of Risperdal. The medication was decreased. • 4/26/11 – The Individual was seen in clinic with increasing gait difficulties. Trileptal was discontinued due to hyponatremia. The individual received multiple psychotropic agents. The Vimpat dose was increased. • 5/17/11 - The individual was seen again with normal gait and no confusion. <u>Individual #301</u> • 5/13/11 – The individual had difficulty with seizure control partly due to medication refusal and had a recent hospitalization due to status seizures. The individual was reported to be on a large dose of dilantin. A drug level was drawn on the day of clinic so results were not available. A PEG was	

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		recommended to improve compliance. There were no further clinic appointments documented. <u>Individual #165</u> • 2/22/11 - The individual had intractable seizure disorder. In clinic the individual was noted to have gait difficulty so severe that standing was not possible. X-rays of spine were recommended and meds adjusted. The follow-up appointment was on 5/9/11 in community. <u>Individual #200</u> • 5/17/11 – The individual had cerebral palsy and diabetes mellitus and hyponatremia that required hospitalization. The recommendation was to continue with Keppra. <u>Individual #146</u> • 9/14/10 The individual had a seizure disorder as well as pseudo-seizures and drop attacks. Klonopin was weaned due to sedation and Depakote started. There have been no follow-up neurology appointments for this difficult individual. There were six half-day clinics over six months. Nine visits were completed off campus. Fifty-six clinic visits over a period of six months would appear inadequate for a facility that supported 135 individuals with a diagnosis of seizure disorder. One hundred sixteen individuals received AED therapy with 58 (50%) having AED polypharmacy. Seventeen individuals had intractable disease. Individual #165 was noted to be unable to stand during clinic on 2/22/11, yet a follow-up appointment was not completed until 5/9/11. Individual #200 developed hyponatremia which resulted in hospitalization and invariably surfaces the issue of the adequacy of follow-up laboratory monitoring. The clinic notes reviewed were brief and often lacked data essential in the management of seizure disorder such as drug dosages, severity of seizures, date of last seizure, adverse effects of drugs, results for drug monitoring, and the impact of seizure disorder and AEDs on the quality of life. None of the notes provided recommendations related to calcium and vitamin D supplementation, screening for osteoporosis, and monitoring for drug side complications. Side effect monitoring tools such as the MOSES and DISCUS evaluations were not utilized in the evaluations. Additionally, several adverse drug reactions identified in the notes appeared to go unreported. The medical director should work with consultants to ensure that assessments include key information. The facility must reassess its provision of neurological services as	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>current availability on campus may not be adequate to meet the needs of the facility.</td><td></td></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td><u>Medical Reviews</u>
The external medical review was completed in March 2011. Two physicians from other SSLCs audited a total of 14 charts. The medical director reported that the Quality Assurance Department had not provided breakdown data and graphs related to the findings of the audits. During a follow-up interview, the medical director reported that the information was made available following intervention on the part of the facility director. The monitoring team was provided audit data consisting of overall compliance rates, compliance with individual elements, corrective actions, and a corrective action status report.

A five percent sample of records (14 records) was examined for compliance with 32 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were seven essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, essential items were required in addition to receiving a score of 80% on nonessential items. The average compliance ratings for essential and nonessential elements respectively were 94% and 79%. The audit scheduled for June 2011 did not occur and was rescheduled for December 2011.

A QA document entitled Action Plans Follow–Up indicated that a total of 60 action plans had been completed. The action plans addressed documentation, provision of appropriate vaccines and other process issues captured in the external review. The medical department developed its own action plans based on an internal review of 14 records completed by the medical program compliance nurse. There were marked variations in compliance rates determined by the external and internal reviews. A few examples of such differences are noted below:

<table>
<tr><th></th><th>Internal Review Compliance* n = 14 (%)</th><th>External Review Compliance n = 14 (%)</th></tr>
<tr><td>Active problem list updated</td><td>8</td><td>85</td></tr>
<tr><td>Immunization compliance</td><td>78</td><td>100</td></tr>
<tr><td>MD response to QDRR</td><td>47</td><td>85</td></tr>
<tr><td>Consults documented in IPN</td><td>33</td><td>75</td></tr>
</table>
*Average score for three physicians</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		Mortality Reviews There were four deaths recorded in 2011. The average age of death was 51 years. Another death occurred during the onsite review. The mortality documents for the four deaths were provided for onsite review. The clinical death reviews and administrative death reviews were completed in accordance with DADS policy. A community physician participated in the clinical death reviews by scan-call. No autopsies were performed. Three of the clinical death reviews resulted in the recommendation to address nursing documentation. The fourth clinical death review produced no recommendations. One administrative death review included the recommendation to address documentation issues. The remainder generated no recommendations. Of the four death reviews, none identified any issues related to medical care or areas in which there was opportunity for improvement. The medical director had recently implemented a review of care by a non-treating physician. The one physician review provided did not identify any issues with care. Mortality Review Management at SASSLC The monitoring team met with the medical director, chief nurse executive, and state office staff to discuss the mortality review process. The monitoring team expressed concern over the lack of any findings related to the provision of medical care. The medical director explained that the facility was completing death reviews as required and had added the additional component of the physician review. Recommendations were generated as deemed appropriate. The monitoring team was informed that the state had contracted with a patient safety organization to perform external mortality reviews. This was in addition to the exiting reviews. This process, which began in April 2011, was intended to produce confidential recommendations to the facility.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The facility had not implemented a formal medical quality program at the time of the onsite visit. Nevertheless, there were ongoing initiatives targeted at improving medical quality: • The department continued to track skin infections, UTIs, pneumonia, and bowel management. Documents containing data analysis and interventions were provided for review. • A database capable of tracking preventive care had been developed and data entry had commenced. • The medical program compliance nurse conducted chart audits that targeted compliance with preventive care guidelines. The data resulting from the nurse audits had the ability to significantly impact the quality	Noncompliance

#	Provision	Assessment of Status	Compliance
		of preventive and routine health services. Examples of findings included: • Did individual get referred to cardiology for possible MI.? • Wound clinic 6/30/11. F/U 2 weeks; no labs to back up FOB testing • On Coumadin, but no clotting studies. No f/u recorded of gall bladder cyst 07. • Last Keppra level was 1/11; last PTT 12/10 • No cholesterol in chart; ENT wanted f/u in 4 -6 months • No proof of FOB testing • GI apt recommendations for a endoscopy, but no proof if this was done; cardiology appointment c/o no records were sent with individual • No medical problem list in chart • Last FOB slip in chart from 2009 • Head CT 9/22/10; no c-spine performed; no paperwork for ENT appointment; no Keppra levels These findings represented potential deficiencies related to the provision of health care services. Equally as important, discovery of these findings presented an enormous opportunity to take corrective action at the individual level. Moreover, such data can and should be analyzed and trended in order to determine the potential causes and solutions for deficiencies. This data should also be utilized to evaluation individual physician performance. The corrective action plan of the internal audits resulted in the providing in-services on documentation and other processes. Additional investigation is needed to determine if there are systemic issues related to the deficiencies noted. <u>Additional Discussion</u> While these efforts should be commended, they fall substantially short of a formal medical quality program. Development of such a program will require training of staff in quality improvement methodology, the appropriate use of data analysis and interpretation of data, as well as selection of quality indicators. This was discussed at length with the medical director and state medical services coordinator. Infection control meeting minutes indicated that antibiotograms would be disseminated to physicians for review. As part of the medical quality initiatives, the medical director should have regular meetings with the medical staff to review key medical quality data, discuss problems and develop interventions and corrective actions. This can occur with the data and information currently generated.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish	The facility's POI indicated that seizure management and bowel management policies were completed in 2010. There had been no further progress for this provision item. No clinical guidelines had been issued by state office.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		

Recommendations:

1. The staffing of the facility with regards to primary care physicians must be addressed. The medical director should not have the primary responsible for provision of care (L1).

2. Consideration should be given to revising the format of the Annual Medical Assessment as discussed section L1. Physicians should include vaccination status in the AMA to ensure that this information is readily available to those who need it (L1).

3. Physicians should update the Active Problem List as required by the Health care Guidelines (L1).

4. The medical staff should be in-serviced on all elements of proper documentation. This includes the requirement to make IPN entries in SOAP format in a legible manner (L1).

5. The preventive care database should be fully implemented. The medical director should utilize these data along with the other tools, such as chart audits to determine compliance with the provision of preventive care (L1).

6. The medical director should review data related to cancer screenings to ensure that the appropriate risk benefit analysis has occurred. When recommended screening s have been canceled or discontinued, the records should clearly document the rationale for the decision (L1).

7. The current process for executing a DNR order should be reviewed. The appropriateness of a DNR order should be discussed with the PST and the recommendations of the PST clearly documented. The Ethics Committee should be involved in determining the terminal nature of the illness. The wishes of the legally authorized representative should not solely drive the DNR process (L1).

8. The facility, along with the Ethics Committee, should review the current DNR list of 28 individuals to determine the appropriateness of the orders. Orders should be revoked for those individuals who do not meet criteria established by the DADS policy (L1).

9. The facility must assess its need for neurological services and the adequacy of services currently provided. The facility should at a minimum, resume the two half-day clinics per month or seek out additional community resources (L1).

10. The medical director should make an effort to work with the neurologist in order to provide more comprehensive assessments and recommendations to the PSTs (L1).

11. Consideration should be given to the development of a standardized template for use in seizure clinic. This practice will ensure that the PSTs have adequate information to determine the status and overall management of the individuals. Key data should include seizure status (frequency and last seizure), previous AED trials, tolerance to medications, and quality of life assessments (L1).

12. The results of the MOSES and DUSCUS evaluations should be provided to the neurologist to ensure that side effects and evidence of tardive are recognized and taken into consideration when making treatment decisions (L1).

13. The medical reviews should include a robust mix of process and outcome indicators. If the frequencies of the reviews are decreased, the sample size for each review should be increased (L2).

14. The facility should assess the mortality review process to determine how to best complete reviews that has value in identifying areas of concern. Identification of issues, specific or systemic, must be viewed as opportunities for improvement that have the potential to benefit individuals supported by the agency (L2).

15. The medical director should ensure that exploration of autopsy occurs with each death. The treating physician or physician on call should be responsible for requesting permission for autopsy for each death. Documentation of the discussion should be provided in the death summary and integrated progress notes (L2).

16. Clinical guidelines must be implemented. This is the rate-limiting step for the development of a formal medical quality program as the desired outcomes must be defined (L3).

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SASSLC Organizational Chart o Map of SASSLC o DADS State Supported Living Center Policy: Nursing Services (5/11/11) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o Alphabetical list of individuals with current PSP, annual nursing assessment, and quarterly nursing assessment (due) dates o A list of all individuals served by residence/home, including for each home an alphabetized list of individuals served, their age (or date of birth), date of admission, and legal status o A list of individuals admitted within the last six months and dates of admission o The agenda for new staff orientation o The curricula for new staff orientation, including training materials used o The schedule for ongoing in-service staff training o The curricula for ongoing in-service staff training, including training materials used o For nursing, the number of budgeted positions; the number of staff; the number of contractors; the number of unfilled positions, including the number of unfilled positions for which contractors currently provide services; and the current FTE o Lists identifying each individual who is identified to be "at risk" utilizing the state's risk categories o For the past year, individuals who have been seen in the ER, including date seen and reason o For the past year, individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), and date of discharge from hospital o For the past six months, individuals who have been diagnosed with pneumonia, including date of diagnosis and type of pneumonia (e.g., aspiration, bacterial); and/or have had a swallowing incident, including the date of incident, item that caused the swallowing incident, and the interventions following the incident o Nursing staffing reports/analysis generated in the last six months o Minutes of the Infection Control Committee for the last six months o Minutes of the Environmental/Safety Committee for the last six months o Minutes of the Department of Nursing meetings for the last six months o Minutes of the Nutrition Management Committee for the last six months o Minutes of the Pharmacy and Therapeutics Committee meetings for the last six months o All SASSLC policies and procedures addressing emergency/code blue drills o SASSLC training curriculum for the implementation of emergency procedures including training materials o All emergency/code blue drills, medical emergency reports, including tracking logs, recommendations, and/or corrective actions based on these reports/analyses for the last six months

	o List of SASSLC staff who were certified in first aid, CPR, or ACLS with expired certification o Documentation of annual consideration or resuming oral intake for each SASSLC individual receiving enteral nutrition o All SASSLC training curricula on infection control, including training materials o SASSLC infection control surveillance and monitoring reports for the last six months o SASSLC nursing audits, data, analysis reports for the last six months o SASSLC medication administration audits and reports for the last six months o For the past six months, list of individual who died at SASSLC or after being transferred to a hospital or other care setting o For the past six months, mortality reviews and recommendations prepared by the QA Department o Job description of Nurse Manager o SASSLC Self-Assessment: POI updated 8/2/11 o SASSLC Meeting Schedule updated 8/15/11, updated o Hospital Report for July 2011 and August 1-18, 2011 o Request to Post Trainings for 3/11 – 8/17/11 conducted by the Nursing Department o Most current New Nurse Orientation Schedule o July 2011 Quarterly Competency Delinquency List (updated 8/10/11) o QA Report for June 2011 o Records and MARs/TARs of: • Individual #142, Individual #54, Individual #61, Individual #149, Individual #108, Individual #254, Individual #173, Individual #216, Individual #274, Individual #95, Individual #39, Individual #311, Individual #36, Individual #288, Individual #143, Individual #40, Individual #325, Individual #19, Individual #37, Individual #136 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Marla Lanni, RN o Nursing Operations Officer, Suri Phanhtharath, RN o Quality Assurance Nurses, Minerva Maldonado, RN and Robert Sertuci, RN o Infection Control Nurse, Sam Lee, RN o Nurse Educator, Clara Wallace, PhD, RN o Hospital Liaison, Gayindria Collier, RN o Nurse Manager, Lola Faulkner, RN o Informal interviews with 10 direct care nurses (LVNs and RNs) <u>Observations Conducted</u>: o Visited individuals residing in 665, 667, 668, 670, 671, 672, 673, 674, and 766 o Medication administration in 665, 668, 670, 671, 672, 673, and 674 o Enteral feedings in 673, 674 o PSTs for Individual #108, Individual #170 o 8/16/11 Pharmacy and Therapeutics Committee meeting o 8/18/11 Nurse Meeting o 8/18/11 Clinical Services Meeting

	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. Across the provision items of Section M, the "Comments/Status" sections failed to describe a comprehensive set of specific actions that were expected to help the Nursing Department achieve the provisions of Section M of the Settlement Agreement. Rather, under each item of the provision, there were lists of discrete events, usually meetings, trainings, and policy revisions, which had occurred over the past year. It was left to the reader to assume what, if any, effect the event/activity had on promoting progress toward achievement of the provisions of the Settlement Agreement. The POI also included a separate section entitled, "Provision of the Settlement Agreement," which listed "Action Steps" to specifically achieve compliance with provision item M.3. This section was especially confusing since it referenced activities – some implemented, most "in process" – that were not referenced in first section of the POI and assigned numbers and letters to action steps without discernable order or time-frame of implementation. The Chief Nurse Executive, Center Lead for Section M, self-rated the facility as being in noncompliance with all provisions of Section M. The monitoring team was in agreement with these self-ratings. During the onsite review, the presentation book was not reviewed because it was reported that it contained no more information than what was already submitted vis a vis the document request and what was already reviewed by the monitoring team in preparation for the visit.
	Summary of Monitor's Assessment: Since the prior monitoring review, there were a number of positive changes in the staffing of the Nursing Department, but within each area of positive change, there continued to be problems and a substantial amount of work to be done to improve the delivery of nursing supports and services and achieve the provisions of the Settlement Agreement. A Chief Nurse Executive and Nursing Operations Officer joined the SASSLC Nursing Department just two to three months prior to the monitoring review. During the CNE's short tenure, she re-established leadership within the Department and took swift action to address some of the more immediate needs of the Department. She reduced RN case manager caseloads, streamlined processes, built bridges with other departments and clinical professionals, and improved the working conditions for the SASSLC's nurses. Notwithstanding the CNE's efforts, the Department, as a result of losing five RN positions to other SASSLC departments, managing without one of its three nurse managers who was on extended leave, continuing to be unable to fill five vacant nursing positions, and experiencing high turnover of both RNs and LVNs, suffered significant setbacks to its efforts to implement interventions to achieve compliance with provisions of the Settlement Agreement.

	During the conduct of the monitoring review, all residential areas were visited, 17 nurses were interviewed, and 20 individuals' records were reviewed. As noted in the prior review, across all 20 sample individuals reviewed, comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. Quarterly and annual nursing assessments were filed in each of the 20 sample individuals' records, but 18 of the 20 nursing assessments failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. Also, as noted in the prior review, across all individuals reviewed, HMPs and ACPs continued to fail to meet basic, minimum standards of practice or the provisions of the Settlement Agreement. At the time of the monitoring review, although SASSLC was eight months into its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process, the facility's POI stated that since the prior monitoring review, "no new initiatives [in this provision item] have been implemented." Since 1/1/11, no more than half of the 20 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. The administration of medication and the management of the medication administration system at SASSLC continued to improve since the prior monitoring review. As indicated in more detail below, although much work still needed to be done to ensure that medications were administered and accounted for in accordance with generally accepted professional standards of care and the Health Care Guidelines, the facility had taken several steps toward identifying and measuring the nature, severity, and scope of their problems in this area.

#	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.	In the prior monitoring review, it was noted that SASSLC had undergone significant changes in nursing management staff and continued to be faced with multiple challenges in communicating and enforcing expectations for performance improvement. At that time, several of the upper level management positions, including the Chief Nurse Executive (CNE) and Nursing Operations Officer (NOO), were vacant. Since the prior monitoring review, a CNE and NOO were recruited, hired, and on the job for only two and three months, respectively. Also, since the prior monitoring review, although SASSLC reported that it was developing templates for documentation of progress notes, monitoring and evaluating, and tracking and trending compliance and needs for further education and corrective actions, progress had not been made toward meeting this provision item. As noted during each of the prior monitoring reviews, there	Noncompliance

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		continued to be a persistent pattern of problems ensuring identification of health care problems, performing complete assessments, implementing planned interventions, conducting appropriate follow-up, and keeping appropriate records to address the significant changes in individuals' health status and needs. Thus, a rating of noncompliance was made in this area. During the conduct of this onsite monitoring review, all residential areas were visited, 17 nurses were interviewed, and 20 individuals' records were reviewed. As noted in the prior review, all individuals' records were organized in a unified form/format. Individual notebooks were present and available to direct caregivers. Notwithstanding these positive findings, nurses' notes (i.e., nursing IPNs) were not consistently in the SOAP format, entries were illegible and/or lacked specific information such as time of day, and a number of nurses' names and credentials were illegible. They were also several occasions when portions of entries were obliterated, written over, and not properly documented/designated as entry errors. The Nursing Department's POI referenced that several "training sessions" were conducted in an effort to improve the facility's nurses' documentation of progress notes, assessments, and care plans. The review of 20 individuals' records, however, revealed that over half of the records included cryptic, uninformative, and incomplete assessments and evaluations of individuals' health needs and risks. For example: • Re: Individual #61's blood pressure – "Some pressures are low and some are high." • Re: Individual #108's response to treatment – "Refusing treatment as usual…Continue to monitor." • Re: Individual #173's behavior needs – "Very well behaved." • Re: Individual #95's and 311's skin integrity – "Less picking this past quarter" and "Redness around stoma ⇓," respectively. • Re: Individual #288's acceptance and tolerance of enteral nutrition – "Has enteral feeding – correct formula and rate." Across the 20 individuals reviewed, there was evidence that their physicians responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen, usually within less than 24 hours. However, there were many examples of occasions when nurses failed to notify individuals' physicians of changes in the individuals' health status and needs in a timely manner. Thus, there were delays in the assessment, treatment, and follow-up of individuals' health needs and risks. There were also many examples of occasions when the only references of follow-up to resolution of significant changes in individuals' health status were periodic follow-up notes by the physicians.	

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		During interviews with the CNE and NOO, it was reported that nurses were required to review the facility 24-hour report, which was the report of individuals with significant changes in health and behavior status during a 24-hour period. A review of these reports revealed that they were primarily focused on individuals' levels of supervision and behavior challenges with little to no information regarding important changes in their health status and needs. Thus, it was not surprising that several direct care nurses were not aware of residents' changes in health needs and risks. For example, during the monitoring team's observations of several nurses' performance of their job duties, upon questioning, it was apparent that the nurses were not knowledgeable of the health status of various residents who were assigned to their care, and their prescribed treatment and monitoring of conditions such as respiratory infection, recent injury, and altered skin integrity. In an effort to address this problem, on 8/11/11, the CNE implemented an "On-Duty RN Shift Report," which required nurses to document information on injuries, restraints, unauthorized departures, seizures, new illnesses, MD notification and follow-up, allegations of abuse, neglect, mistreatment, transfers, hospitalizations, and other concerns/comments from one shift to the next. A review of the shift report from 8/11/11-8/18/11 revealed that these reports were a work in progress and in need of improvement in order to effectively track, record, and communicate significant changes in individuals' health in a complete and timely manner. For example, an individual was described as having been "punched" by another individual, however, there was no information pertaining to whether or not the individuals were injured and/or treated. Another individual, who was described as having had "skin cancer removed yesterday," had no information pertaining to his/her tolerance of and recovery from the procedure, whether or not his/her physician was aware, etc. And, another individual who was described as having "left home [and] heading toward the gate" during the 2 pm-10 pm shift had no other information or follow-up to his/her attempt to leave without authorization. According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the DADS Nursing Services Policy and Procedures stipulated that nursing staff members will document all health care issues and will have follow-up documentation reflecting status of the problem, actions taken, and the response to treatment at least once per day until the problem has resolved. Notwithstanding these requirements, as noted in the prior review, across all 20 sample individuals reviewed, comprehensive documentation in the	

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		individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. • On 8/10/11, at 10:10 am, Individual #143's dentist "sent [her] home due to regurgitation. Within the hour, at 11:00 am, Individual #143's nurse noted that she was "very agitated" and had "frothy secretions," "coarse crackles," and a rapid heart rate, and he/she planned to "monitor" Individual #143's response to her hand-held nebulizer treatment. Over an hour later, at 12:15 pm, Individual #143's nurse continued to note Individual #143's "crackles" and rapid heart rate and indicated that he/she would "inform on-coming shift." Over the next eight and one-half hours, Individual #143 suffered obvious signs of respiratory distress – agitation, rapid heart rate, yellow oral secretions, etc. But, it was not until she was found with "her face reddish purple [and] frothy secretions coming out from her nose and mouth (emphasis added)" that her physician was notified and he/she ordered Individual #143's transfer to the hospital. Of note, according to Individual #143's nurse's notes, her physician was notified of her change in health status at 7:00 pm. It was unclear why, once notified, it took over an hour and a half for medical personnel (Amb-Trans) to arrive, respond to the medical emergency, and transport Individual #143 to the hospital. • On 3/22/11, Individual #254's RN case manager noted that his home staff members reported that he "has been incontinent of bowels since his return from the hospital [on 3/16/11]." Despite this significant, undesirable change in Individual #254's health status and his RN case manager's identification of his "new onset of bowel incontinence," there was no follow-up and no plan to address this problem other than the RN case manager's recommendation to "Offer Depends and monitor (emphasis added)." • On 5/13/11, Individual #108's RN case manager noted that he was "coughing evenings this week x2, PCP away, and CXR 4/27/11 shows no acute changes." On the basis of an incomplete assessment and evaluation of Individual #108's respiratory status, his RN case manager noted that he was "at risk for impaired gas exchange" and planned to "continue to monitor." Over the next week, Individual #108's respiratory status was incompletely and inadequately monitored and evaluated. Thus, on 5/20/11, it was noted that he was "sent out to Methodist ER" for evaluation and treatment of lethargy, respiratory wheezing, rapid heart rate, and difficulty breathing. Individual #108 was diagnosed with pneumonia and hospitalized for five days. • Over the past six months, there were a number of changes in Individual #149's health status that were not promptly identified, addressed, and monitored until resolution. For example, on 4/1/11, at 6:50 pm, Individual #149 returned to SASSLC from the hospital where she was treated for pneumonia. There was no evidence that she was monitored during the evening and night shifts and no	

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		evidence that she was appropriately assessed/evaluated until her physician saw her the next day. On 7/12/11, Individual #149's physician noted that Individual #149 had an abscess on her buttocks and required treatment every day with hot soaks and coverage for MRSA. On 8/2/11, Individual #149's nurse noted that she "had a fever this morning" and that "PRN acetaminophen ordered." Despite these significant changes in Individual #149's health status and high risk of aspiration and infection, there was no evidence of follow-up interventions and evaluations. <u>Regarding numerous individuals</u> A clear-cut example of an opportunity for nurses to help ensure that significant changes in individuals' health were quickly identified, their physicians were promptly notified, and appropriate care was delivered was within the realm of their role and responsibility to ensure that staff members adequately and appropriately respond to actual medical emergencies vis a vis medical emergency drills. A review of the facility's 138 Medical Emergency Drill Checklists, which were associated with drills conducted by the Nurse Educator during the period of 1/11-6/11, revealed that staff members failed to respond to over 51% of the 138 drills conducted during the six-month period. Despite the facility and statewide policies related to Medical Emergency Response Drills that required staff members to respond to drills, the majority of the drill checklists revealed disturbing examples of instances when nurses and other staff members stepped over and around and hid in offices during the drills. There were also examples of staff members who were argumentative during the drills and one particular report of a staff member who stated that she "doesn't do CPR." Not one of the medical emergency drills conducted during the six-month period included bringing to the drill and practicing the use of emergency medical equipment, such as ambu bags, one-way masks, and oxygen. For some reason, which was not explained or clarified, this practice was not considered relevant or "applicable" to the drills. None of the problematic drills where staff members failed to respond or failed to bring emergency medical equipment to the drill referenced a plan of action to address these serious problems. Thus, as expected, without correction, this problem persisted throughout the six-month period. Of note, during the monitoring team's interview with the Nurse Educator, it was evident that all of her efforts to address the problems referenced above were rebuffed by staff members' supervisors and other management and supervisory personnel. In addition, there was no evidence in any of the nursing reports, meetings, minutes, etc. that indicated that the Nursing Department had discussed and took action to address these	

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		serious problems. However, during the week prior to the review, on or about 8/8/11, the State Office Nursing Coordinator, Valerie Kipfer, identified similar problems in the facility's capacity to ensure appropriate responses to medical emergency drills and the availability of functioning medical equipment. Ms. Kipfer, who immediately intervened and worked closely with the CNE and Nurse Educator throughout the week, ensured that, as of 8/12/11, drills were conducted on all homes and at the DC and all medical emergency equipment was available in designated locations and in working order. Another critically important feature of ensuring adequate, appropriate, and timely response to significant changes in individuals' health was the presence and availability of nurses. The SASSLC Nursing Coverage policy (reviewed 8/00) stated that the facility will "arrange for licensed nurses sufficient to care for the health related needs of the individuals, including those persons with medical care plans." However, the presence and availability of nursing staff members, especially on the night shift (10 pm-6 am) to address the health needs of the individuals was a problem. Over the past several months, according to the Nursing Coverage Forms, there were a number of nights when two or fewer licensed nurses were on duty and responsible for the delivery of medications and nursing services for the entire campus. It is strongly recommended that SASSLC administration and nursing leadership review this 11-year-old policy and consider revisions to ensure that there are adequate numbers of nurses present and available across all shifts, in accordance with relevant clinical factors and the presence, severity, and complexity of individuals' current health and medical needs across the entire campus.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	According to this provision item of the Settlement Agreement, nurses are responsible to perform and document assessments that evaluate the individual's health status sufficient to identify all of the individual's health care problems, needs, and risks. In accordance with the provisions of the Settlement Agreement, the DADS Nursing Services Policy and Procedures affirmed that nursing staff would assess acute and chronic health problems and would complete comprehensive assessments upon admission, quarterly, annually, and as indicated by the individual's health status. Properly completed, the standardized comprehensive nursing assessment forms in use at SASSLC would reference the collection, recording, and analysis of a complete set of health information that would lead to the identification of all actual and potential health problems, and to the formulation of a complete list of nursing diagnoses/problems for the individual. Quarterly and annual nursing assessments were filed in each of the 20 sample	Noncompliance

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		individuals' records. However, only 2 of the 20 nursing assessments had most of the elements of the comprehensive nursing assessment documented in a complete and accurate manner. For example, Individual #39 was a 35-year-old woman with several significant health and behavior needs and risks. Individual #39 had a plan to address her obesity, but, over the past several months, she suffered a rapid weight loss and continued to lose weight at a higher rate than what was planned or desired. This problem prompted her physician to order a dietary consultation and close monitoring of her diet and nutrition status. In response to the changes in Individual #39's health status, her RN case manager ensured that her quarterly nursing assessment was kept updated and referenced the significant changes in her health status and needs on Individual #39's nursing assessment as they emerged. Eighteen of the 20 nursing assessments, however, failed to provide a complete, comprehensive review of the individuals' past and present health status and needs and their response to interventions, including but not limited to medications and treatments, to achieve desired health outcomes. Thus, the conclusions (i.e., nursing diagnoses) drawn from the assessments did not consistently capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. This was a serious problem because the HMPs, and the selection of interventions to achieve outcomes, were based upon incomplete and/or inaccurate nursing diagnoses derived from incomplete and/or inaccurate nursing assessments. As a result, a rating of noncompliance has been given to this provision item. Across 18 of the 20 sample individuals reviewed, comprehensive nursing assessments had many of the deficiencies described below: • Lists of current active medical diagnoses were incomplete and not up-to-date, • There were no meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments, • Dates and results of mealtime monitoring were occasionally blank or documented with limited, uninformative phrases, such as "Ate fairly well," • When significant weight changes were documented, there were no evaluations of the nature and impact of the changes on the individuals' health status, • Tertiary care reviews were incomplete, • Individuals' significant histories of chronic and acute conditions, including, but not limited to, genetic syndromes, aspiration pneumonias, contagious diseases, sensory impairments, etc., were not completely identified and evaluated, • Nursing assessments that indicated that nonverbal individuals' pain might be determined by their self-injurious behavior and gestures, failed to reference an evaluation of the location, intensity, onset, duration, quality, etc. of the individuals' pain, and none explained how, where, when, and what	

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		behaviors/gestures were associated with the individuals' communication of pain. • Individuals' persistent, recurring problems, such as alteration in skin integrity, infection, vomiting, diarrhea, constipation, insomnia, etc., were sometimes noted by their nurses in the nursing assessments, but frequently they were not. Thus, they were not adequately evaluated, diagnosed, or addressed vis a vis care plan(s). • Frequently, the conditions of individuals with severe contractures, spasticity, scoliosis, and other deformities were not accurately portrayed. Rather, the "musculoskeletal" sections of their nursing assessments indicated that there were "no abnormal findings." • A number of Braden Scales were significantly underscored, especially in the sections of the scale that quantify the presence of moisture, inactivity, immobility, and inadequate nutrition. Thus, individuals with high risks of developing pressure sores were not identified and plans to address their risks were not made. • Lists of nursing problems/diagnoses were incomplete and, occasionally, referenced problems/diagnoses that were not identified or revealed during the comprehensive assessment or elsewhere in the individuals' records. • Nursing summaries were confusing. The summaries were usually run-on sentences and/or lists of discrete events, such as medication changes, appointments, lab test results, clinic visits, etc., which failed to provide an organized, thoughtful, recapitulation of the individuals' health status over the quarterly review period and failed to put forward nursing interventions/recommendations to address the individuals' progress/lack of progress toward the achievement of their desired health outcomes. Sometimes they summarized the review period, and other times they referenced events, illnesses, etc. that occurred in the distantly related past. The following examples from this sample indicated the seriousness of this problem at SASSLC. • Individual #142 was a 39-year-old man diagnosed with mild mental retardation, schizophrenia, seizure disorder, myopia, and periodontitis. Over the past several months, Individual #142 suffered fractures of his left foot and right ankle, both of which failed to heal in an uncomplicated manner. Rather, he suffered several setbacks, such as increased swelling and bruising, displacement/movement of the fracture line, etc., and required an extensive period of time immobilized and without bearing weight on his affected extremities. Notwithstanding these health problems, needs, and risks, his past two quarterly nursing assessments failed to reference his need for a habilitation	

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		consultation and use of adaptive aids, such as wheelchair, walker, cast, Cam boots, etc., inaccurately portrayed him as "independent" with toileting, underscored his risk for developing pressure sores, and implausibly indicated that an assessment of his musculoskeletal system revealed "no abnormal findings." In addition, his nursing assessments failed to make any reference to the fact that during the review period he was diagnosed with and treated for possible exposure to an infectious and contagious condition. • Individual #143 was a 49-year-old woman diagnosed with many health needs and risks that included spastic quadriplegia, severe thoracolumbar scoliosis, seizure disorder, neurogenic swallowing disorder, asthma, osteoporosis, constipation, history of abscess and cellulitis, and history of recurrent pneumonia. The most current comprehensive nursing assessment filed in Individual #143's record was dated 4/24/11. This assessment failed to accurately portray Individual #143's current health needs and risks. Of note, since the 4/24/11 nursing assessment, Individual #143 was hospitalized on two occasions – once for an acute febrile illness and once for sepsis and acute bronchitis. As of this review, there was no evidence that head-to-toe, updated assessments were completed after Individual #143's serious illnesses and hospitalizations. This was a significant omission that had resulted in the failure to develop adequate and appropriate HCPs to meet Individual #143's health needs and risks. As of this review, Individual #143 was back in the hospital for evaluation and treatment of yet another episode of acute respiratory distress. • Individual #288 was a 32-year-old female diagnosed with profound mental retardation, hydrocephalus with bilateral shunts, spastic quadriplegia, bilateral dislocated hips, osteoporosis, GERD, recurrent small bowel obstruction, allergic rhinitis, blindness, and constipation. Despite Individual #288's gastrointestinal problems, needs, and risks related to her GERD, dysmotility, and recurrent small bowel obstruction, her 5/19/11 nursing assessment failed to include the results of a current mealtime monitoring by her nurse. Rather, there was only the cryptic reference to a meal monitoring conducted by her nurse on 2/15/11 that stated, "[Individual #288] has enteral feeding – correct formula and rate." In addition, although Individual #288 has severe flexion contractures of all extremities, spastic quadriplegia, and bilateral dislocated hips, her nursing assessment erroneously indicated that there were "no abnormal findings" of her musculoskeletal system. Also of significance, Individual #288's nursing assessment failed to evaluate and reference the impact of her hydrocephalus with bilateral shunts on Individual #288's health and safety risks related to her potential for infection, obstruction, increased intracranial pressure, neurological deficits, etc. • Individual #136 was a 44-year-old woman diagnosed with many health needs	

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		and risks that included microcephaly, blindness, immobility, spastoathetoid quadriplegia, spastic scoliosis, IgA nephropathy, hypercholesterolemia, constipation, and anemia. Individual #136's nursing assessment failed to completely list her current active medical diagnoses, weight, significant history of pneumonia, and transfer to the emergency room for treatment of a laceration to the left side of her head/face. In addition, Individual #136's nurse referenced in her nursing assessments that Individual #136 suffered from all of the negative side effects of her prescribed medications. For example, Individual #136's nurse noted that she responded to her multivitamin with "upset stomach and diarrhea," responded to her calcium with "vomiting, belching, and constipation," responded to her Tylenol with "rash and hives," etc. Notwithstanding the documentation of these exceedingly undesirable responses to her medications, her nurse concluded that all of her medications were "effective." The nurse's apparent misunderstanding of how to correctly follow the "Guidelines for Comprehensive Nursing Assessment" generated a multitude of misinformation, which went unnoticed by Individual #136's interdisciplinary team members and not corrected for at least the past year.	
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.	According to the facility's POI, Section M3, since the prior review, the RN case managers received training that included detailed instructions regarding the individualization of care plan interventions and ensuring planned interventions to achieve person-centered goals versus over reliance on standardized plans. According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of the interventions. At SASSLC, Health Management Plans were usually assembled by the individual's RN Case Manager and/or the On-Duty RN in response to identified health needs, identified risks, and/or significant changes in health status. Thus, all of the 20 individuals reviewed had some aspects of some of their health needs and risks referenced in Health Management Plans (HMP) and/or Acute Care Plans (ACP). However, as noted in the prior review, across all individuals reviewed, HMPs and ACPs continued to fail to meet basic, minimum standards of practice or the provisions of the Settlement Agreement. Some general comments regarding the 20 sample individuals' care plans are below.	Noncompliance

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		• Individuals' records often contained a hodge-podge of various and overlapping HMPs with various dates and time frames, some of which incorrectly indicated that the implementation date of the plan preceded the baseline assessment date. • Current plans were mixed with outdated plans that lacked information and/or evidence of resolution/discontinuation, which made it difficult, if not impossible, to discern what interventions the nurses and direct care staff were expected to implement and evaluate. • Thus, not surprising, there were significant discrepancies between the interventions referenced in the plans that were expected to be implemented versus the actual delivery of health services and supports to the individuals. • Plans were generic, "stock" mini-plans that did not provide specific person-centered interventions as a foundation for positive, desired health outcomes. Thus, despite the dramatic differences between individuals, such as a physically healthy young male and a contracted, immobile, blind, nonverbal, medically fragile woman, the "Components/Common Causes," "Subjective and Objective Findings," "Nursing Diagnoses," "Nursing Interventions/Plan," "Actions," "Criteria for Prompt/Immediate Referral to the Primary Care Practitioner," "Criteria for Consultation with the RN/LPN," "Criteria for Implementation of Nursing Protocol," "Documentation," and "Follow-up" requirements of their HMPs were identical. • Although there were a few plans with dates and signatures indicating periodic, albeit not quarterly, reviews of HMPs, changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes did not trigger or results in revisions to their HMPs and ACPs. • The objectives and expected outcomes referenced in the HMPs and ACPs were not appropriately individualized, and they did not reflect the individuals' participation in the development of their desired health outcomes. Rather, the "goals" were sometimes confused with the interventions and duties of nurses and direct care staff members and/or appeared to be based upon the individuals' nurses' limited expectation that the individuals should suffer one-less frequent negative health event/outcome than they did the year before. • Three of the 20 individuals reviewed had a "Medical Care Plan" developed by the Medically Fragile Unit Nurse that was filed in their record. It was unclear, what, if any, relation these plans had to the actual delivery of medical and nursing interventions since there was no evidence that these plans were reviewed by anyone and/or revised, when appropriate. Rather, they appeared to be outdated, stagnant, not implemented, and unrelated the current status of the delivery of health care services and supports to the individuals.	

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		Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #54 was a 54-year-old man with many health needs and risks that included schizophrenia, depression, neurofibromatosis, seizure disorder with VNS, osteopenia, GERD, dyslipidemia, benign prostatic hypertrophy, small hiatal hernia, gingivitis and very poor oral hygiene, and nocturnal enuresis. Over the past several months, Individual #54 was hospitalized twice – once for treatment of urinary tract infection, and once for hematemesis. Notwithstanding Individual #54's many chronic and acute health problems and needs, there was no evidence that comprehensive health care plans had been developed to meet his needs. Rather, at the time of the review, he had only two health care plans filed in his record – one for vomiting, and one, albeit incomplete, for urinary tract infection. A review of both of these plans and the IPNs filed in Individual #54's record revealed that the interventions, actions, follow-up activities, and documentation requirements specified by the plans were not consistently implemented. • Individual #311 was a 59-year-old man with Down Syndrome, hypothyroidism, heart disease with pacemaker, history of recurrent aspiration pneumonia, enlarge cerebral ventricles, vision impairment, and onychomycosis. Despite his many health needs and risks, there were only two incomplete health care plans filed in his record – one related to aspiration pneumonia, and the other related to his gastrostomy tube. The absence of a complete individualized health care plan placed Individual #311's health and safety at risk. • On 5/6/11, Individual #61's interdisciplinary team affirmed that one of the areas where Individual #61 needed the most support was "maintaining her health." Thus, Individual #61's team strongly recommended "medical monitoring daily." Indeed, Individual #61 was a 69-year-old woman who was diagnosed with profound mental retardation, nonalcoholic fatty liver disease, diabetes mellitus, hypertension, seizure disorder, degenerative joint disease, osteopenia, constipation, failure to thrive with anorexia and weight loss, spasticity and hyperreflexia of lower extremities, right ankle fracture, and constipation. At the time of the review, Individual #61 had seven health care plans related to diabetes, fracture, seborrheic dermatitis, failure to thrive, chronic pain, vomiting, and g-tube filed in her record. These plans were related to some, but not all of Individual #61's health problems. Thus, several of her significant health needs, which were longstanding and related to her liver disease, osteopenia, constipation, hypertension, immobility, and sensory impairments, were not addressed. Although most of the plans that needed at least quarterly reviews had a date of review documented on the plan, there was no evidence that the plans were appropriately revised in response to Individual #61's failure to progress toward achieving her desired health outcomes. Also,	

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		none of the plans were integrated or related to one other, and many were based upon general strategies and interventions that were almost completely unrelated to Individual #61's strengths, limitations, needs, and risks. • Individual #95 was a 21-year-old woman diagnosed with moderate mental retardation, Cornelia de Lange Syndrome, intermittent explosive disorder, oppositional defiant disorder, self-injurious behavior, constipation, and history of significant weight loss. Over the past several months, Individual #95 lost 30 pounds, suffered a number of self-inflicted injuries, including a serious head injury that required emergency medical treatment and staples to close, and was evaluated and treated for left knee cellulitis/MRSA infection. At the time of the review, Individual #95 had health care plans related to her head injury, pain, oral hygiene deficit, constipation, cellulitis/MRSA infection, psychotropic medication side effects, and nutritional imbalance/underweight status. Most of Individual #95's plans were developed almost one year ago, and none were reviewed at least once every three months. In addition, despite Individual #95's history of significant weight loss to the point of insertion of an enteral feeding tube when her weight dropped to 71 pounds, there was no evidence that several of the interventions referenced in Individual #95's health care plan, such as monitoring her weight on a weekly basis, keeping a food diary, assessing caloric intake every two to four weeks, etc. were implemented. Of note, none of Individual #95's health care plans referenced the impact of her genetic disorder – Cornelia de Lange Syndrome – on her health status. This deficiency in health care planning was especially significant because Individual #95's genetic disorder was associated with many common medical and health problems, such as GERD, seizure disorder, heart defects, vision problems, hearing loss, musculoskeletal difficulties, etc., all of which had the potential to adversely impact Individual #95's health and safety.	
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.	Since the prior monitoring visit, the plans and priorities of the Nursing Department with regard to establishing and implementing nursing assessment and reporting protocols at SASSLC were recently bolstered by the new additions to the facility's nursing leadership team. At the time of the review, the Chief Nursing Executive and the Nursing Operations Officer, who had been on the job only two and three months, respectively, were in the midst of implementing a number of positive changes in the Nursing Department. But, within each area of positive change, there continued to be a substantial amount of work to be done in order to achieve compliance with this provision item. SASSLC's progress toward the establishment and implementation of nursing assessment and reporting protocols sufficient to address the health status of the individuals had weakened from the loss of five RN positions to other departments, extended leave of absence of one nurse manager, and vacancies of five nursing positions, and high turnover	Noncompliance

#	Provision	Assessment of Status	Compliance
		of nurses, especially the LVNs. Therefore, this provision item was rated as being in noncompliance. Over the past two months, the new CNE immersed herself into her role, re-established leadership in the Nursing Department, and took swift action to address some of the more immediate needs of the nurses at SASSLC. For example, she reduced RN case manager case loads, streamlined assessment and reporting protocols, improved working conditions for nurses, built bridges with other departments and clinical professionals, and drafted several careful, strategic plans for the future. The Nursing Operations Officer worked closely with the CNE. During the interview with the NOO, he reported that, with the assistance of the State Office Nursing Coordinator, there were several positive changes in the Nursing Department since the prior monitoring review. He reported more equitable distribution of responsibilities and duties, decreased favoritism, and increased accountability from nursing staff members. He also reported that the once overwhelming and confusing assessment and reporting protocols had been simplified and clarified, such that nurses across the facility were aware of what was expected of them and how they would be monitored and evaluated. "Increased team building," "leading by example," and "closely looking at what's being done and how it's done," were considered by the Nursing Operations Office to be the three most important processes implemented by the new nursing leadership team to address problems with staffing, morale, and nursing conduct and performance. The CNE, NOO, and Nurse Managers met on a weekly basis. During these meetings, staffing issues, policies and procedures, nurses' education and training topics, plans of correction, and other management matters were discussed. During the review, the monitoring team attended one of the weekly meetings and observed that various plans to address staff turnover, fill vacant positions, improve medication monitoring, and provide training in weight and vital sign monitoring were being made. These plans were slated for communication at the next general staff meeting tentatively scheduled to occur during the last week of August 2011. This would be the first general staff meeting convened by the new nursing leadership team. According to the facility's POI, since the prior monitoring visit, "no new initiatives" were implemented to address this provision of the Settlement Agreement. However, during the review, it was evident that there were indeed some steps that had been taken to help communicate expectations for the delivery of quality nursing care to the facility nurses. For example, to promote interdisciplinary communication, the dietician was added to the membership of the daily clinical services meeting, team representatives such as the QMRP Coordinator, QA staff members, etc. were invited to attend the weekly nursing leadership meetings, and, as of 8/11/11, a new communication tool – the On-Duty RN	

#	Provision	Assessment of Status	Compliance
		Shift Report - was implemented. The CNE reported that she spent considerable time and effort working with other disciplines as part of her efforts to create and shape systems of communication and collaboration between departments and among members of the interdisciplinary team. This collaboration had worked especially well with the Quality Assurance Department, specifically through the Nursing Department's collaboration with the Quality Assurance Nurse. As a result of this collaboration, there were extensive analyses and reports of the results of the monthly monitoring activities, reliability measurement, identification of patterns and trends, specific recommendations for corrective actions, and follow-up to resolution of problems that were identified through the monitoring reviews (also see section E above). Since the prior monitoring visit, the Nursing Department conducted baseline monitoring assessments of performance across 12 areas of nursing care. Thus, they were at the point where the monitoring process had begun to provide them with valuable information about the status of their performance improvement activities and the outcomes of their long-standing and newly established nursing assessment and reporting protocols. Truly, this aspect of the development of assessment and reporting protocols had markedly progressed since the prior monitoring review. Currently, the Nursing and Quality Assurance Departments were collaborating on developing a revised 180-day order form and a worksheet for annual lab tests and consultations, which would help ensure that physicians' orders for lab tests and consultations were accurately recorded, effectively communicated, and properly implemented in a timely manner. The QA Nurse continued to conduct Quality Improvement Death Review of Nursing Services. Each review resulted in a number of pertinent and relevant findings and recommendations, and, together, all reviews revealed a similar pattern of problems and resulted in similar recommendations. For example, the QA Nurse astutely recommended that (1) nursing leadership should develop strategies to address problems in documentation, assessment, and planning, and (2) the Nurse Educator should provide direct care RNs and RN case managers additional training and education across all aspects of the nursing process. As of the review, there was no evidence of follow-up to these recommendations. The monitoring team met with the Infection Control Nurse during the onsite review to discuss the status of SASSLC's infection control and surveillance program. As noted during the prior monitoring review, the Infection Control Nurse was directly involved in regular processes of assessment and reporting of infections, and he continued to conduct weekly reviews of antibiotics and monthly infection control rounds of a sample of living and program areas. All of the information related to identification, tracking and trending,	

#	Provision	Assessment of Status	Compliance
		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 explained that he uses a "practical approach" to infection identification, reporting, and prevention that starts with "hygiene." For example, the Infection Control Nurse provided direct care staff members 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. Although the Infection Control Nurse had received the state's Infection Control Manual, he had not yet had the opportunity to ensure that SASSLC's infection control policies and procedures were aligned with the state's policies, procedures, standards, and expectations. This was a project that was planned for when, and if, the Infection Control Nurse had time to spare from his direct care duties. The Infection Control Nurse was only one person, and as he well stated, "[infection control] is something that others can do, too." The Hospital Liaison was directly involved in the daily processes of nursing assessment and reporting protocols. She ensured 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, interdisciplinary team members, and home supervisors, and were also filed in the individuals' records. She was able to describe the status of Individual #143's hospital course, collaboration she had with her hospital physician, and discharge planning efforts recently initiated. She reported collaboration and coordination with facility staff including physicians, RN Case Managers, and direct support staff in order to assure a safe and complete transition of the individual upon readmission. The Hospital Liaison was also identified as the "Skin Nurse," but since the prior monitoring review, she candidly reported that she was no longer able to well cover this important aspect of individuals' health, nursing, and medical care. She described the current system whereby the Infection Control Nurse reportedly monitored skin infection and the Hospital Liaison reportedly monitored alteration in skin integrity due to pressure, but the disjointed system was not working. As a result, the identification, tracking, recording, monitoring, and follow-up of alterations in skin integrity had fallen far short of where they had been and needed to be.	

#	Provision	Assessment of Status	Compliance
		Another area of assessment and reporting that needed improvement to achieve substantial compliance with the Settlement Agreement was nursing education and training. SASSLC continued to employ a full-time Nurse Educator, who was an accomplished, experienced nurse with over 30 years experience in nursing education and training. She continued to coordinate the annual competencies skills fair as well as provided required new employee and annual training. As noted in the prior monitoring review, 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, but the staff and resources to provide competency-based training on assessment, including physical assessment, and care plan development were still not available. A review of the results of the 2011 Annual Nurse Competencies Physical Assessment Test scores revealed disturbing results. Eighty percent of the nurses who were tested scored less than 80%, and 44% of the nurses who were tested scored less than 70%. In addition, a number of nurses who scored 70% or higher were "coached," that is, the Nurse Educator prompted them to correctly answer the competency test question(s). When the Nurse Educator was asked what, if any, follow-up occurred to address the very low competency test scores, she stated that nurses were always offered an opportunity to receive refresher education and training to address their knowledge deficits, but they almost always refused to participate or attended the scheduled refresher training sessions. The absence of a successful competency-based training and education program continued to contribute to the problems noted in Sections M1 –M3, M5, and M6. In addition, there continued to be challenges and frustrations among the ranks of the nurse managers, charge nurses, and nurse case managers. All of these nurses voiced concern regarding the need for additional training and support to achieve expectations of the provisions of the Settlement Agreement, especially in the realm of nursing assessment and development of care plans. They also reported that staff turnover, unscheduled absence, and minimum staffing levels, which were outdated and based upon acuity levels present at the facility over a decade ago, continued to present daily barriers to the delivery of safe, quality nursing care.	
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	At the time of the monitoring review, although SASSLC was eight months into its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the PSP process, the facility's POI stated that since the prior monitoring review, "no new initiatives [in this provision item] have been implemented." During the conduct of the review, the monitoring team attended two special PSPA meetings with the full monitoring team, which were held as a result of significant	Noncompliance

#	Provision	Assessment of Status	Compliance
	individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	changes in individuals' health and/or behavior status and needs, and so that the monitoring team could learn more about SASSLC's implementation of the at risk policies and procedures. Both of the QMRPs who chaired the meetings were prepared, organized, and participated in keeping the meeting discussion focused and on track. Although the QMRPs gave some of that role/responsibility to the individuals' clinical professionals, it did not take away from the process. The conduct of the RN case managers who participated in the PSPAs continued to need improvement. For example, during Individual #108's PSPA, the nurse case manager came to the meeting somewhat prepared, but frequently did not have a well-informed and/or well-formulated opinions regarding the individual's level of risk for particular areas of his health status. For example, during the discussion of Individual #108's risks of aspiration and choking, it was unclear whether or not the nurse case manager had an adequate understanding of the relationship between the individual's behavioral manifestations of hand mouthing and rumination and his gastrointestinal distress and pain. In fact, the nurse case manager actively sought to limit the discussion of the impact of the individual's behavior on his health risk assessment and its relevance to his risk action plan and stated, "We have a BSP for that [hand mouthing and rumination]." Individual #170's nurse case manager attended the PSPA, but did not contribute to the discussion of his health and behavior risks. After the meeting, however, Individual #170's nurse case manager introduced herself to the monitoring team and explained that she failed to contribute to the discussion because she was only recently hired and had not had the opportunity to participate in prior risk assessment team meetings. It was apparent that in order for the facility to achieve compliance with this provision of the Settlement Agreement, additional steps must be taken to ensure that all clinical professionals are aware of the expectations that they must be knowledgeable of all of the individual's relevant health risk information within their scope of practice, come to the meetings prepared, and actively participate in identifying level of health risk(s) and developing action plans that reduce the risk of negative health outcomes. All 20 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and several individuals reviewed were referred to as having one or more "high" health risks. Since 1/1/11, no more than half of the 20 sample individuals whose records were reviewed were also reviewed by their PSTs and assigned levels of risk that ranged from low to high across several health and behavior indicators. Also, health risk ratings were not consistently revised when significant changes in individuals' health status and needs occurred. Therefore, this provision item was rated as being in noncompliance.	

#	Provision	Assessment of Status	Compliance
		Examples included the following: • Over the past several months, Individual #40 suffered two hospitalizations for treatment of aspiration pneumonia, cellulitis of the site of her gastrostomy tube, and urinary tract infection. Her recovery from these acute illnesses was affected by her chronic health problems such as diabetes, hypothyroidism, heart disease, seizure disorder, and hypoalbuminemia. Despite Individual #40's negative health events and compromised health status, Individual #40's respiratory risk remained "medium" because, according to her PST, "[Individual #40] receives breathing treatments for her asthma," her skin integrity and urinary tract infection risks remained "medium" because, according to her PST, "[Individual #40's] only two episodes of alteration in skin integrity were primarily stoma site," and "[she] has not had a urinary tract infection in six months," and her risk of infection remained "low" because, according to her PST, "[Individual #40 had] none." Apparently, Individual #40's PST failed to receive adequate input and information from Individual #40's clinical professionals who would have presumably clarified that her (1) risks of aspiration and aspiration pneumonia were not resolved by breathing treatments for asthma; (2) altered skin integrity, which progressed to cellulitis, had pre-existing conditions (moisture, friction/pressure, and other conditions conducive to growth of bacteria/fungus), which were likely present across other areas of Individual #40's body, and (3) aspiration pneumonia, pneumonia, cellulitis, and urinary tract infection were without a doubt evidence of four episodes of infection during the review period. • Individual #54 had a history of frequent vomiting and hematemesis. On 6/23/11 he was sent to the emergency room for treatment of vomiting, and on 6/30/11 he had an upper endoscopy due to several episodes of hematemesis. In addition, Individual #54 was diagnosed with a seizure disorder, GERD, and a small hiatal hernia. Individual #54 was also prescribed several psychotropic medications that could potentially worsen his respiratory status. Notwithstanding Individual #54's vomiting, reflux disorder, and other gastrointestinal problems, as of the review, Individual #54's risk of aspiration remained "low." • Individual #61 was diagnosed with liver disease, hypertension, seizure disorder, degenerative joint disease, osteopenia, vision impairment, failure to thrive with anorexia and weight loss, and spasticity and hyperreflexia of her lower extremities. Over the past months, Individual #61 suffered a fractured right ankle, alteration in skin integrity of her perineum and buttocks, fungal infection, recurrent episodes of vomiting, and a 22-pound weight gain during the three-month period of April 2011-July, 2011. Notwithstanding her many health needs, as well as her PST's conclusion that her "overall medical risk [was] high," oddly, all of her individual risk ratings were scored either "medium" or "low."	

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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 improve since the prior monitoring review. As indicated in more detail below, although much work still needed to be done to ensure that medications were administered and accounted for in accordance with generally accepted professional standards of care and the Health Care Guidelines, the facility had taken several steps toward identifying and measuring the nature, severity, and scope of their problems in this area. This provision item, however, was rated as being in noncompliance because there continued to be serious problems in this area. During the review, medication administration observations were conducted on homes 665, 668, 670, 671, 672, 673, and 674. As noted in previous reviews, observation of medication passes revealed numerous problems with nurses' compliance with standards of practice and the Health Care Guidelines. • Nurses did not consistently wash and/or sanitize their hands prior to pouring medications and/or between contacts with individuals. • Nurses did not change their soiled gloves between contact with individuals' ostomy sites/dressings and contact with the individuals' medications and clean supplies. • Nurses did not review or properly reference the individuals' Medication Administration Records (MARs) during the assembling and administration of medications. • Nurses, who did not have medications available at the time of administration, stated that they would "have to get [medication], and give [medication] later," but there was no evidence that this would, or could, occur in a timely and appropriate manner. Thus, for all intents and purposes, it appeared as though the individuals failed to receive their medication(s) within the time frame(s), as ordered by their physician. • Nurses were observed setting up and, sometimes, documenting the individuals' receipt of medications on the MARs prior to administration. • During the enteral administration of medications, one nurse failed to check for placement using the facility's two approved/required methods. In addition, the individual's enteral tube was flushed and medications were administered using force/pressure from a syringe versus gravity. • Over half of the individuals reviewed had either a SAM (self-administration of medication) or a pre-SAM assessment and designation filed in their record. During the observations of medication administration, there were little to no distinctions made between the individuals who had abilities to participate more versus the individuals who had abilities to participate less in the self-administration of medications.	Noncompliance

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		A review of the 20 sample individuals MARs/TARs for the period of 7/1/11 – 8/17/11, revealed that more than half had had multiple missing entries in their MARs/TARs which indicated numerous potential medication errors in the administration of seizure medications, laxatives, psychotropics, calcium/vitamin D, diabetes medications, antihypertensives, eye drops, skin treatments, breathing treatments, enteral feedings/fluids, etc. Notwithstanding the problems noted above, a review of the results of the facility's monitoring of medication administration and documentation revealed very high scores that ranged from 96% to 100% compliance. It remained unclear whether or not the facility's monitoring review protocol had been modified to include the observation of an entire medication pass, from start to finish, versus observation of only one or two individuals. It was also unclear whether, or how, the facility's monitoring review protocol captured problems, such medication(s) not given because it was not available at the time of administration, late administration of medications, that is, medications administered over one hour past the prescribed hour of administration, and other problems affecting the safe and accountable administration of medications. Since the prior monitoring review, on 3/23/11, the Chair of the Pharmacy and Therapeutics Committee proposed the establishment of a Medication Error Reduction Committee (MERC). The members of the committee, however, did not accept this recommendation. Thus, as of the review, the Chair of the Pharmacy and Therapeutics Committee continued in her role as the sole receiver/investigator of reported medication errors, data gatherer, analyzer, and reporter. During the review, the monitoring team attended the 8/16/11 Pharmacy and Therapeutics Committee meeting. In addition to polypharmacy data, chemical restraints, adverse drug reaction reports, drug utilization reviews, and updates from the Food and Drug Administration, medication error and variance data were presented. As noted during the prior monitoring review, the majority of the errors were related to pharmacy issues with robot or cart-fill errors that were identified and did not reach the individual. Almost all "errors" were extra dose omission errors 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. Over the past six months, there were only 32 medication errors reported that reached the individual. The most common theme across these errors was the failure of nurses to clarify physicians' orders and correctly administer medications in accordance with the individuals' physician's orders. Of note, there was no evidence that specific	

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		recommendations and or plans of action emerged as a result of these findings. During the Pharmacy and Therapeutics Committee meeting, the following initiatives were put forward for consideration and approval by the Committee: • Reconsideration of a MERC, • Eliminate identified pharmacy omissions and extra doses addressed and resolved before reaching the individual from reported errors, • Take steps to reconcile non-pill form medications, • Consider counting actual "occurrences" of medication variance versus "episodes" of medication variance as potential errors, and • Review the State's new processes for identifying, measuring, and correcting medication variance. As of the monitoring review, the above initiatives were pending further review.	

Recommendations:

1. The facility should develop a plan to address the effect of the transfer of five RN positions out of the Nursing Department, vacant nursing positions (five), the extended leave of one Nurse Manager, increased unscheduled absence, and high turnover rates among nurses (M1-M6).

2. The Nursing Department's structure and utilization of nurses at all levels from LVN to Nurse Manager should be closely re-examined (M1-M6).

3. It is strongly recommended that SASSLC administration and nursing leadership review the 11-year-old Nursing Coverage policy and consider appropriate revisions to ensure that there are adequate numbers of nurses present and available across all shifts, in accordance with relevant clinical factors and the presence, severity, and complexity of individuals' current health and medical needs across the entire campus (M1-M6).

4. The Nursing Department should re-examine its current plan to meet the provisions of Section M of the Settlement Agreement and revise it to ensure that it clearly defines how the department should look, how it should operate, where it needs to go, and how it will get there vis a vis a temporal set of intended actions (M1-M6).

5. Take steps to address the lapses in facility's implementation of its oversight and monitoring of individuals with actual/potential alteration in skin integrity, where timely identification, evaluation, treatment, and prevention measures are critical (M1-M5).

6. Ensure that nursing assessments are accurate, complete, comprehensive and updated when there are significant changes in the individual's health status and/or functioning (M2).

7. Take steps to ensure that the RN case managers are adequately informed of the expectations for them during the conduct of health risk reviews, i.e., the expectations for them to be adequately informed and prepared prior to the scheduled reviews and the expectations for their active participation in the assessment, review, and planning processes to address individuals' health risks (M5).

8. Nursing Care Plans should be revised to include specific goals/objectives that are objective and measurable, as well as individualized interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed, and when they should be modified (M3).

9. Documentation, particularly the SOAP charting as specified in the Health Care Guidelines, needs to be trained and monitored until nurses are implementing the process as it is intended (M1, M4, M5).

10. In addition to new employee orientation and annual mandated training, develop and conduct a rotating cycle of education and training in basic health care that is offered to direct care staff members, who are often delegated a number of health care duties (M4).

11. Take steps to assist the Hospital Liaison to fulfill the roles and responsibilities of her position by ensuring that the Hospital Liaison may conduct hospital visits during the time of day that is most conducive to communication and collaboration with tertiary care clinical professionals (M4).

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines o DADS Policy #009.1: Medical Care, 2/16/11 o Texas Department of State Health Services, Medication Audit Criteria and Guidelines Revised 4/10 Texas Department of State Health Services, Drug Audit Checklist, Revised April 2010 o San Antonio State Hospital/State School Texas Center for Infectious Disease Pharmacy Department Standard Operating Policies and Procedure Manual, 2011 o SSLC Policy: Pharmacy Services, 1/1/11 o SASSLC Policy and Procedure: o SASSLC Lab Procedure Matrix o Pharmacy and Therapeutics Committee Meeting Minutes, 1/26/11, 2/7/11, 3/23/11, 5/18/11, 6/29/11 o SASSLC Medication Error, FY 2011 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #45, Individual #159, Individual #11, Individual #15, Individual #99, Individual #248, Individual #160, Individual #43, Individual #250, Individual #330, Individual #214, Individual #303, Individual #133, Individual #103, Individual #311, Individual #256, Individual #315, Individual #284, Individual #270, Individual #96, Individual #59, Individual #217, Individual #22, Individual #240, Individual #157, Individual #267, Individual #48, Individual #23, Individual #247 o MOSES and DISCUS forms for the following individuals: • Individual #245, Individual #67, Individual #32, Individual #333, Individual #282, Individual #87, Individual #304, Individual #159, Individual #83, Individual #335, Individual #3, Individual #145, Individual #274, Individual #88, Individual #156, Individual #11, Individual #205, Individual #95, Individual #302, Individual #243, Individual #129, Individual #68, Individual #254, Individual #141, Individual #12, Individual #160, Individual #223, Individual #79, Individual #92, Individual #250, Individual #330, Individual #194, Individual #268, Individual #171, Individual #74, Individual #137, Individual #13, Individual #277, Individual #166, Individual #240, o Single Patient Interventions and Notes Extracts: January 2011 – June 2011 o Drug Utilization Evaluation Summaries: • Lithium • Topiramate

	Interviews and Meetings Held: o Sharon Tramonte, PharmD, Clinical Pharmacist o Ashley Smith, PharmD, Clinical Pharmacist o Carmen Mascarenhas, MD, Medical Director Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Daily Clinical Meetings
	Facility Self-Assessment: SASSLC submitted its self-assessment, the POI. It was updated 8/2 /11. The POI did not actually indicate what activities the facility engaged in to conduct the self assessment. The monitor reviewed the presentation book with the SSLC's lead for Provision N. The POI did not indicate how the self-assessment was used in determining the self-rating. The facility rated itself noncompliant for all provisions. Based on observations, interviews and document review, the monitoring team found evidence of substantial compliance for Provisions N4 and N5. Other provisions made significant advances, but fell short of substantial compliance. Provisions N1 and N8 will require much additional work to achieve compliance. An action plan was included in the POI. The plan addressed only three provision items and failed to address two of the most critical provisions, N1 and N8. The facility will need to address all provision items in order to achieve substantial compliance.
	Summary of Monitor's Assessment: The pharmacy department had made advances in most provision items. The State Hospital was documenting interactions in the notes extracts, but additional documentation of the resolutions was needed. The QDRRs were completed in a timely manner, but the parameters outlined in the lab matrix were not always clearly utilized. This resulted in sub-optimal monitoring of the use of psychotropics per the lab matrix. The MOSES and DISCUS evaluations were completed, reviewed and signed, but appeared to have little relevance to the medical staff apart from the psychiatrists. Physicians were responding to the recommendations of the pharmacists. Adverse drug reaction reporting increased, although several ADRs were identified that remained unreported. Drug utilization evaluations were completed, although there were problems related to

	generation of corrective action plans based on recommendations. There was no facility specific policy related to ADRs and DUEs. The facility submitted an SSLC Pharmacy Services Policy dated 1/10/11. This policy appeared to be applicable to all SSLCs and was not a local policy. It was not clear that state office had issued an approved pharmacy services policy. Medication errors remained a serious cause for concern. First, there was no process to reconcile liquid medications. Second, it appeared that errors were underreported based on a failure to count every episode of an incorrect administration or omission. Third, medications returned to the State Hospital were not reconciled. The exact extent of the problem of medication errors will remain unknown until these issues are addressed.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>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.</td><td>Medication orders for the facility continued to be filled by the pharmacy department of the San Antonio State Hospital. Medication orders were faxed directly from the facility to the State Hospital. 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.

During an interview with the clinical pharmacist, it was reported that the State Hospital Pharmacy utilized the notes extracts component of the WORx software. The clinical pharmacists at the SSLC utilized the Single Patient Interventions. The SPIs were primarily utilized to report issues discovered during clinics attended by the clinical pharmacists.

The document request required submission of copies of all Single Patient Intervention Forms and notes extracts since the last monitoring visit. Notes extracts from the State Hospital were provided. This document, consisting of more than 450 pages, provided information on notes extracts from January 2011 through June 2011. The extracts were categorized by type. The number of entries and examples were as follows:

<table>
<tr><th>Type of Note</th><th>Number of Entries</th><th>Examples of Note Text</th></tr>
<tr><td>drugalert</td><td>18</td><td>Entries primarily related to drug restrictions</td></tr>
<tr><td>INTERA</td><td>7</td><td>• 1/13/11 13:40: 1/11/11 at 17:48 - Severity level 1 interaction-naltrexone is an opioid antagonist and thus inhibits the effects of the opioid analgesics – Tylenol #3. Per RPh " couldn't leave message for doctor and unit notified. They stated they would clarify in am,, but please follow up on Wednesday am to make sure. Thanks"
• 2/16/11 16:25: 2/16/11 - Doctor aware of level 2 interaction between Luvox and Cymbalta (possible serotonin syndrome). Plan is to monitor patient and taper off Luvox</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status			Compliance
		INFO	14	• 6/30/11 12:23: Order written 6/28/11, but received drug on 6/30/11 • 4/6/11 15:01: 4/6/11 - Change to solutab due to G-tube clogging • 2/17/11 10:27: 2/9/11 - Changed to 300 mg SR due to shortage of 450mg SR	
		HIST	7	• 5/12/11 12:28: Thicken liquids to pudding • 1/8/11 7:03: There is a history of GI symptoms with divalproex	
		DRUG	3	• 2/14/11 - Drug clarified as Lotrimin cream per nurse on unit • 1/12/11 13:40: 1/12/11 - Changed to Solutab due to capsule beads clogging G-tube per doctor	
		DOSE	2	• 4/3/11 10:28: 4/3/11 – Called doctor to verify Valtrex dose of 2gm q 12hrs x 2 doses – new regimen and this is correct.	
		CLIN	15	• 6/23/11 14:43 – NPO for breakfast on 6/24/11 for Gyn appt • 1/25/11 12:40: Doctor does not agree with changes per Neurology consult • 6/21/11 7:36: Last dispensed 5/26/09. Informed doctor of this. Requested that order be discontinued	
		ALLERG	6	• 6/9/11 16: 49: 6/9/11- Patient has no known drug allergies per RN case manager on unit • 4/15/11 - Patient has no known drug allergies per admission order	
		ADMIN	28	• If refuses liquids, thicken liquids to honey and spoon feed • May give meds in applesauce/pudding • NPO. Crush meds and give through G-E	
		alleralert	68	See comments below	
		ddialert	142 pages		
		duplalert	282 Pages		

Of the 68 allergies noted, only 5 of the entries contained explanations from the SSLC staff.

<u>Drug Interactions Alerts</u>
Multiple pages of alerts were provided. The notes dated January 2011 contained several explanations such as "physician is aware and approved" and "drug monograph will be sent to MD for review." The notes from subsequent months did not document physician explanations or responses.

<u>Therapeutic Duplication</u>
Therapeutic duplication alerts were documented for issues, such as the use of multiple forms of a drug, multiple doses, and the use of multiple drugs within the same class. The entries did not appear to include documentation of physician notification or response.

The requirement to have documentation of physician notification of prescribing issues required that actual physician notification and response to the recommendations be documented. The documentation provided did not consistently indicate resolution to the

#	Provision	Assessment of Status	Compliance
		problems identified. The clinical pharmacist informed the monitoring team that regular meetings occurred with assistant pharmacy director at the State Hospital and she believed that process improvement would be incremental.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	A total of 30 QDRRs were reviewed to determine substantial compliance. The clinical pharmacists completed Quarterly Drug Regimen Reviews within the required timelines. The QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. The State Hospital/State School policy indicated that concurrent drug regimen reviews "required monitoring parameters for the medication regimen which have been ordered." The facility had adopted the lab matrix as the official set of monitoring parameters for drug use. This required monitoring related to labs, vital signs, and other diagnostics associated with drug use. Overall, the QDRRs were completed thoroughly and in a timely manner. Each review contained a table listing pertinent lab values. In most instances, all values were documented. In the case of complete blood counts and metabolic panels, only the abnormal values were provided. Normal ranges were included in the table. In addition to lab values, the clinical pharmacists commented on monitoring parameters, such as EKGs, eye exams, and DEXA scans. Monitoring parameters included in the lab matrix, such as heart rate, blood pressure, and orthostatic vital signs were not documented in the reviews. This was concerning because the facility had no other audits in place to capture compliance with these requirements. Daily clinical services meeting notes indicated that compliance with vital sign monitoring was poor and the CNE was considering implementation of corrective measures. This was a significant problem given the importance of monitoring vital signs with the use of psychotropic agents. Seventeen of 30 (56%) of the QDRRS contained recommendations from the pharmacists. The following are some examples of problems identified with the QDRRs: <u>Individual #15 (6/10/11)</u> • Received quetiapine; orthostatic blood pressures and annual eye exam was required. There was no documentation of either. • No recommendations were made. <u>Individual #214 (6/9/11)</u> • Received propranolol which required monitoring of heart rate and blood pressure. • No recommendations were made.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #133 (6/13/11) • Received alendronate for treatment of osteoporosis. The last DEXA scan was in 2007 and there was no documentation of a Vitamin D level. • The individual also received Atorvastatin, but the last lipid profile was 8/12/10. • There was no documentation of monitoring of heart rate and blood pressure for the use of propranolol. • The last vision exam was 9/16/09. • The recommendation was made to have annual exams due to use of psychotropics. Individual #303 (6/10/11) • Received metformin, valproic acid, and olanzapine. There was no discussion of a significant thrombocytopenia. • The last eye exam was 4/4/10. • The recommendation for eye evaluation was made. Individual #103 (6/13/11) • Received fish oil for elevated triglycerides; also received propranolol. • The last triglyceride level was 383. There was no recommendation given for treatment or follow-up. • No heart rate or blood pressure for propranolol monitoring was documented. Individual #159 (6/21/11) • There was a significantly elevated TSH of 7.03, but no recommendation was made for follow-up. Individual #43 (6/23/11) • Received lithium. The last UA was 12/6/10. There was no recommendation made for a repeat UA as required every 6 months. • There was no documentation of the required annual EKG. • No recommendations were made. Individual #11 (6/21/11) • Received lithium. There was no UA documented. • The individual also received propranolol and had an EKG on 7/30/10 that showed a sinus bradycardia. An EKG was required annually. There was no BP and heart rate monitoring documented. • No recommendations were made.	

#	Provision	Assessment of Status	Compliance
		Individual #250 (6/23/11) • Received quetiapine. There was no documentation of monitoring of orthostatic blood pressures. • No recommendations were made. Individual #330 (6/23/11) • Received propranolol, but no heart rate and blood pressure monitoring was documented. • Received olanzapine which required an annual EKG and eye exam. • No recommendations were made. Individual #99 (6/15/11) • There was no monitoring of heart rate and blood pressure for propranolol use. • No recommendations were made. Individual #160 (5/4/11) • Received lithium. There was no documentation of the EKG findings. • There was no recommendation to obtain an EKG. Individual #45 (5/27/11) • Received Atorvastatin. The last lipids were in 2009. • No recommendations were made. Individual #248 • Received ergocalciferol, but the last Vitamin D was 2/17/10. • No recommendations were made. Individual #170 • Received levothyroxine for treatment of hypothyroidism. The TSH was 8.71 on 4/11. The recommendation was to write orders for routine lab monitoring. There was no recommendation regarding immediate follow-up of the TSH. No further labs were documented. Individual #213 (7/14/11) • Received levothyroxine for hypothyroidism. The TSH was .19 on 10/10. The QDRR commented on low TSH, but did not make an actual recommendation to repeat.	
N3	Commencing within six months of the Effective Date hereof and with	The use of stat drugs was discussed in the daily clinical services meeting attended by the primary care physicians, psychiatrists and psychologists. The P&T meetings also	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	contained some discussion related to stat drug use. The facility did not have a polypharmacy oversight committee. The use of polypharmacy was justified by the psychiatrist and the team in the quarterly clinic notes. Polypharmacy data were also documented in the P&T minutes. The use of the new generation antipsychotics and the risk of developing metabolic syndrome were monitored through the Quarterly Drug Regimen Reviews. The facility lab matrix outlined the parameters for monitoring. Monitoring of monthly weights and BMIs was added in May 2011. Generally, this monitoring was completed. It was reported that monitoring of vital signs was problematic. Compliance with these parameters was not captured in the QDRRs although the facility lab matrix required monitoring of blood pressure, pulse and orthostatic vital signs for the use of some psychotropics. The use of benzodiazepines and the anticholinergic burden was consistently documented in the QDRRs.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	In order to determine substantial compliance with this provision item, the 30 QDDRs discussed in item N2 were assessed to determine the adequacy of the responses from both the primary providers and the psychiatrists. Data related to the primary provider response showed: • 30 of 30 documents included signatures of the primary care provider indicating that review occurred • 17 of 30 reviews had recommendations made by the pharmacist • 12 of 17 reviews indicated that the PCP would consider the recommendation • 1 of 17 reviews indicated the PCP would not consider the recommendation and an explanation was provided on the document. • 4 of 17 were documented as not applicable The psychiatric provider was also required to review the QDRRs: • 20 of 20 reviews included signatures of the psychiatrist indicating that review occurred • 20 of 30 reviews involved the use of psychotropics • 11 of 20 reviews included recommendations by the pharmacist • 5 of 11 reviews were considered not applicable • 6 of 11 reviews indicated the psychiatrist would consider the recommendations Signatures were included on every QDRR reviewed. Some completed by the psychiatrist	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		lacked a date.	
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.	A request was made for forty MOSES and DISCUS tools. Forty one examples of MOSES and DISCUS evaluations were provided. The last two reviews for each individual were submitted resulting in 82 documents in each class. Eighty two MOSES tools were reviewed. The findings of the documents were: • 82 of 82 (100%) were signed and dated by the physician • 53 of 82 (65%) documented no action necessary • 21 of 82 (26%) documented drug changes made • 8 of 82 (10%) documented no conclusion by the prescriber Eighty one DISCUS evaluations were reviewed and showed that: • 82 of 82 (100%) were signed and dated by physician • 70 of 82 (85%) indicated no TD • 8 of 82 (9.7%) indicated TD • 4 of 82 (4.9%) documented no prescriber conclusion The MOSES evaluation was to be completed every six months while the DISCUS evaluation was required every three months. These evaluations were completed in a timely manner. This was evident in the document sample as well as the record sample. Physician response and comments noted in the evaluations indicated that the information was being reviewed and responded to appropriately. The information did not appear to be shared with the neurologist and was never noted in any of the neurology consults. Moreover, even when relevant, the findings were not included in the annual medical summary.	Substantial Compliance
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.	Significant improvement was noted in the reporting of adverse drug reactions. It was evident that the facility was beginning to make progress in safe medication practices through the interfacing of several processes such the ADR and DUE systems. Moreover, there was continuous and ongoing training for staff related to recognition of ADRs. Beginning in February 2011, all new employees received training on adverse events associated with the use of psychotropic medications. In March 2011, the clinical pharmacists began providing in-services to the direct care professionals on psychiatric medication changes and the potential side effects of these medications. Notes from the Pharmacy and Therapeutic Committee meetings documented that ADRs were reviewed and discussed in the meetings. The documents reviewed contained ADR reports from January 2011 through June 2011.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Four additional ADRs were reported in the August P&T Committee meeting. Documentation of the July 2011 ADRs was not submitted and minutes of the July 2011 P&T meeting were not available at the time of the onsite review. Twenty-seven adverse drug reactions were reported from January 2011 to June 2011. • 6 of 27 ADRs were related to alternations in blood counts • 3 of 27 ADRs involved elevated prolactin levels Quetiapine, trazodone, clonidine, and lorazepam were implicated in ADRs discussed in the August 2011 P&T Committee meeting. Two of the ADRs are summarized below. <u>Individual #104</u> • A prolonged QTc interval was associated with the use of quetiapine. It was reported that the computer provided an incorrect reading of the QT interval resulting in this incident being considered an ADR. The facility did not require the EKGs to be over-read by a cardiologist, but accepted the computer interpretation and over read by the primary care physicians. <u>Individual #7</u> • The individual experienced a drop in BP to 88/58 with HR of 91 associated with the use of clonidine. The individual remained stable and clonidine was discontinued. The facility pharmacy operational policy required that all expected ADRs be reported. Numerous documents provided contained evidence of potential ADRS: • 6/16/11 - The daily clinical meeting notes discussed a case of gynecomastia possibly related to Reglan. This resulted in discussion related to the frequency of breast exams in males. • 6/21/11 - Individual #165 experienced a decreased appetite possibly related to medication. • Individual #93 had hyponatremia possibly associated with Trileptal P&T meeting notes contained a summary of all ADRs submitted since September 2010. A concise analysis of the data was also provided. It was good to see the various monitoring systems were connected through data analysis. For example, summary data indicated that 11 ADRs involving the drug valproic acid were reported. This represented 19.6% of all ADRs during that time per period. This data resulted in the P&T Committee requesting a more extensive assessment of the use of this drug. Consequently, valproic acid was placed on the DUE calendar.	

#	Provision	Assessment of Status	Compliance
		The facility had not developed a formal facility-specific policy. There was no clear process related to follow-up of recommendations generated. There was also no process in place to trigger an intense review of serious cases such as those that involved hospitalization. The facility should develop a local policy for the ADR reporting and monitoring system. This operational procedure should specify the steps in the process. It should also set thresholds for completion of an intense case analysis.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The clinical pharmacist reported that the facility completed three DUEs in 2011. The facility did not have a specific policy for this process, but had determined that one DUE would be completed each quarter. DUEs completed in 2011 included lithium, topiramate, and warfarin. A calendar was provided to the monitoring team. Future DUEs included valproic acid and a follow-up to the October 2009 risperidone DUE. Reports were submitted for lithium and topiramate DUEs. The 4th quarter DUE on warfarin was discussed in the August P&T Committee meeting, but no report was provided. The two DUEs submitted were quality evaluations completed by the clinical pharmacists. The reviews are summarized below. <u>DUE #1 - Lithium – March 2011</u> The objective of the DUE was to review appropriateness of indications and compliance with monitoring of baseline and follow-up lab studies. The results of the DUE documented baseline labs, changes in serum creatinine and serum calcium levels, TSH monitoring, and lithium level monitoring. The DUE included several recommendations related to appropriateness of indications, obtaining baseline studies prior to initiation of drugs, and the importance of adequate laboratory monitoring. <u>DUE #2 - Topiramate - February 2011</u> The objective of the DUE was to review indications, contraindications and compliance with laboratory monitoring. The findings of the DUE included: • Topiramate was utilized more for weight attention rather than as a treatment for a psychiatric illness. • Patients on both topiramate and VPA usually had psychiatric indications as opposed to seizure disorder indications.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Topiramate levels were obtained more in the psychiatric population than seizure population. Recommendations were made regarding the documentation of accurate indications, appropriate use of topiramate, appropriate monitoring of drug levels and renal function, and consideration of dose reduction with renal compromise. <u>Additional Discussion</u> The drug selections for the DUEs were excellent choices, relevant to the practices at the facility. Equally as impressive was the quality of the actual evaluations. Even so, the monitoring team believed that some issues related to the specific DUEs and the overall process were worthy of attention: • Compliance rates with requirements for laboratory monitoring were not documented within the text of the lithium DUE, although deficiencies related to compliance were noted in the patient specific data. These deficiencies were the basis of the recommendations made related to monitoring. Compliance with CBC monitoring should have also been included in the review. • The DUE calendar listed a follow-up DUE in fulfillment of the completion of quarterly DUEs. A new DUE should be completed each quarter. As with any performance improvement initiative, there should be follow-up of the implementation of corrective actions to determine if improvement is noted. This follow-up should be ongoing until problems are resolved. Additionally, there should be long term periodic follow-up to document sustained improvement. Follow-up should not be considered a DUE. SASSLC should develop a facility-specific policy to guide the DUE process. The policy should include the requirements of the health care guidelines. Moreover, the policy should specify how recommendations are reviewed, adopted, implemented and followed up.	
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 maintained a system for tracking medication variances. Medication variances were reviewed by the Pharmacy and Therapeutics Committee. Over the past several months, many processes were changed and some new processes were implemented including: • Changes is the renewal process of the 180 day orders • Improvements in robot loading • A change to pharmacist only order entry The document Medication Errors, FY 2011 was reviewed. The total number of errors and non-pharmacy errors are presented below. The non-pharmacy errors were those	Noncompliance

#	Provision	Assessment of Status	Compliance
		errors that actually reached the individual. Medication Errors 2010 - 2011 Sep Oct Nov Dec Jan Feb Mar Apr May Jun July Total Errors 7 15 12 195 138 117 134 113 80 80 93 Non-Pharmacy Errors * -- -- -- -- -- 0 2 19 0 6 3 *Actual Errors The number of medication errors increased with implementation of the reconciliation process implemented in late 2010. In January 2011, nurses began a bagging process with cart exchanges. Data provided indicated that medication errors decreased during the four months prior to the onsite review. This decrease was attributed to several process changes related to the dispensing of medications. Notwithstanding a favorable data trend, the monitoring team noted several problems related to the medication variance reporting system: • Discussion of data during the August 2011 P&T meeting revealed that in several instances, multiple occurrences of an error were reported as a single event or error. • The facility had yet to implement any process for reconciling medications that returned to the State Hospital pharmacy. The clinical pharmacist reported that this was due to a lack of resources. • The facility had no process for reconciling liquid medications resulting in exclusion of errors related to liquid medications, drops, ointments, etc. This represented a significant problem as many medications were provided in liquid form for use in enteral tubes. • The facility did not utilize a Medication Review Committee for in depth analysis of medication errors. During the February 2011 review, it was noted that this was problematic as the discussion of medication errors required significantly more time than allotted in the P&T meeting. The clinical pharmacist reported and documented in the P&T notes that the medical director believed this was not necessary. The state nursing services coordinator indicated during the August P&T meeting that all SSLCs were required to have a separate committee to review medication errors. The extent of medication errors in the facility was not known. Errors related to liquid medications were not fully captured, pharmacy returns were not reconciled, and data in	

#	Provision	Assessment of Status	Compliance
		some instances were being under-reported. There was no group assigned apart from the P&T Committee to review and analyze problems and data. The facility should consider further assessment of this system to be an urgent need.	

Recommendations:

1. The pharmacy must document all interactions between the pharmacists and the clinicians. Documentation should include resolution of problems (N1).

2. Pharmacy intervention data should be consistently collected and analyzed. The medical director should regularly discuss this data with the medical staff, counsel physicians as necessary and provide educational opportunities based on data analysis and needs assessments (N1).

3. The facility will need to determine how to achieve compliance with the requirement for the prospective review of labs given that dispensing occurs at another facility (N1).

4. 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. For example, individuals being treated with levothyroxine should have the most recent TSH reported for each review. The results should be documented even when normal and reference values should be provided. The frequency of lab ordering should be in accordance with the facility's lab matrix or as clinically indicated (N2).

5. The facility should explore revision of the lab matrix to include medications used to treat common conditions. For example, diuretics could be included to ensure that metabolic panels were obtained appropriately (N2).

6. Physician compliance with recommendations should be tracked. If the physician agrees with the recommendation, there should be evidence that the recommendation has been implemented (N2).

7. The facility should develop a local policy related to the adverse drug reaction monitoring and reporting system. The ADR policy should be revised include a threshold for intense case analysis. Another requirement should be that any ADR associated with hospitalization require an intense case analysis or review of the circumstances surrounding the adverse event. When deficiencies are noted, a corrective action plan should be developed that provides action steps, responsible persons, and timelines for completion (N7).

8. The medical director should review ADR data to determine any trends relative to physician practice. Issues related to physician practice should be viewed as opportunities for education targeted at improving performance (N7).

9. A policy for completion of DUEs should be developed. It should specify requirements for completion, such as determination of calendar, drugs for review, and sample size selection. It should also specify requirements for corrective action plans such as the specification of action steps, responsible parties and timelines (N6).

10. The facility must take several steps in advancing the medication variance system:

a. A separate medication error committee is needed to review medication variances. Discussions and information resulting from this committee should be presented to the P&T Committee.
b. The facility should standardize the method for counting variances. Each episode that results in an individual not receiving medications in accordance with the physician's order should be counted as a variance.
c. A process for reconciling liquid medications, drops, etc. should be developed and implemented.
d. A process is needed to reconcile medications returned to the state hospital pharmacy.

*** The facility should consider this matter worthy of immediate attention and correction (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC Organizational Chart o Individuals Served- Alpha o PNMT member list o CVs/resumes for PNMT members o PNMT Continuing Education documentation o Section O Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section O-Physical Nutritional Management o Admissions list o Guidelines for Use of Bedrails and Plexiglas Shields Policy #300-31 (Revised 4/25/11) o Dining Room Procedures Policy #300-40 (Revised 4/28/11) o Bathing Policy #300-41 (Revised 4/26/11) o At Risk Individuals Policy #300-22 (2/18/11) o Facility Physical/Nutritional Management Team Policy 300-43A (4/28/11) o List of hospitalizations/ER visits o Adaptive Equipment spreadsheet o Physical Management Monitoring form template o Completed PNMP Monitoring Forms submitted o Dining Plan template o Dining Plans and training sheets submitted o Individuals with Modified Diets o Individuals with Thickened Liquids o Individuals with diet downgrades in the past 12 months o List of individuals with poor oral hygiene o Completed Validation monitoring forms submitted o Monitoring Forms list o NEO training curriculum for PNM o List of Risk Levels for Choking, Falls, Skin Integrity, Constipation, Osteoporosis, Aspiration, Respiratory o Individual Risk Level summary spreadsheet and Risk Lists o Mealtime High Risk Monitoring list o Physical High Risk Monitoring list o Mealtime and Physical Management Monitoring summary (bar graphs) o Pneumonia Diagnosed Past Year o List of individuals with aspiration or pneumonia incident in the last year

	o List of individuals with chronic respiratory infections in the last 12 months o List of individuals with a choking incident in the past 12 months o Follow-up documentation related to choking incidents since the previous review (Individual #8 and Individual #94) o List of individuals with fecal impaction in the last year o Individuals with BMI equal to or less than 20 o Individuals with BMI equal to or less than 30 o Individuals with unplanned weight loss of 10% or greater over six months o Individuals with chronic dehydration o List of individuals who have had a fall in the last 12 months o List of individuals with prescribed analgesics o List of individuals with enteral nutrition o List of individuals with Decubitus Ulcers in the last six months o List of individuals who have had a fracture in the last year o List of individuals receiving MBSS/VFSS in the past year o Individuals who were non-ambulatory or require assisted ambulation o People Who Use Wheelchairs as Primary Mobility o People Who Use Wheelchairs for Transport Only o Individuals with Orthotics and Braces o List of individuals using Ambulation Assistive Devices – Gait Belts o PNMPs submitted o Sample Aspiration Pneumonia/ Enteral Nutrition Evaluations for: Individual #30, Individual #248, Individual #197, Individual #151, Individual #37, Individual #199, Individual #32, Individual #311, Individual #300, and Individual #164 o PNMT evaluations and PSPs: • Individual #227, Individual #91, Individual #19, Individual #165, Individual #200, Individual #265, and Individual #39 o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Chest X-rays, GI Consults, Orthopedic consults, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab (included Communication assessments and updates), Nutrition tab and PNMP tab for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. o PNMP section in Individual Notebooks for the following:

	• Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. o Mealtime Observation/PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs and photographs for last 12 months for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MS, CCC-SLP Habilitation Therapies Director o Patricia Delgado RN o Allison Trammell, MA, CCC_SLP o Leona Bludau, RD o Edward Harris, PT, OPT o Kelly Patrick, BS, OTR o Various adjunct PNMT members o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o PNMT meetings for o Risk Meeting with Monitoring Team for Individual #108
	Facility Self-Assessment: SASSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Director review the Presentation Book onsite and a copy was submitted for review per request. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements, or the status of a variety of tasks since the previous review in February 2011. The correlation of these tasks to each provision was not always clear. Also, there was no mechanism to determine how the facility had determined noncompliance with each item in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section O- Physical Nutritional Management self-audit tool and

	Guidelines were included in the Presentation Book and completed audits for four individuals were submitted for May 2011 and June 2011. In the case of Individual #122, they were reviewed during both consecutive months. It was not clear how the sample was identified for these audits. Compliance levels at 100% were reported for 16 of 22 indicators in June. 2011 It did not appear that the audits were used to determine compliance with the provisions. A list of 4 Action Steps with 5 sub-steps was included in the POI, related to O5 only. It was reported that the Department was to pick one provision to focus on and submit the Action Steps for that provision. These actions were not all particularly pertinent to the provision and did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. Projected completion dates were listed, but not actual dates of completion. Each of the other six action steps listed was identified as in process with completion dates of 8/31/11 (1), 12/1/11 (2), and 12/31/11 (3). This approach appeared to merely document completion of tasks rather than to serve as clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, and stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. It was not clear what these specifically related to and how the trend analysis submitted would constitute completion of the review data action or that sign in sheets would sufficiently demonstrate that staff had been adequately trained. The monitoring team concurs with SASSLC self-assessment of noncompliance for each of the items in provision O.
	Summary of Monitor's Assessment: The PNMT at SASSLC was a fully constituted team at the time of this review. Only the RN member was a dedicated team member, while the others each had significant other clinician duties. In fact, the RD on the team served as the sole dietitian for the facility as well as the dietitian for this team. Her participation was weak, generally anecdotal rather than data driven, and her competency to serve on this team was of significant concern to the monitoring team. There were, however, improvements noted in the team process, particularly related to attempts to use pertinent data to guide decision-making and plan development. Discussions by the group were excellent and it was apparent that the PNMT was moving forward in its development with this process. Suggestions were made by the monitoring team during the meetings held during this week and it is anticipated that improvements will be noted. While a number of meetings had been held for approximately six individuals since the previous review, core team attendance was inconsistent. Alternates were generally noted, but team building and consistency will continue to be difficult unless this issue is addressed. It is critical that the PNMT recognize

	that this process is not merely a meeting, but an assessment process. Some professionals did not come prepared. The team tended to identify interventions without a clear rationale to guide what they needed to track to determine efficacy. There was a clear statement of why the individual was referred to the PNMT but no clearly stated outcomes related to discharge and transition back to the PST. This should consist of a well outlined plan, a PST meeting with completion of necessary training and establishment of monitoring frequency and focus. There should be follow-up by the PNMT and guidelines to recognize individual triggers indicating that the plan was not working. The PNMPs were of a consistent format and each was current within the last 12 months. SASSLC had incorporated instructions related to bathing for some and for oral hygiene and medication administration for most individuals. The content of these sections was limited, however, and consideration of presentation strategies, utensils needed, and additional instruction is recommended. Implementation of these plans, while improved, continued to be problematic and staff did not understand the rationale for the strategies they were instructed to apply. In addition, there was no evidence that a strong skills-based competency training for elements of the plans was provided. Monitoring was scheduled one time monthly for most individuals, while extra monitoring who were considered to be at high risk was scheduled as well. Review of the monitoring forms submitted suggested that neither of these schedules was adhered to and may also impact staff compliance. Most of the monitoring also occurred for the first shift only. The PSTs will require ongoing clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. A meeting related to the risk assessment process with one PST was conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly	**Standard: PNM team consists of qualified SLP, OT, PT, RD, and, as needed, ancillary members (e.g., MD, PA, RNP).** SASSLC formally initiated the new process for the Physical Nutritional Management Team (PNMT) 11/16/10. At that time there was no nurse permanently assigned to the team. Per the POI, this position was filled on 5/1/11. Core team members at the time of this onsite review included: • Patricia Delgado, RN • Allison Trammell, MA, CCC-SLP • Kelly Patrick, BS, OTR • Edward Harris, PT, OPT • Leona Bludau, RD, LD, MS	Noncompliance

#	Provision	Assessment of Status	Compliance
	identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	Adjunct members included the QMRPs, nurse case managers, psychology, home managers, direct support staff, and other PST members for the individuals reviewed during the PNMT meeting. License numbers were submitted for each of the team members listed and resumes/CVs were submitted for all except the dietitian, Leona Bludau. Current licenses were verified online for each. The resumes/CVs submitted for the indicated that each of these clinicians had at least three years of experience with individuals who had developmental disabilities. This was not verified for the dietitian. PNM-related continuing education documented since the previous review included the following: Patricia Delgado, RN (7.3 hours), Allison Trammell, MA, CCC-SLP (8 hours), Leona Bludau (12 hours), and Kelly Patrick, BS, OTR (6 hours). The RN, SLP, OT and Edward Harris, PT, OPT attended Oral Care Practices for Seriously Ill and Nursing Home Patients, though no CEUs were awarded for this course. **Standard: PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.** The PNMT met routinely to assess and review individuals at risk for PNM concerns. Meetings were documented in PNMT action plans. Initial assessments were completed using the PNMT Evaluation form. Each team member was responsible to contribute information to the assessment. Subsequent reviews were scheduled by the team at each meeting. The monitoring team requested minutes, including documentation of attendance, for all PNMT meetings. The documents submitted included sign in sheets and the most recent copies of the action plans for each individual as all entries from previous meetings were reported to be maintained in these plans and new entries added with each additional meeting. There were 46 meetings documented for seven individuals from 11/16/10 through 6/23/11; 27 of these 46 occurred since the previous review: • Individual #108: 2/17/11, 3/3/11, 3/17/11, and 3/31/11). • Individual #122: 2/17/11, 2/24/11, 3/10/11, and 5/25/11. • Individual #200: 3/3/11, 3/10/11, 3/31/11, 4/14/11, and 5/5/11. • Individual #54: 5/26/11, 6/9/11, 6/17/11, and 6/23/11. • Individual #91: 2/17/11, 2/24/11, and 3/3/11. • Individual #265: 3/31/11, 4/7/11, 4/14/11, 4/28/11, 5/5/11, 5/12/11, and 5/26/11.	

#	Provision	Assessment of Status	Compliance
		Attendance sign in-sheets were submitted for 21 of these 27 meetings. Core team member attendance was as follows: • PT: 20 of 21 (95%) • SLP: 14 of 21 (67%) • RN: 6 of 21 (29%) • RD: 14 of 21 (66%) • OTR: 16 of 21 (76%) Alternate professionals attended some of the meetings in addition to, or instead of, a core team clinician. There were some instances, however, when there was no representation by a specific discipline as follows: OTR (2 meetings), RD (7), and RN (1). Only the RN member was a dedicated team member, while the others each had significant other clinician duties. In fact, the RD on the team served as the sole dietitian for the facility, as well as the dietitian for this team. As observed in several meetings, her participation was weak, generally anecdotal rather than data driven, and her competency to serve on this team was of significant concern to the monitoring team. Aside from this, there were improvements noted in the team process and discussions by the group were excellent. Meetings for other individuals were held during the week of this onsite review (Individual #39, Individual #227, and Individual #91). Attendance by all core team members was noted by the monitoring team for each of these meetings. Draft evaluations were used in the meetings for Individual #91, Individual #227 and Individual #39 conducted during the week of this onsite review. The monitoring team attended these meetings and requested and received the drafts of their PNMT evaluations dated 8/4/11, 7/7/11, and 8/16/11 respectively. Review of the PNMT assessments and action plans revealed a number of problems: • Broad statements of reason for referral did not permit the PNMT to focus in on the issues. For example, Individual #265 was referred because she was identified in "multiple high risk categories." • The PNMT identified interventions for individuals without sufficient data collection and rationale established. For example, it was recommended that Individual #265 be provided a gluten free diet for one month. There was documentation that her family had a history of GI problems and that this diet had helped them. Individual #265, however, had Hirschsprung's disease and there were no baselines or outcomes established to determine what they would be expecting related to change in her status secondary to this intervention.	

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		• Follow-up on even simple data was inconsistent, such as weight history. For example, Individual #265 was identified in the low end of her weight range so tracking her weight was of importance to the team. During the meeting observed on 8/18/11, it was stated that the last available weight was on 8/4/11, at which time she had lost 3.5 pounds. The dietitian stated that "no one had told me her weight" and "the last I had it was the same as before." It would be expected that the expert in nutrition on the PNMT would not wait for someone to give her a weight, but that she would actively get it, even it meant weighing the individual herself. • Action items were not clearly resolved. For example, in Individual #122's action plan (3/10/11), it was stated that his weight was to be closely followed. There were entries listed from 1/14/11 to 3/10/11. The last entry merely stated that he weighed 101 pounds, though it was not stated what his starting weight was. It was not clear what the goal was for Individual #122 and why this documentation just stopped on that date. There was no evidence that he had met any established outcome relative to weight gain. • There was no one present at the meeting who knew for certain whether a pneumonia experienced by Individual #91 was aspiration. • The discussion/analysis of the PNMT Evaluation did not offer any thoughtful clinical impressions or analysis, that is, the "so what" of all the information presented. For example, this section for Individual #91 stated the following: o Residuals discussed (no data offered) o Question was asked if duration of enteral feeding could be changed (no answer or plan to resolve) • The PNMT did not appear to recognize that this was an assessment process, not just a meeting to review existing information. The purpose is to look at each individual in a new way in order to identify an appropriate intervention plan. In Individual #39's PNMT Evaluation, dated 8/16/11, the nursing information reflected a previous assessment two months earlier. Previous information is important, but should not be solely relied on. The PNMT nurse and other team members should conduct their own assessments, ideally together for some aspects. • There was insufficient analysis of the data presented. For example, the discussion related to Individual #39 began to dismiss her recent weight loss as an issue until the monitoring team pointed out that she had experienced a 36 pound weight loss from 10/10 to 11/10 and 13 pounds from 12/10 to 1/11. There was another significant weight loss recorded from 7/11 to 8/11. • It was reported that the intake sheet for July 2011 could not be reviewed for Individual #39 because it was locked up and staff could not gain access to it. This was not acceptable.	

#	Provision	Assessment of Status	Compliance
		• Some participants did not come prepared. Weight was a particular issue in several meetings observed. • The team tended to identify interventions without a rationale to guide what they needed to track to determine efficacy. There was a clear statement of why the individual was referred to the PNMT, but no clearly stated outcomes related to discharge and transition back to the PST. This should consist of a well outlined plan, a PST meeting with completion of necessary training, and establishment of monitoring frequency and focus. There should be follow-up by the PNMT and guidelines to recognize individual triggers indicating that the plan was not working.	
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.** Based on the number of PNMPs submitted, there were 246 individuals identified with PNM needs at SASSLC, or, 88% of the current census (278). A new policy and process used to establish health risk levels was implemented statewide in January 2011. The goal was to have discussions of risk occur during each individual's PST meetings. At the time of this review, the teams were working to integrate this into the new PSP process that had been initiated in the Fall 2010. The PSTs will require ongoing clinical instruction and support regarding risk assessment and real time modeling by state leaders (as was the plan) to effectively implement these new policies and procedures. A meeting related to the risk assessment process with one PST was conducted by the monitoring team during the week of this onsite review with significant discussion about strategies for the team to consider as they implement this policy. Further evaluation of the effectiveness of this process will be necessary during future onsite reviews by the monitoring team. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks. 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 had initiated assessments on individuals who had been referred, but also others for whom they had identified a significant need for PNM supports. There were a number of individuals with multiple PNM-related risk factors or issues who potentially would benefit from the coordinated, comprehensive supports and services of the PNMT. The monitoring team is providing this level of detail in hopes that it will assist the facility to attend to their risks and PNM needs. • There were 246 (88% of the current census) individuals identified with PNM needs and were provided a PNMP.	Noncompliance

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		• There were 119 (43%) individuals with poor oral hygiene in the last six months. Four of these individuals were diagnosed with aspiration pneumonia in the last year (Individual #311, Individual #243, Individual #108, and Individual #227). • There was one individual diagnosed with chronic dehydration (Individual #250). • There were 11 (4%) individuals with 12 incidences of skin breakdown in the past year. Two of these were listed as unresolved per the documentation submitted (Individual #212 since April 2011 and Individual #238 since February 2011). Of these, only Individual #254 was listed at HIGH risk for skin integrity concerns and only six were identified at MEDIUM risk. Individual #49 had experienced at Stage II ulcer on his sacrum in August 2010 that was healed two months later, but reopened. He was not identified with skin integrity risk. • There were eight (3%) individuals whose diet had been downgraded in the last year. • There were 30 (11%) individuals who were obese with a BMI of 30 or over and three of these with a BMI over 40. • There were 22 (8%) individuals with a BMI less than 20, with five of these with a BMI under 18.5 (underweight). • There were 13 (5%) individuals listed with unplanned weight loss. These individuals had lost more than 10% of their weight in six months' time. • There were two choking events in the last 12 months (Individual #8 and Individual #94). There were four (1%) individuals listed as HIGH risk for choking and 46 individuals (17%) listed at MEDIUM risk for choking including the two individuals listed above who had a choking event in the last year. • There were 58 (21%) individuals who required assistance at mealtime. • There were 183 (66%) individuals with modified diet textures and 42 (15%) with thickened liquids. At least seven individuals' diet texture had been downgraded in the last 12 months. • There were 53 (19%) individuals who were enterally nourished per the diet list submitted. There were 17 of these individuals who were listed with pneumonia in the last year. Four also received some level of oral intake. • There were six individuals with a fecal impaction during the last 12 months. • There were approximately 34 (12%) individuals with pneumonia in the last 12 months, though dates or types of pneumonia were not documented on one list submitted. Another listed 23 individuals with 27 episodes of pneumonia, 12 described as aspiration pneumonia. There were 13 individuals listed at HIGH risk for aspiration. Of those with aspiration pneumonia, nine were identified at HIGH risk and two others were listed at MEDIUM risk for aspiration. Individual #259 had an occurrence of aspiration pneumonia, but was considered only to be at low risk for this significant issue. • There were 13 (5%) individuals identified with chronic respiratory infections	

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		during the last 12 months. Only four were identified at HIGH risk and three were identified at MEDIUM risk for respiratory concerns. • There were 160 (58%) individuals identified as non-ambulatory or requiring assistance for ambulation and/or transfers. • There were 113 (41%) individuals who used a wheelchair as a primary means of mobility. • There were 68 (24%) individuals who used assistive equipment for ambulation including gait belts. • There were 26 (9%) individuals who used transport wheelchairs as needed. • There were 25 (9%) individuals with upper or lower extremity orthotics or specialized footwear. • There were approximately 61 (22%) individuals who had experienced approximately one or more falls with injury in the last year. Twelve individuals had sustained a serious injury and Individual #142 had two such serious injuries (11/28/10 and 3/21/11). There were approximately 23 of these individuals who required assistance for ambulation and/or transfers and Individual #164 and Individual #198 were identified as non-ambulatory. Eleven of these had one fall with Individual #309 sustaining a serious injury on 2/12/11. There were five of these who had at least two falls with Individual #47 sustaining a serious injury on 3/14/11. Six individuals had three falls, with Individual #41 (8/5/10), Individual #344 (11/5/10), Individual #261 (3/26/11), and Individual #127 (3/14/11) each sustaining serious injuries. Individual #254 (3/29/11) had four falls, Individual #39 (11/2/10) had five falls, and Individual #106 (6/17/11) had seven falls with each sustaining a serious injury on the date specified in parentheses. Only Individual #39, Individual #254, Individual #41, and Individual #106 were identified at high risk for falls. • There were 12 (4%) individuals who sustained an injury resulting in a fracture in the last year. Five of these individuals used a wheelchair as their primary means of mobility per the list provided (Individual #294, Individual #93, Individual #36, Individual #19 and Individual #234). Two others used transport wheelchairs (Individual #254 and Individual #41). • There were nine (3%) individuals listed at HIGH risk for osteoporosis. There were 33 (12%) others listed with a MEDIUM risk for osteoporosis. • There were 88 (32%) individuals admitted to the hospital in the last year, 16 who had three or more hospitalizations. Individual #311, Individual #164, Individual #91, Individual #324, Individual #334,Individual #19, Individual #200, Individual #106, and Individual #325 each had three. Individual #185 had four. Individual #37, Individual #143, Individual #36, and Individual #227 each had five, Individual #108 and Individual #54 had six hospitalizations. A number of ER visits were also PNM-related issues or diagnoses.	

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		• There were 98 (35%) individuals listed as prescribed analgesics for chronic pain. The complexity of PNM-related risk indicators requires comprehensive and collaborative team assessment, intervention plan development, implementation, and monitoring. The current system of risk identification continued to be problematic.	
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).** As stated above, there were approximately 246 individuals identified with PNM needs provided with PNMPs. The PNMPs were generally of a consistent format and contained information related to the focus, assistive equipment, mobility, transfers, positioning, bathing, dining plan, dining equipment and position, food texture and liquid consistency, and communication. The majority of plans referenced oral hygiene and medication administration, but only related to position. Many of the 119 individuals with poor oral hygiene and those with swallowing concerns would have benefited from oral care instructions in their PNMP, including texture, liquid assistance, swallowing precautions, and/or special presentation techniques or utensils. This would also be true related to medication administration for many. Other plans addressed handling, skin integrity, precautions, and other supports as indicated. The monitoring team selected 27 individuals for a record sample (included in the above list of documents reviewed) and the PNMP for one other individual reviewed to date by the PNMT was included, too (Individual #39). Comments are provided in great detail below in hopes that the information will be useful to the facility: • PNMPs were submitted for 28 of 28 (100%) individuals included in the sample. • PNMPs for 28 of 28 individuals in the sample (100%) were current within the last 12 months. • In 28 of 28 PNMPs reviewed (100%), positioning was addressed. • In 6 of 11 PNMPs reviewed (55%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included. • In 27 of 28 PNMPs reviewed (96%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 6 of 28 PNMPs reviewed (21%), the PNMP listed bathing instructions and listed equipment when needed. Some of the plans identified the number of staff needed for bathing, others identified the position. The PNMPs consistently listed the equipment needed. In some cases, the instructions were included under other headings which were difficult for a reader to locate. None of the PNMPs reviewed provided toileting instructions.	Noncompliance

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		• In 23 of 23 PNMPs reviewed (100%) for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. • In 28 of 28 PNMPs reviewed (100%), instructions related to mealtime were included. Dining plans were also submitted for 23 of 27 individuals included in the sample as requested by the monitoring team. • 14 of 28 individuals (50%) received enteral nutrition. Instructions for no oral intake were clearly stated in the PNMPs for 13 individuals only. • In 25 of 28 PNMPs reviewed (89%), dining position for meals or enteral nutrition was provided. • In 28 of 28 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally or instructions for nothing by mouth for those with non-oral intake (100%). Individual #37's PNMP or Dining Plan did not specify "nothing by mouth." In the case of Individual #335, his PNMP stated that he should receive nothing by mouth, yet the plan also listed a pureed diet with pudding thick liquids. There were no assistance techniques for oral intake provided in the plan. A Dining Plan was not submitted for Individual #335. • In 12 of 14 PNMPs for individuals who received liquids orally (87%), the liquid consistency was clearly identified. Liquid consistency was listed for Individual #335 though as stated above he was to receive nothing by mouth per the most current PNMP submitted (4/29/11). • In 14 of the 14 PNMPs for individuals who ate orally (100%), dining equipment, including regular dinnerware and utensils was specified in the dining equipment section • In 25 of 28 PNMPs reviewed (89%), a heading for medication administration (included with oral hygiene) was included in the plan. In some cases the heading was not bolded as were the other headings so the information was difficult to locate on the plan. In other cases, the heading referred to positioning for oral hygiene and medication administration. The format and content provided varied from plan to plan. • In 25 of 28 PNMPs reviewed (89%), a heading for oral care was included (with medication administration). A primary intent of addressing oral care in the PNMP is to ensure appropriate position and, most importantly, proper alignment during oral hygiene/tooth brushing activities conducted by the direct support professionals several times daily. Another critical issue is related to whether the individual required thickened liquids or special techniques to assist with swallow/breathe synchrony. This is critical to ensure effective oral hygiene in a manner that is safe for those at risk for aspiration. There were no written instructions or pictorial support to direct staff in oral care strategies and techniques.	

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		• 28 of 28 PNMPs (100%) reviewed included a heading related to communication. The information included generally described how the individual communicated expressively rather than strategies that staff could use to be an effective communication partner. **Standard: PNM plans were incorporated into individual's Personal Support Plans.** Sixteen of the 27 annual PSPs submitted with the sample individual records selected for review by the monitoring team were of the new format. Six of the others were not current within the last 12 months or were current, but in the previous format. PSP meeting attendance by PNM professionals was as follows: • Medical: 0 of 16 (0%) in attendance per the signature sheet. • Dental: 0 of 16 (0%) in attendance • Nursing: 15 of 16 (94%) in attendance • Physical Therapy: 2 of 16 (13%) in attendance • Nutrition: 1 of 16 (6%) in attendance • Communication: 9 of 16 (56%) in attendance • Occupational Therapy: 10 of 16 (63%) in attendance There were approximately 134 PSP addendums (PSPA) submitted and reviewed. Attendance was 84% for nursing, 0% for dental, 3% for medical, 16% for the RD, 12% for the SLP, 33% for OT, and 4% for PT. Some of the topics for the PSPA were PNM-related, including post-hospitalization and risk assessment tools. It would not be possible to achieve adequate integration given the limitations in PNM-related professional participation in the PST meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective support plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. **Standard: PNMPs are developed with input from the IDT, home staff, medical and nursing staff.** As stated, above poor attendance at PSP meetings and the lack of integration in the PSP negatively impacted the ability to develop the PNMPs in a comprehensive and collaborative manner. There was a section titled Physical Nutritional Management Plan in approximately nine of the 16 PSPs reviewed, though in some cases this section was not easy for the reader to locate within the text of the document. In some PSPs, this information was included under	

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		OT/PT. The content of these varied greatly from plan to plan. In some cases, an action step that the individual would be provided a PNMP was noted and, in other cases, the specifics of the plan were listed as individual action steps. Rarely was the focus of the plan identified as a measurable outcome in the PSP actions. For example, in the case of Individual #106, the equipment required in his PNMP was listed as well as the focus of the plan. Recommendations listed here were from the annual OT/PT assessment rather than in the OT/PT section of the PSP. The focus of the PNMP was identified as reduce risk of injury due to falls, promote good skin integrity, facilitate safe swallowing, and encourage independence in dining. Only two were listed as an action or training objective. The other action steps merely indicated that he would be provided the equipment listed in the PNMP. The PNMP was not well integrated into the individual's PSP as a result. **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 by therapy clinicians, however, there was no evidence of review by the PST in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the PSP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full PST. The PNMPs were updated by the therapy clinicians based on change in status or need identification and indicated in the plan by the revised date, the PSP date (annual) and by highlighting of new instructions that were added to the previous plan.	
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 with limited input by other PST members. Generally, the PNMP was located in the individual notebook in the back of an individual's wheelchair, if he or she had one, or was to be readily available nearby, otherwise. In most cases, pictures were available with the PNMPs related to adaptive or assistive equipment as well as various positioning outlined in the plan. These pictures were large and easy to see, however, in some cases, the pictures with the PNMPs or those in the Dining Plans did not represent optimal alignment and as such would not offer adequate visual cues for staff. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright, described the angle of recline, seatbelt use, and the type of transfer to be used. General practice	Noncompliance

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		guidelines with regard to transfers, position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in New Employee Orientation, but not generally specified in the PNMPs. Dining Plans were noted to be available in the dining areas, Staff were observed to read the plan when the food and beverage was served from the kitchen. As noted during the previous review, though not as prevalent, this appeared to be an exercise as some errors were not identified prior to serving the meal. In some cases, where an error was noted by the monitoring team, the staff was asked to read the plan. They were also not always able to recognize the error observed. Though improved since the previous reviews, a number of errors were noted in staff implementation of interventions and recommendations outlined in the mealtime plan portion of the PNMP and/or Dining Plans. A number of examples are presented below in hopes that this detail will be useful to the facility: • Individual #23 was observed being offered a snack in the day program area while he was seated in a recliner. He was poorly supported and his head was not upright placing him at risk for aspiration and choking. His PNMP indicated that he should always eat in his wheelchair. When this was pointed out to staff, they reported that they always offer snacks to him and others while in the recliner and that PNMPCs had observed this but had not intervened. Others who received a snack in the recliner included Individual #228, Individual #328, Individual #287, and Individual #325. • After the event described above, staff transferred Individual #228 from the recliner to her wheelchair. Staff did not use appropriate body mechanics and once she was placed in the wheelchair, they did not reposition her to optimize her alignment and support. They allowed her head to hang off the headrest too long before correcting this. She was not positioned all the way back in her chair, and her head was very low in relation, and not well supported on the headrest for her snack. • Staff used a quick pace to present pudding to Individual #228. They used a rough paper towel to wipe her mouth. She had a visual impairment and staff did not provide any cues or prompts before placing the next bite in her mouth. • Individual #248 had no pictures or enteral nutrition in a recliner during day program. He was reclined too far back. When nursing was asked about this she indicated that he was to be 20 to 30 degrees and that his position was acceptable. Individual #306, Individual #239, Individual #32, Individual #126 and Individual #151 each received some enteral nutrition while in the day program, per staff report. • Individual #72 was observed during a meal in a transport wheelchair with a sling	

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		seat and back and no footrests. Staff reported that they could not find her personal wheelchair. • Individual #244 was observed eating at a fast pace with no prompts or intervention to slow her down. • Individual #31 was provided a built up handle spoon but not the one prescribed in his Dining Plan. By report, his spoon had broken and a new one ordered before the previous OT left her employment at SASSLC two to three months ago. This was not acceptable and there should always be backups of adaptive mealtime equipment in case of loss or damage. • Individual #214 was lifted by his gait belt and was dragged/pushed into the Dining Room by two staff rather than permitted to walk at his pace. • The Dining Plan for Individual #257 instructed that he should be presented one level teaspoon per bite. Staff was presenting bites that were large mounded spoonfuls. The PNMPC was prompted to review this with the staff. • Individual #14 drank a whole glass of his beverage without stopping and no staff intervened to slow him. • Individual #41 was taking huge bites and was not swallowing what was in his mouth before taking another bite. Staff did not intervene other than to provide intermittent verbal prompts that were ineffective. Individual #41 ate a whole bowl of cole slaw in three bites. • Individual #213 was observed being repositioned after prompting from the monitoring team. The staff, including a PNMPC, used the gait belt to lift her for repositioning, which is not a generally accepted practice. The seatbelt was too short and could not be accessed to appropriately tighten it across her pelvis. • Individual #72 was observed in her personal wheelchair with a soft seat cushion that appeared to provide inappropriate support and alignment. Her legs were extended and not supported properly. • No one was observed to be re-positioned prior to beginning their meal in any home without being prompted to. **Standard: Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.** Though improvements were certainly noted, 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. In addition, staff were not able to recognize when alignment was inappropriate in order to remedy or report it as a problem. See other examples in section P below. In addition, when staff were asked questions as to why an individual had honey-thick liquids or a particular spoon, they were generally not able to answer appropriately. A number of staff stated "aspiration" (a "safe"	

#	Provision	Assessment of Status	Compliance
		answer), but could not provide specifics why honey thick would be a safer liquid consistency for Individual #110, for example. In one case, a staff sitting at the table near Individual #31 provided an excellent description as to why he required a built-up, curved handle spoon. Unfortunately, the spoon he was using was not the one specified in his Dining Plan. One direct support staff attempted to explain how Individual #38's PKU diet was necessary to address her reflux. Also as reported above, staff in the day program did not connect that instructions related to mealtimes requiring that individuals sit in their wheelchairs would also apply to snacks offered in that area.	
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.** Staff training for New Employee Orientation related to PNM included the following: • Bed rails and safety • Body mechanics and gait belts • Pressure ulcers • Osteoporosis and preventing fractures • Wheelchair safety • Bathing using a shower chair • Providing hygiene • Stand pivot transfer • Two-person manual lift • Two-person mechanical lift • Gait belt • Food and liquid texture • Assisting people into and out of vans • Head of bed elevation • Positioning in a wheelchair • Reading a dining plan • PNMP review The items in bold above were specified as competencies. After participation in the training, the PNMPCs conducted a check-off with the staff to establish competency in each of these areas. A program to establish competency for existing staff had recently been established beginning with the home supervisors and had been completed in one unit at the time of this review. The plan was that the supervisors and home managers would be trained first to competency, and then they would be responsible to train their other staff. A tremendous amount of content was to be presented with the intent of establishing	Noncompliance

#	Provision	Assessment of Status	Compliance
		competency in a short time in NEO. It will be necessary to increase the amount of time new employees have for the PNM aspects of their training and competency check-offs. There was no evidence in the training documentation for Dining Plans or PNMPs that the individual-specific training that was provided was competency-based by return demonstration. Skills-based competency testing should involve an outline of each of the steps necessary to complete the task and each would be checked off as it was correctly completed by the participant. Checklists must be sufficiently discrete so as to ensure proper evaluation of their abilities to demonstrate and apply specific skills necessary for knowledgeable and accurate implementation of PNMPs and Dining Plans. Those conducting the training must be competent in the skills themselves as well as with regard to teaching the skills and completing the check-offs to establish competency. **Standard: Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre-/post-test, which may also include return demonstration as applicable.** See above. **Standard: All foundational trainings are updated annually.** Annual refresher courses were currently being developed for existing direct support staff. The monitoring team expects to see significant changes in this area in subsequent reviews. At the time of this review only the lifting portion of the training was conducted as a block refresher course. **Standard: Staff are provided person-specific training of the PNMP by the appropriately trained personnel.** Tools and checklists used to establish competency and documentation for staff trained to implement PNMPs and Dining Plans were submitted. This consisted of training rosters signed by participants. A description of the knowledge or skill trained was documented on the roster which appeared to imply competency, though this was not clearly stated and instead most likely only required passive listening or a verbal response rather than a skills-based competency established via demonstration. **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.** Training was not consistently effective as evidenced by the implementation errors noted	

#	Provision	Assessment of Status	Compliance
		by the monitoring team and described above. The current system of monitoring had recently implemented a system of targeted review of individuals at highest risk at an individually prescribed frequency to ensure appropriate implementation of supports designed to mitigate PNM risks. In addition to the monthly monitoring conducted by the PNMPCs, the therapy clinicians had developed a schedule of monitoring for those at highest risk on a more frequent basis. Individual #302, Individual #106, Individual #212, Individual #255, and Individual #149 were scheduled to be monitored at mealtime two times monthly, while nine were scheduled monthly and 14 others were scheduled every other month. Five were scheduled quarterly. PNMP monitoring was scheduled twice monthly for Individual #164, Individual #311, Individual #92 and Individual #108. There were 14 individuals scheduled monthly and 10 others scheduled every other month. The PNMT was including the frequency of monitoring as an aspect of their assessment and review. **Standard: Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.** There was no evidence that there was competency-based individual-specific training for staff before they worked with individuals who were at high risk or for pulled/float staff. Training for changes to plans was conducted by therapists and PNMPCs. Competency had not been clearly established via this system to date. There was a new system in which the PNMPCs followed up with staff after completion of the NEO training to conduct competency check offs.	
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 formalized policy related to the process of PNM monitoring (lifting, transfers, positioning, mealtime, and communication). There was no formalized curriculum for training the PNMPCs. Validation of PNMPCs was conducted using the same tool used for monitoring. The licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. A database developed to track PNM monitoring should also track the completion of validation checks with the PNMPCs, as well as the findings of those checks. **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 forms had been developed to address implementation of the PNMP, mealtime,	Noncompliance

#	Provision	Assessment of Status	Compliance
		lifting and transfers, and wheelchair and bed positioning. Though listed on the form, there was no mechanism to ensure that monitoring occurred during bathing, medication administration, or oral care. There were 170 completed Meal Observation forms submitted for review. These had been completed by the PNMPCs in July 2011 (163) and by the therapy clinicians in May 2011 (7). Monitoring was to occur across meals as well as snacks and medication passes. Findings were reviewed and it was determined that 59% of the monitoring had occurred at lunch, 29% had occurred at breakfast, but only 9% had occurred at dinner on second shift. No monitoring had been conducted during a snack or medication pass. Approximately 184 Physical Management Observations Forms had been submitted with 55% of these observations occurring before noon. Of the other 83 completed after noon, 66% of those were completed prior to 2:00 pm. Again, the majority of the monitoring had occurred only with first shift. A greater variety of activities was noted, though there was no established mechanism to ensure that these were covered consistently for each individual. The distribution was as follows: • Health and Hygiene: 4% • Recliner: 3% • Bed: 2% • Positioning: >1% • Transport: 7% • Transfers: 10% • Wheelchair: 23% • Bathing: 4% • Meal: 9% • Medication Administration: 8% • Ambulation: 3% • Active Treatment: 5% • Multiple Activities: 11% • Not specified: 15% The monitoring schedules continued to be under development with the intent to base frequency on health risk indicators. Further examination of the monitoring results should look at the activities monitored as well as the times of day. It will be critical to evaluate the effectiveness and compliant implementation of PNMPs in the afternoon and evenings as well rather than basing the schedule solely on existing staffing schedules. There was a database established to congregate data and to track compliance findings and analyze findings, issues, staff re-training, and problem resolution. Aspects of these	

#	Provision	Assessment of Status	Compliance
		elements were reviewed during weekly meetings. Currently, findings were presented in a bar graph, but the findings were not shared or addressed in a systematic manner at this time. A system to require plans of correction primarily related to mealtime observations was being trialed at the time of this review. There was no existing policy that outlined the process of monitoring, identifying the roles and responsibilities of monitors, training and validation of monitors, frequency, distribution, documentation, or follow-up and communication of findings. The monitoring team will further evaluate this process as it is better established in the future. **Standard: All members of the PNM team conduct monitoring.** The therapy clinicians had implemented a system of monitoring intended to provide greater frequency for those at higher risk. This was limited to the OTs, PTs, and SLPs rather than the specific PNMT core team members. As such, the RN and RD were not involved in this process. Other team members were not as yet participating in this process to date. Monitoring results were not consistently reported or reviewed in the PNMT process. A weekly meeting by Habilitation Therapies was held, however, to ensure that issues identified were appropriately addressed in a timely manner. **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.** There was no system implemented to address monitoring by the PNMT at the time of this onsite review. The system used to track and trend findings should be available to the PNMT and used in their assessment and follow-up on action plan elements and person-specific outcomes that are measurable, meaningful, and functional for the individual. Issue specific monitoring was discussed in some meetings and the findings were documented as discussion in the Action Plan updated at each meeting. **Standard: Immediate intervention is provided if the person is determined to be at risk of harm.** Immediate intervention was to occur if an individual was determined to be at risk of harm. The monitor was to notify the appropriate person, such as the charge, home manager, nurse, or therapist. The forms themselves provided a mechanism to document these actions or to document follow-up, but this was not consistently done as described further in section P.	
O7	Commencing within six months of the Effective Date hereof and with	**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.**	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	The new health risk assessment process was introduced in January 2011 and the PSTs continued to face challenges in order to fully implement this process. Discussions with PST members were conducted with the monitoring team in an attempt to understand where the teams were with this and to hopefully move it along. **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 at least on an annual basis, or more frequently based on PST referrals, findings from scheduled monitoring, or other informal observations. In the case that an individual participated in direct therapy, progress notes were written, with monthly assessments intended to justify continuing or discontinuing the plan. More in depth discussion is addressed in provision P below. The system continued to need to be more fully developed and refined so as to ensure assessment of the effectiveness of the plans on a regular basis, in addition to the PNMP and dining plan monitoring conducted by the PNMPCs and soon-to-be others.	
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 53 (19%) individuals who were enterally nourished per the diet list submitted. There were 17 of these individuals who were listed with pneumonia in the last year. Four also received some level of oral intake. There were approximately 34 (12%) individuals with pneumonia in the last 12 months, though dates or types of pneumonia were not documented on one list submitted. Another listed 23 individuals with 27 episodes of pneumonia, 12 described as aspiration pneumonia. There were 14 (4%) individuals listed at HIGH risk for aspiration. Of those with aspiration pneumonia, only eight were identified at HIGH risk and two others were listed at MEDIUM risk for aspiration. Individual #243 had an occurrence of aspiration pneumonia, but was considered only to be at low risk for this significant issue. These individuals were to receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Sample assessments were submitted for Individual #164, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #30, Individual #151, Individual #197 and Individual #248. These assessments provided a significant amount of data, but little content to provide appropriate justification for continuing with enteral nutrition only or the consideration of transition to oral intake. None of the evaluations proposed an action plan to address identified issues, though three had episodes of	Noncompliance

#	Provision	Assessment of Status	Compliance
		pneumonia in the last year. The PSTs, instead, identified only that the current interventions were satisfactory. There was no analysis of findings, recommendations, or action plans and, as such, the evaluation was not satisfactorily complete. Measurable outcomes were primarily that the individual would not experience aspiration or pneumonia but without careful examination of the current plan and its effectiveness toward that end. The monitoring team expects significant and timely progress with these assessments prior to the next review. **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 in the selected sample had been provided a PNMP and Dining Plan that included the same elements described above. **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 formal protocol outlined for this process. **Standard: A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).** As stated above, assessments for 10 individuals were reviewed and were found to be unsatisfactory. SASSLC will require extensive modeling and coaching to ensure proper implementation of this process. **Standard: Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.** The intent of the PNMP and dining plans was to provide consistent and effective supports to minimize the incidence of aspiration, oral intake to promote weight maintenance, and positioning and assistance techniques to ensure safe eating and drinking. Further focus on these areas should occur as the At Risk and PNMT systems are implemented.	

Recommendations:

1. Consider changes to nutritional services provided at SASSLC. An increase in nutritional staff is certainly indicated. One dietitian for the facility and assignment to the PNMT was insufficient to adequately meet the needs of all individuals living at SASSLC (278 individuals). Performance reviews and supports will be necessary with the existing dietitian in the interim (O1).

2. Revise documentation of PNMT evaluations and Action Plans to better reflect data, problem-solving and analysis, actions, decisions, plans for interventions, monitoring findings, follow-up, and timelines for review (O2).

3. Ensure that the PNMT functions as an assessment team that may include collaborative interaction and observation rather than merely a meeting forum to conduct chart review and history. Evaluations must be based on new data or information in order to yield a new perspective to address specific issues that drove the referral to the team (O1).

4. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (O2).

5. All core PNMT members as well as designated adjunct members must attend and participated fully in the process. This means that information is gathered, assessments conducted, documentation completed and all is available at the meeting. All members must be knowledgeable about the individual and be well prepared to discuss all related issues during the meeting (O1).

6. Increase the time available for NEO training related to PNM and ensure that refresher courses are developed to address areas other than just lifting (O5).

7. Ensure that competency-based training is skills-based whenever indicated. Staff generally learn better by learning and trainers get a better idea of the effectiveness of their training through return demonstration rather than mere verbal responses. Verbal responses do not suffice in the case that the staff need to perform a specific skill (O5).

8. The establishment of a more interdepartmental/interdisciplinary implementation of PNMPs and Dining Plans is indicated as well as to conduct trend analysis of all monitoring data. Review findings and make system adjustments. 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 (O6-O7).

9. Use a collaborative approach to assist the PSTs for improved activity analysis in the development of SPOs for teaching individuals to slow down or take smaller bites. Integrate strategies and prompts like taking a drink, using a napkin, or putting the utensil down for individuals who do not respond to verbal cues. Provide inservice training to staff regarding the appropriate use of physical prompts during meals to redirect (O4).

10. Separate incidental monitoring data from the scheduled monitoring. When a concern is observed while walking through the dining room, and included in the other data, the results will be skewed as it is not likely that when staff are observed implementing the plan correctly, a form would not be completed (O6-O7).

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 SASSLC Organizational Chart o Individuals Served- Alpha o Admissions list o Budgeted, Filled and Unfilled Positions by Job Code (6/30/11) o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section P-Physical and Occupational Therapy o Facility Occupational/Physical Therapy Services 300-49A (4/28/11) o PNM Needs list o Individuals receiving direct OT/PT o List of hospitalizations/ER visits o Adaptive Equipment spreadsheet o Physical Management Monitoring form template o Completed PNMP Monitoring Forms submitted o Completed Validation monitoring forms submitted o Monitoring Forms list o NEO training curriculum for PNM o List of Risk Levels for Choking, Falls, Skin Integrity, Constipation, Osteoporosis, Aspiration, Respiratory o Individual Risk Level summary spreadsheet and Risk Lists o Mealtime High Risk Monitoring list o Physical High Risk Monitoring list o Mealtime and Physical Management Monitoring summary (bar graphs) o Pneumonia Diagnosed Past Year o List of individuals with aspiration or pneumonia incident in the last year o List of individuals who have had a fall in the last 12 months o List of individuals with prescribed analgesics o List of individuals with enteral nutrition o List of individuals with Decubitus Ulcers in the last six months o List of individuals who have had a fracture in the last year o Individuals who were non-ambulatory or require assisted ambulation o People Who Use Wheelchairs as Primary Mobility o People Who Use Wheelchairs for Transport Only o Individuals with Orthotics and Braces o List of individuals using Ambulation Assistive Devices – Gait Belts

	o PNMPs submitted o Habilitation Therapy Comprehensive Evaluation template o OT/PT Evaluation tracking log o PNM Maintenance Log o PNM Wheelchair Clinic Progress Notes for: Individual #227, Individual #36, Individual #259, Individual #93, Individual #75, Individual #176, Individual #331, Individual #35, Individual #62, and Individual #268 o Habilitation Therapies Comprehensive Evaluation for individuals newly admitted to SASSLC: Individual #173, Individual #170, Individual #184, and Individual #203. o SPOs, PSPs, PSPAs, Assessments and related documentation for: Individual #301, Individual #135, and Individual #254 o OT/PT inservice documentation submitted for the past quarter o Habilitation Therapy evaluations and PSPs: • Individual #294, Individual #347, Individual #269, Individual #209, Individual #275, Individual #310, Individual #314, Individual #143, Individual #90, Individual #36. o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Chest X-rays, GI Consults, Orthopedic consults, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab (included Communication assessments and updates), Nutrition tab and PNMP tab for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. o PNMP section in Individual Notebooks for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. o Mealtime Observation/PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs and photographs for last 12 months for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual

	#170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. Interviews and Meetings Held: o Margaret Delgado-Gaitan, MA, CCC-SLP Habilitation Therapies Director o OTs and PTs, PTA o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day Programs o Workshop
	Facility Self-Assessment: SASSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Director review the Presentation Book onsite and a copy was submitted for review. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements, or the status of a variety of tasks since the previous review in February 2011. The correlation of these tasks to each provision was not always clear. Also, there was no mechanism to determine how the facility had determined noncompliance with each element in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication self-audit tool and Guidelines were included in the Presentation Book and completed audits for 15 individuals were submitted for May 2011 and June 2011. In the case of Individual #173 and Individual #337, they were reviewed during both consecutive months. It was not clear how the sample was identified for these audits. Compliance levels at 100% were reported for 10 of 18 indicators in June 2011. It did not appear that the audits were used to determine compliance with the provision items. A list of five Action Steps was included in the POI, related to P2 only. It was reported that the Department was to pick one provision to focus on and submit the Action Steps for that provision. These actions were not all particularly pertinent to the provision and did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provision items, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. This approach appeared to merely document completion of tasks rather than to serve as clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps.

	Example action steps stated: • As needed, train staff on the intervention (identified as completed on 8/1/11) • Review data (identified as completed on 7/1/11) It was not clear what these specifically related to and how the trend analysis submitted would constitute completion of the review data action or that sign in sheets would sufficiently demonstrate that staff had been adequately trained. The monitoring team concurs with the self-rating of noncompliance for each of the items in this provision.
	Summary of Monitor's Assessment: Current staffing had changed since the previous onsite review with loss of two key clinicians, though two contract PTs had been hired and were scheduled to begin soon. In addition, a contract OT had been hired with a start date in September 2011. The other existing clinicians appeared to be strong competent clinicians and had worked at SASSLC since the baseline review. The contract therapists were much needed additions to the department. The monitoring team hopes they can be retained beyond the three month term of their contracts. The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated. The assessments were generally improved since the previous review. A sample evaluation was reviewed with the therapists onsite (per their request). The health risks identified by the PST were generally identified. Information contained within the OT/PT assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. Functional skill performance was outlined more consistently across the domains included in the assessment. Equipment supports to address issues in each domain was documented in most of the more current comprehensive evaluations though via different formats in some. The focus however, continued to be primarily on the provision of the PNMP rather than skill acquisition strategies. Interventions provided beyond the PNMPs, with a focus on minimizing regression and enhancing skills, were limited and not integrated into the PSP. These were generally referral based only. There were no OT interventions in place at the time of this review, though a number of individuals were identified with limitations in fine motor and activities of daily living skills. Specific objectives were stated in the PT assessments described above to outline direct services provided to three individuals. Progress was consistently well documented. Though equipment generally was available, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. In addition, the staff were not

	confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing. For example, approximately 75% of staff were not able to answer key questions about the plans they were observed to be implementing. Ongoing coaching and drills with staff related to risks and the rationale for interventions and supports was indicated to ensure that they were able to discuss the rationale for interventions and to recognize their role in management of health risk issues. The clinicians are commended for their efforts in the development of the current system for monitoring, but clearly it was a work in progress. Monthly reviews of monitoring results continued to be conducted. This process should become more formalized and perhaps evolve into a facility-wide group to examine trends and specific implementation issues that require collaboration across disciplines.

#	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.** Current staffing was changed since the previous onsite review and was now comprised of one contract PT (approximately 32 hours a week), one full time PTA (newly hired since the previous review), and two full time OTRs. License numbers were submitted for each of these clinicians and a current license was verified online for three of the four clinicians. Verification was not possible for Cynthia Buckmeyer, PTA. Per Margaret Delgado-Gaitan, MA, CCC-SLP, two contract PTs had been hired for a minimum of three months and they were scheduled to begin soon. In addition, a contract OT had also been hired with a start date in September. This was also a three month contract. There was one OT vacancy and a 1.5 PT vacancy. There were no COTA positions at SASSLC. There were two OT/PT technicians. There were five Physical Nutritional Management Coordinators (PNMPCs) (one was in NEO during the week of this onsite review). Interviews for a seventh PNMPC were to be conducted soon. Continuing education documented for these clinicians included a program related to oral care attended by Edward Harris, PT, Kelly Patrick, OTR, and Patricia Hajny, OTR. Other courses attended by the PT were related to home care, obesity, mental illness, ethics, and seating/mobility evaluations, for a total of 2.30 CEUs. Courses attended by the OTs were mounting and positioning technology and dysphagia (Hajny: 5 hours, Patrick: 6 hours). Fabrication and maintenance of seating systems and other assistive technology continued to be conducted onsite with two technicians. After co-pay issues were resolved, a local vendor was scheduled to begin to provide services to the facility. Previously, three assessments for new seating systems had been conducted with this vendor in April 2010 and due to financial issues, these were not delivered to Individual #335, Individual #164,	Noncompliance

#	Provision	Assessment of Status	Compliance
		and Individual #284. Re-assessments were conducted one year later in April 2011 and it was reported that these systems were to be delivered by 8/31/11. A number of documents requested by the monitoring team were not submitted, so it was not possible to determine the number of individuals who were identified as having PNM needs. Instead, based on the current census of 278 and a total of 246 PNMPs submitted, the monitoring team presumed that approximately 88% of the individuals living at SASSLC were identified as requiring PNM supports. As currently staffed, the caseloads were 246 for the part time PT and 123 each for OT. The OTs divided responsibilities across the homes, and the contract PT generally completed acute need evaluations and provided direct intervention as indicated. The PT Assistant were not licensed to conduct assessments or develop intervention plans; they required supervision by the PT. They were able to gather specific data for assessments, provide interventions, staff training, conduct monitoring, and other responsibilities. The other clinicians appeared to be strong competent clinicians and had worked at SASSLC since the baseline review. The contract therapists were much needed additions to the department. The monitoring team hopes they can be retained beyond the three month term of their contracts. 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 caseloads, with additional supports available from the therapy assistant or technicians. Annual assessments or updates were completed by OT and PT, collaboratively. Some of those who did not have established PNM needs required occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement, mobility, fine motor skills, and independence. OT/PT assessments were submitted for 26 of 27 individuals included in the sample selected by the monitoring team. Of those submitted, three were not current within the last 12 months (Individual #122, Individual #94 , and Individual #37) and the assessment submitted for Individual #93 was incomplete (7/20/11). Of the remaining 22 assessments, 18 were identified as a Habilitation Therapy Comprehensive Evaluation and four were identified as a Habilitation Therapy Evaluation Update. Each was current in the last 12 months. Additionally, most current assessment samples from each therapist (five each) were also requested and 15 were submitted. These consisted of eight OT/PT Comprehensive Evaluations, two OT/PT/ST Evaluation Updates, one Habilitation Therapies Update Assessment, and four Physical Therapy Assessments (each completed by Edward Harris, PT). The comprehensive assessment for Individual #254 was duplicated in both requests. The total number of assessments included for review was 37.	

#	Provision	Assessment of Status	Compliance
		At least 33 of the 37 (89%) individuals were identified as having concerns related to movement, mobility, range of motion, limitations in levels of independence, and/or regression of functional skills. Most of the recommendations were for a variety of indirect services via the PNMP, the provision of assistive equipment, and/or orthotics, other consults, and dining supports. One individual was recommended for PT services beyond the PNMP (Individual #254). Two others participated in a movement related program in their home or day program (Individual #32 and Individual #106). Three individuals were recommended for follow-up and included Individual #165, Individual #234, and Individual #199. The physical therapy assessments were completed for Individual #301 (6/15/11), Individual #93 (6/10/11), Individual #142 (3/23/11), and Individual #135 (5/30/11). Each of these was referral-based and completed in no more than three days. These assessments were related to a change in status (dependent ambulation, edema, fracture, and refusal to ambulate, respectively). Home programs were recommended for Individual #142 and Individual #93 and direct PT services for Individual #135 and Individual #301. The interval for reassessment was not specified as a recommendation in 11 of the comprehensive and update evaluations. In the other 15 assessments, recommendations related to subsequent assessments were inconsistent. Examples were as follows: • No further OT/PT assessments required unless there was a change in status (equipment review annually): Individual #269 and Individual #108. • No need for an updated OT/PT comprehensive evaluation next year unless there was a change in status: Individual #135, Individual #238, Individual #347, Individual #314, Individual #90, Individual #300, and Individual #143. • No further assessment required unless there was a change in status: Individual #209 and Individual #275. • No further assessment required for three years unless there was a change in status: Individual #170. • Comprehensive assessment in two years unless there was a change in status: Individual #151, Individual #248, and Individual #310. Per the documentation submitted, only three individuals received direct PT services (Individual #301, Individual #135 and Individual #254). No direct OT was provided to any individual. **Standard: All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.** Assessments were completed rather than screenings. Most of the assessments were completed by both OT and PT and in some cases the SLP. As stated above, four had been completed by the PT only. Six individuals had been admitted since the previous review: Individual #203, Individual #170, Individual #173, Individual #1, Individual #56, and	

#	Provision	Assessment of Status	Compliance
		Individual #184. Five of these six were submitted, though each was unsigned and undated. As such, the timeliness of these could not be verified, though four of the six were listed as completed within 30 days of admission per the assessment tracking log. One had been included in the sample selected by the monitoring team. Individual #170's assessment was completed within 30 days of his admission. **Standard: All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.** While the Settlement Agreement indicated that assessment should occur within 30 days of the identified need, this standard is not acceptable when there are urgent issues with potential for further injury or health and safety risks. The assessment tracking log listed only four consults for Individual #336 (2), Individual #268, and Individual #96. Each of these was completed on the due date or the day before, though the referral dates were not included. There were six annual OT/PT assessments listed as completed on the due date and four listed as completed after the due date (Individual #135, Individual #268, Individual #254 and Individual #35). PT assessments submitted were referral-based and had been completed in a timely manner, within a day or two of the referral date listed. The only comprehensive assessment submitted was one for Individual #93, dated 9/29/10, more than two months after his readmission following a hip fracture and surgery. **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.** Per this standard, at least 246 individuals at SASSLC should receive a minimum of a comprehensive assessment every three years with interim annual updates (because each of these individuals was identified with PNM needs through the provision of a PNMP). As described above, 22 of the individuals included in the sample had received a comprehensive assessment within the last 12 months. Three individuals had received a comprehensive assessment in 2010 with an update in 2011 (Individual #8, Individual #151, and Individual #248). There did not appear to be an annual update provided consistently for others (Individual #238 and Individual #19). There was no evidence that Individual #19 had received a comprehensive assessment since 1999, though he had been provided an update on 7/19/10. There was no subsequent update within 12 months despite his identified PNM needs. There was no evidence that Individual #238 had received an interim update since his comprehensive evaluation on 4/21/09 until another comprehensive was provided on 4/26/11. Each of the assessments submitted were generally consistent with regard to format with limited differences between the updates and the comprehensive reports. The assessments did not, however, make reference to a previous assessment in any way.	

#	Provision	Assessment of Status	Compliance
		The assessments were improved since the previous review. The health risks identified by the PST were identified. Information contained within the OT/PT assessment report should contribute to the team discussion to determine risk levels. Risk levels identified by the collective PST should then drive the supports and interventions via the PNMP and other more direct services. Functional skill performance was outlined more consistently across the domains included in the assessment. Equipment supports to address issues in each domain was documented in most of the more current comprehensive evaluations (Individual #108) though via different formats in some (Individual #164). The focus, however, continued to be primarily on the provision of the PNMP rather than skill acquisition strategies. For example, in the case of Individual #108, it was reported that he sat on the edge of the mat table with minimal assistance and righted himself. In addition, he was able to move his arms throughout most of his range of motion, though he was reluctant to release preferred items in his grasp. He demonstrated mature grasps and transferred objects left to right. He held his arms and legs out for dressing and was able to remove his shirt independently. He required coaching and constant redirection during work to prevent hand mouthing. Despite numerous potentials for skill enhancement, learning and participation in his daily activities, there were no recommendations by OT or PT to promote these. One recommendation merely suggested consideration of manipulatives on his lap tray to reduce hand mouthing behaviors. Other issues noted in the assessments included: • A tremendous amount of data were presented in the evaluations, such as previous consults and diagnostics, though much of this did not appear to be considered in the analysis of findings. • There was a section by the SLP related to communication separate from the communication evaluation, though this was inconsistent across individuals. There was no clear rationale as to why this was provided for some and not for others. The information and recommendations contained in the Habilitation Therapies assessment and the communication assessment were not always consistent (e.g., Individual #170, Individual #108, Individual #300). • The clinical reasoning used by the clinician to guide the development of an intervention plan was not clearly stated in the reports. • Even though the assessments more consistently provided functional examples of systems level findings, such as range of motion, strength, and muscle tone, this information was not consistently utilized to guide intervention. • There was no assessment as to the effectiveness of the interventions and supports.	

#	Provision	Assessment of Status	Compliance
		• There was no consistent comparative analysis of health and functional status from the previous year. • There was only a limited analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update. The following information was also noted. These individuals would likely require supports and interventions by OT and/or PT beyond only a PNMP. There were: • 246 (88% of the current census) individuals identified with PNM needs per the PNMPs submitted. • 90 (32 %) individuals identified as non-ambulatory, 57 (21%) as requiring assistance for ambulation and 40 (14%) requiring assistance with transfers. • 65 (23%) individuals required a gait belt for assisted mobility and/or transfers. • 113 (41%) individuals who used a wheelchair as a primary means of mobility. • 26 (9%) individuals who used transport wheelchairs as needed. • 26 (9%) individuals with upper or lower extremity orthotics and/or braces. • 12 (4%) individuals sustained an injury resulting in a fracture. Five of these required assistance with ambulation and/or transfers and three were non-ambulatory. • 61 (22%) individuals had experienced one or more falls in the last 12 months. Thirteen of these incidents occurred for 12 individuals experienced a slip, trip, or fall resulting in a serious injury. Individual #142 experienced two serious injuries. There were 23 of these individuals who required assistance for ambulation and/or transfers and two others who were non-ambulatory. Five (2%) of these were considered to be at medium risk of falls (Individual #71, Individual #180, Individual #5, Individual #261 and Individual #302) and two (less than 1%) others were high risk (Individual #39 and Individual #254). Individual #39, Individual #254 and Individual #261 had each experienced a serious injury secondary a fall. • 11 (4%) individuals had one or more incidences of pressure ulcer in the last year. Eight (3%) individuals were considered to be at high risk and 65 (23%) were considered to be at medium risk. • 34 (12%) individuals were diagnosed with aspiration pneumonia. 12 (4%) individuals were considered to be at high risk for aspiration with 50 (18%) considered to be at medium risk. There were 13 individuals with chronic respiratory infections. 18 (6%) individuals were considered to be at high risk for respiratory concerns and another 32 (12%) at medium risk. • 98 (35%) individuals received prescribed analgesics for pain. • 8 (3%) individuals were listed at high risk for osteoporosis. 33 (12%) others were considered to be at medium risk.	

#	Provision	Assessment of Status	Compliance
		As the PSP and Health Risk Assessment processes are refined over the next year, they will likely further impact the content, analysis, and recommendations in the OT/PT assessments over the next year. **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)** As stated above, the assessments generally addressed range of motion and movement skills, such as transfers and ambulation. Other functional skills were now more consistently addressed, particularly in the area of fine motor skills and activities of daily living, though improvements were still needed in this area. For example, there was usually no discussion of release, but rather general statements as to reach and grasp only (Individual #294). There was, unfortunately, little consideration for the potential for learning new skills via training objectives (as also described above). The monitoring team met onsite with the therapy clinicians to review a recent assessment for Individual #294 per their request. Examples of issues identified included the following: • Report did not identify the reason for assessment or date. • Report did not identify date of previous assessment and type (comprehensive vs. update, for example). • Report did not identify the dates of the health risk ratings reported. She was listed at medium risk for falls despite at least six falls during the last year and a fall on 6/28/11 resulting in a hip fracture. • There were insufficient data and examples related to findings in the areas of range of motion, particularly lower extremities. She had recently had a left hip fracture and subsequent surgery. • Statements that function had not changed did not include dates of review, such as since the previous comprehensive assessment or update. • Report did not identify supports and interventions provided and a statement of their effectiveness. She had participated in two weeks at a rehabilitation center following her surgery and there was no discussion of the outcomes of this therapy. • The report summary and analysis was improved over many of those submitted	

#	Provision	Assessment of Status	Compliance
		for review with more extensive analysis. • New information, use of pain medication, was introduced in the summary rather than presented with other data. • Data presented was not consistently addressed relative to the analysis. • Recommendations provided PT goals for active intervention to be provided daily (Monday through Friday) though performance criteria were not consistently stated. **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.** Assessments submitted, included four PT assessments for: Individual #135 (5/30/11), Individual #301 6/15/11), Individual #142 (3/23/11), and Individual #93 (6/10/11) and a Special Needs Update for Individual #93 (9/29/10), though this was incomplete. In the case of Individual #301, the PT assessment reported that there had been a referral for PT assessment following a PEG tube placement on 6/6/11. There was no evidence that there had been a comprehensive assessment by OT and PT, however, after this significant event. At that time, PT did not recommend direct intervention, but rather walking with 1:1 staff only. The physician referred Individual #301 again for assessment of the need for a wheelchair because he was not ambulating in his home. At that time, direct PT was recommended and was initiated on 6/15/11. There was no evidence of a PSPA to address this change in his plan. Individual #301 participated in 13 intervention sessions and achieved the stated goals, and was discharged per an unsigned, undated progress note. Individual #142 was referred for PT assessment after multiple foot fractures. There was no evidence of a comprehensive OT/PT evaluation following these events. This report identified up to three separate fractures on 9/6/10, 11/29/10 and 3/20/11. Direct PT was not recommended at that time but rather implementation of a home program. Additional documentation was not submitted related to follow-up with Individual #142. He was not identified at medium or high risk for falls and no recommendations were noted by PT in regard to this. Individual #135 was referred for PT assessment secondary to bilateral knee pain and refusals to ambulate. Direct PT intervention was recommended for 90 days. There was no evidence of a PSPA to address this change in her plan, though the assessment stated that training objectives would be added to her PSP to ensure that functional gains achieved during therapy would be maintained. Intervention was initiated on 5/30/11. She was discharged per an unsigned, undated progress note with no reference to a home	

#	Provision	Assessment of Status	Compliance
		program or additional training objectives. A Special Needs Update was completed for Individual #93 on 9/29/10 following hip fracture on 7/1/10 and subsequent ORIF surgery. Recommendations were not included in the partial assessment contained in his record. Individual #93 was referred for a PT assessment on 6/10/11 due to a "less than optimal recovery from a hip surgery" and subsequent dependent ambulation status. At the time of the referral, he was non-ambulatory due to lower extremity swelling and a blister on his right foot due to friction. Direct PT was not recommended, but rather improved staff compliance with orders to keep his legs elevated. The PNMP was to be revised to reflect this. A PNMP dated 7/20/11 indicated that his wheelchair should be tilted to 30 degrees and that his legs should be elevated to 90 degrees unless he was being transported. The picture submitted with this plan, however, did not appear to be a tilt-in space wheelchair as listed in the PNMP and his legs were not elevated. He appeared to be in a posterior pelvic tilt and there was a strap across his chest. This photo was not consistent with the instructions for staff regarding his position. **Standard: Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment.** The assessments did not typically recommend further specialized evaluations for wheelchair seating or for other issues because these were typically assessed at the time of the comprehensive evaluation. The annual assessments typically provided a brief description of the seating system components for individuals with a rationale for their selection, but did not consistently address whether the system was appropriate as to fit, function, and condition. **Standard: Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.** As reported above, a section of the assessment that listed the PST-identified health risks had been included in the assessment template, though the date that these were established was not consistently documented. The rationale for interventions generally was loosely associated to these risk concerns via the PNMP focus statements. Inconsistencies with the identified risk levels were not highlighted by the clinicians in the analysis of findings and there was no recommendation offered for reconsideration of this issue by the PST. • For example, Individual #108, described above with hand mouthing behaviors (often associated with GE reflux) had an extensive history of Barrett's esophagus, erosive esophagitis, and hiatal hernia (though was not considered to be at even	

#	Provision	Assessment of Status	Compliance
		low risk for GERD). Per nursing on 7/11/11, Individual #93 was above his recommended body weight range and had decreased mobility since his hip fracture in July 2010. There was no evidence that this had been addressed via assessment by Habilitation Therapies. The risks addressed in the OT/PT assessment should be consistent with those established by the PST. Though if at any time there was evidence that the risk rating should be modified due to a change in status, the PST should meet to review this. The PNMP should be modified as needed to reflect these changes. This should also be reflected in the OT/PT assessments. Information contained within the OT/PT report should contribute to the team discussion to determine risk levels. If there was a rationale for a difference in these ratings identified in the annual assessment this should be stated in the report for PST consideration. Risk levels identified by the collective PST should then in turn drive the supports and interventions via the PNMP and other more direct services provided by the therapists to assist in addressing those concerns. Efforts to identify the rationale for some supports were noted in the comprehensive assessments. The summary and analysis did not address both health and medical concerns with a description of functional limitations, skill abilities, and potentials for the development of an integrated therapy intervention plan, and to provide a foundation for non-clinical supports and programs. The clinicians reported that they used to consistently receive risk ratings that were updated monthly. These were not consistently added to the Habilitation Therapy database, though this would appear to be a redundancy in the system. As reported above in section O, the therapists did not attend each of the annual and quarterly meetings so they were not always aware when changes were implemented. As such, their absence also limited the information available to the PST for discussion related to risk and for the assignment of risk levels. While they used to get notices, they reported that they did not now, nor have these been requested by the department. **Standard: Evidence of communication and or collaboration is present in the OT/PT assessments.** The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and other supports and services as indicated.	

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P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**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.** Approximately 246 individuals at SASSLC had been identified with PNM needs and, as such, were provided a PNMP. These plans were reviewed by the therapy clinicians as an aspect of the annual assessment; there was no other more frequent routine review. Implementation of the plans was monitored by the PNMPCs and therapy clinicians. Changes were highlighted to alert staff to a change from the previous version. Interventions were generally referral-based only and were limited with regard to minimizing regression and enhancing skills. There were no OT interventions in place at the time of this review, though a number of individuals were identified with limitations in fine motor and activities of daily living skills. Specific objectives were stated in the PT assessments described above to outline direct therapy and interventions, though these were not consistently integrated into the PSP as training objectives (SPOs). The assessments were conducted within no more than a few days of the referral date and interventions, when recommended, were implemented immediately. Documentation was consistent via weekly progress notes by the PT or PTA with a monthly summary of interventions provided. The weekly progress notes and some other progress notes were included in the integrated progress note section, though the monthly notes were filed in the Habilitation Therapies tab rather than included as an aspect of the integrated progress notes or as an aspect of the PSP. **Standard: Within 30 days of development of the plan, it was implemented.** Though interventions provided beyond the PNMPs were limited and not integrated into the PSP, specific PT goals and progress were consistently well documented. There was no evidence of intervention provided by OT. Generally, when an action was identified as necessary to address a more acute issue, these actions were taken well within the 30-day period. Interventions initiated were generally consistently implemented, though the rationale for gaps in service was not well documented. Despite an order for therapy, the clinician had a responsibility to establish a clear justification for therapy and a specific plan of treatment with measurable and functional goals and outcomes. Likewise, continuing or discontinuing an intervention required an adequate and appropriate rationale and justification. All therapy-related SPOs should be an action step in the PSP. They should also be subject to routine PST review with reported data related to progress. **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.**	Noncompliance

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		There was inconsistent analysis of findings in the assessment reports to provide a rationale for the PNMPs developed for individuals or for other interventions. The clinicians' clinical reasoning process used as a foundation for the recommendations was not well documented. PSP Addendums were not consistently developed to address modifications to PNMPs and other therapy interventions for individuals. **Standard: Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression.** The primary support provided was via the PNMPs. PNMPs provided staff instructions or precautions related to assistance and supports for positioning, transfers, handling, and mobility. Additional areas addressed included skin integrity, communication, food texture, liquid consistency, precautions, dining equipment and positioning, and dining instructions. Assistive equipment was included, as well. The focus statements were intended to identify the justification for the supports outlined in the plan. Bathing instructions were provided in the PNMP for 10 of 27 (37%) of the plans in the sample. Oral care instructions were provided in the PNMP for 25 of 27 (93%) of the plans in the sample, though this was generally limited to positioning only. Instructions for medication administration were noted for 25 of 27 (93%) individuals in the sample, though generally also limited to positioning. As described above only three individuals participated in direct intervention to address movement, mobility, range of motion, or independence, even though numerous individuals presented with PNM needs and likely potential for skill acquisition. **Standard: The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used.** Each of the PNMPs reviewed listed specific assistive/adaptive equipment to address individual needs. The assessments inconsistently provided a rationale for the specific equipment recommended for use, though the rationale for the wheelchair seating was more consistently noted. Positioning instructions with pictures were provided for staff reference as an adjunct to the PNMP. These photos were large and very clear, but often were taken when the individual was not in optimal alignment per the plan (Individual #200, Individual #93, Individual #165, Individual #227, Individual #254, and Individual #106).	

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		Standard: Therapists provide verbal justification and functional rationale for recommended interventions. There were few intervention plans. A rationale for initiation of intervention was generally clearly established and documentation was consistent and described progress. **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, documentation was noted weekly with monthly progress notes in most cases. These did not provide a comparative analysis of progress from month to month, however. Documentation for direct services by the PTA was included in the integrated progress note section, but the monthly notes were separate from the rest of the program documentation and the integrated progress notes, filed in the Habilitation tab of the individual record. Reviews of the PNMP were conducted annually, upon referral, or based on the findings of monitoring. There was evidence of the therapists addressing some issues identified through monitoring or referral, yet documentation of follow-up through to resolution was inconsistent.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	**Standard: Staff implements recommendations identified by OT/PT.** Though equipment generally was available, and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. As described above, the pictures provided did not consistently show optimal alignment and support for the intended individual and, as such, would not provide adequate visual cues to staff. There was a continued need for improved staff attention to the details of proper positioning and alignment and compliance with the PNMPs. A number of individuals were observed sitting with a posterior tilt, loose seatbelt, extremities not adequately supported, or the pelvis not well back into the seat of the wheelchair (e.g., Individual #228, Individual #248, and Individual #72). No one was observed being repositioned prior to their meal, and a number of individuals were not appropriately aligned or supported. Most of the transfers completed by staff were properly done (with the exception of Individual #213, Individual #228, and Individual #215), though attention to personal body mechanics continued to need improvement (e.g., Individual #228, Individual #287, Individual #325). It is critical that the PNMPCs confidently and consistently apply their knowledge and skills in their interactions with direct support staff to ensure appropriate implementation of all aspects of the PNMP and other supports. One of the PNMPCs was observed assisting	Noncompliance

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		another staff to reposition Individual #213 at the request of the monitoring team, using improper techniques. In addition, the seat belt strap was too short and could not be adjusted properly. This clearly had been an issue for some time and had not been identified via monitoring by the PNMPCs or other staff. **Standard: Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.** NEO training related to the PNMP had been revised to address additional areas, including reading the PNMP, bathing, getting on and off a van, and positioning and handling during check and change activities, in addition to lifting and transfers. A written test was required for each aspect of the training and the PNMPCs conducted a skills-based check-off following the training. Individual-specific training was also reported to be competency-based. Licensed therapy staff provided inservice training to PNMPCs who then provided training for home supervisors and home managers. These staff were subsequently responsible for training additional staff. This system had the potential to weaken the accuracy of the training relative to that intended by the clinicians when they designed the PNMP interventions. **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 and therapists, though staff names were not consistently listed on the monitoring forms. There was no method to track if this covered all staff who were responsible for implementation of PNMPs. When an issue was identified by the monitor, there was no evidence that competency-based training occurred consistently in conjunction with the findings of the PNMPCs or therapists. • For example, in the case of Individual #311, the clinician found him to be slumped in his wheelchair and his positioning could have been improved on 5/9/11. On 7/28/11 the PNMPC found that Individual #311's bed was not in reverse Trendelenburg and the head of his bed was not at 30 degrees. There was no documentation of action taken with regard to these problems. There was no evidence that staff were prompted to address this or trained to recognize this issue. • In the case of Individual #259, he was found to be lying flat at the bottom of his bed on 4/20/11. No staff member was identified and the clinician documented that she asked the PNMPCs to provide an inservice related to using reverse Trendelenburg. Emails associated with this were included in the Presentation Book for section P. The clinician did not indicate that intervention or training was	

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		initiated at the time of the monitoring. It was not clear if this was a scheduled monitoring or an incidental finding. The clinician requested that he be in reverse Trendelenburg at all times and that staff must be diligent in keeping his head above his stomach secondary to aspiration pneumonia risk. The attached inservice sheet stated only that staff should use reverse Trendelenburg at all times, though there was no evidence of return demonstration or follow-up monitoring to ensure that this guideline was properly implemented following the inservice for six staff . **Standard: Staff verbalizes rationale for interventions.** The staff were not confident in their responses to the monitoring team's questions and appeared to be unsure of why they were doing what they were doing in relationship to the PNMP and other responsibilities. For example, approximately 75% of staff were generally not able to answer questions, such as why an individual needed honey thick liquids or why a glass was only partially filled. Staff in the sensory area did not appear to understand that when the PNMP instructed that individuals were to eat upright in their wheelchair, that presenting a snack to them in a recliner would not be acceptable. By report, this was a daily occurrence and was observed by the monitoring team (Individual #23). After intervention by the monitoring team, staff were observed transferring individuals to their wheelchairs for their snack (Individual #228). In the case of Individual #248, he was noted to be in a significant reclining position during enteral feeding. When the nurse was asked about this, she stated that the proper position was around 20 to 30 degrees and that his position was acceptable. Individual #248's PNMP stated that he should be upright as possible in the recliner and head should be at least 30 degrees for nutritional intake (he was neither, as observed by the monitoring team). The rationale for interventions and supports was stated in the focus statements of the PNMP, but in many cases these were general in nature rather than specific to strategies outlined in the plan. This is an important aspect of staff training. 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. Ongoing coaching and drills with staff related to risks and the rationale for interventions and supports was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues.	

#	Provision	Assessment of Status	Compliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Standard: System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.** As stated above, adaptive equipment was reviewed on at least an annual basis at the time of the PSP assessments, in addition to review per referral by the PST to address fit and function. This was conducted by the licensed therapy clinicians. There was no system established for the clinicians to proactively review equipment for fit and function on a quarterly schedule. The AT workshop technicians completed all maintenance and repairs as identified via that monitoring system or as reported by direct support staff. Work orders were tracked in a log/database. The date requested was documented with a projected date of completion. The database, however, did not document the actual date of completion. It was suspected that the projected date was the actual date though this was not possible to verify from the documentation submitted. If that was the case, it appeared that most, though not all, were completed on the same day as the request or within 24 to 48 hours. Monitoring by the therapists and PNMPCs was routinely conducted to review the availability of equipment and its condition, and to document any associated problems with the equipment or its use. Most individuals were monitored for mealtime on a monthly basis by the PNMPCs, while others with high aspiration and choking risk were to be monitored more frequently by the therapists. • The following individuals were to be monitored two times monthly: Individual #302, Individual #106, Individual #212, Individual #255 and Individual #149. • Nine others were scheduled to be monitored monthly and included Individual #200 and Individual #8 also in the sample selected by the monitoring team. • There were 14 others scheduled every other month and five others scheduled quarterly. • PNMP monitoring was to be conducted twice monthly for Individual #164, Individual #311, Individual #92 and Individual #108, and monthly for 14 others including Individual #91, Individual #197, Individual #19, Individual #227 and Individual #335 also in the sample selected by the monitoring team for review. • Ten others were to be monitored every other month. This schedule was designed by the therapists only and was not directly linked to the variety of risks identified for individuals by their PSTs. A system to require the homes to develop a plan of correction related to negative findings was recently implemented. Based on the monitoring sheets submitted for those included in the sample for the last three months, this schedule was not adhered to for Individual #108, Individual #8, Individual #227, Individual #197, Individual #19, or Individual #164.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The PNMP Monitoring form included indicators to address availability, cleanliness, and condition of equipment and the implementation of the components of the plan, such as transfers and positioning. Additionally, the monitoring form was also used to document issues noted informally. The current data base included this type of monitoring and, as such, would likely bias the overall findings analyzed for compliance. For example, if a PNMPC or therapist noticed a problem as he or she passed through a home, the system would permit the issue to be documented using the form, but would lend a bias to noncompliance because observed monitoring typically would focus on instances of noncompliance only. Inclusion of these with the scheduled monitoring would skew the findings. Assessments were conducted as needed for new seating systems or for modifications to existing systems. Specific mat evaluations and assistive technology assessments documented this process. There were no assessments conducted during the week of this onsite review. The monitoring team will need to observe this during future reviews. Improvement in the design of seating systems was needed and the addition of the ATP vendor would likely lend expertise and a greater variety of products for matching needs of the individuals identified in the assessment process. **Standard: Person-specific monitoring was conducted that focused on plan effectiveness and how the plan addresses the identified needs.** PMNP Monitoring forms were used to conduct monitoring by the PNMPCs and therapists. This form addressed availability of plans, use of proper lifting and transfer techniques, appropriate positioning, and condition of equipment. The individual and direct support staff were identified. The type of observation included general, individual-specific, and staff competency. The monitor was to document concerns, comments, and actions taken. There was a section on the form to document follow-up and closure, but this was not completed on the forms submitted for review. Completed monitoring sheets for the last month (July 2011) were requested. There were 143 completed PNMP monitoring sheets for 106 individuals submitted that were completed in July 2011 by the PNMPCs. Three forms submitted did not identify the first and last name of the individual. These tools were to be completed for each individual at least one time monthly. There were 124 completed forms designated as individual-specific. Three others were identified as general and 10 were considered to be staff competency. The remaining forms had no designation specified. This monitoring focused on implementation and condition of equipment because the PNMPCs were not qualified to make determinations as to the effectiveness of the plans. Additional monitoring for individuals identified at high risk was conducted by the therapists per the schedule	

#	Provision	Assessment of Status	Compliance
		described above. There were 48 completed forms for 32 individuals submitted completed in May 2011. One form identified the first name only. There were 37 of these forms designated as individual-specific, and 5 were identified for staff competency as well. Others had no designation. Per the schedule submitted the following individuals were supposed to be monitored twice monthly due to their high risk status for aspiration and or fractures: Individual #229, Individual #311, Individual #92 and Individual #108. Forms reflecting this frequency were not submitted for Individual #229 (1), Individual #108 (0), or for Individual #92 (1). There were 14 individuals scheduled for additional monthly monitoring by the therapy clinicians. Forms reflecting this level of frequency were submitted for only seven of them. Every other month monitoring was scheduled for 10 individuals and was provided for eight of these individuals, though not in the designated month for Individual #93, Individual #151, Individual #212 and Individual #236. Combined, the monitoring sheets submitted documented monitoring for approximately 125 individuals over two months (May 2011 and July 2011). Clearly, all of the 246 individuals with identified PNM needs who had been provided a PNMP had not been monitored even one time during either of those months. Only 38 individuals had been monitored more than once during those months and only 10 of those had been monitored in both May 2011 and July 2011. A database was developed to track monitoring forms during each month. This database was not sorted by individual. **Standard: For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.** This was reported to be true by therapy clinicians, per the POI, however, there was no system to assure that those who were most at risk were assisted by competent and well-trained direct support staff only. **Standard: Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.** The clinicians are commended for their efforts in the development of this system for monitoring, but clearly it was a work in progress. The findings of only the forms completed by both PNMPCs and therapists were analyzed by the monitoring team. Approximately 50% of the forms documented a "no" on one or more indicators. A variety of issues were identified, such as PNMPs not being available, staff not implementing the plan properly or assistive equipment needing repair. Only 35% of these plans documented any action taken to address the identified issue.	

#	Provision	Assessment of Status	Compliance
		Immediate issues were to be addressed at the time of the monitoring. By report, the forms were reviewed weekly to identify actions needed. However, there was inadequate documentation of follow-up. There was a system of analysis of the completed forms in the form of bar graphs reflecting findings of aggregated data for January 2011 through June 2011. This method of comparing findings from month to month will become useful, though the monitors will require ongoing training to ensure that the forms are completed accurately. Numerous items were marked "not applicable" and this finding should also be tracked. For example, numerous forms marked NA related to transfers as these were not observed (per 130 forms or approximately 68%), though a few of the forms indicated that the individual was independent. It would be critical to analyze how often this activity is monitored to determine if in fact staff were performing safe and appropriate transfers. In addition, in many cases the staff first names only were recorded which will make it difficult to determine the frequency of staff monitoring for continued competency and compliance. Another issue to track would be the number of issues identified and the percentage addressed and clearly documented. Some examples included the following: • Individual #213: She was monitored on 7/15/11 in her home. It was identified that her PNMP was not available, and her hips were not positioned correctly (though it was marked yes that she was positioned according to her PNMP). She was described with poor posture, slouched in a chair. Transfers were not observed on this date. There was no documentation of action taken, training provided, or other staff notified of these concerns. • Individual #311: He was observed on 7/28/11 in his home. He was reported to be in bed which was not in reverse Trendelenburg as instructed in his PNMP, and the head of his bed was not at 30 degrees. Transfers were not observed on this date. There was no documentation of action taken, training provided, or other staff notified of these concerns. • Individual #34: She was observed on 7/20/11 and it was identified that she refused to wear shoes and socks, so her feet were not protected and there was no gait belt available. It was reported that she had also refused this. There was no documentation of action taken, training provided or other staff notified. **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, though procedures were in development, as described above. Validation of PNMPCs was conducted using the same tool used for monitoring. The	

#	Provision	Assessment of Status	Compliance
		licensed clinician and the PNMPC completed the tool simultaneously and discussed the results. At that time, additional follow-up or training was provided as well as follow-up as indicated. These were scheduled, but it was not clear how consistently this was conducted. **Standard: Intervention plans are reviewed monthly by the program author to include observation of staff implementation.** Interventions by the PT were reviewed on a monthly basis with documentation in a progress note, however the objectives were not consistently written with appropriate performance criteria. Some of these would be met if the individual completed the behavior one time. **Standard: Data collection method is validated by the program's author(s).** There were no SPOs submitted for review that required data collection by direct support staff or validation of implementation and documentation this time.	

Recommendations:

1. Consider a reference to the baseline/comprehensive assessment and updates in subsequent updates. In other words, the therapist should clearly cite the date of the previous assessment in the current one. It may make sense to maintain the comprehensive assessment with the subsequent updates in the active record until a new comprehensive was completed. Clear statements as to when the next assessment or update was to be completed should be included in the recommendations (P1).

2. Consider the integration of risk information in the NEO training (P2).

3. There is a significant need to develop programs to address increasing or expanding functional skills. Formal programming is indicated for a number of individuals. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P2).
    a. A temporary shift in focus from assessment to action and implementation to address the intense need for active treatment may be necessary. Working with the home and day program environments on a day to day basis rather than merely referring or making recommendations promotes improved and relevant supports as well as ultimately permits ongoing assessment over time throughout the year rather than only at the time of the annual review. It permits observation and interactions in a meaningful way and allows the clinician to take note of potential for skill acquisition (P2).

4. Integrate direct and indirect supports into the PSP through the development of SPOs that include measurable goals with performance criteria. Ensure that there is a clear measure of progress related to the goals and that these and other critical clinical measures as well as functional health status indicators are used to justify initiation, continuation, and/or termination of interventions (P2).

5. Consider the strategy of observation rounds with professional staff, technicians and PNMPCs to conduct drills for additional training for PNMPCs and to assist staff in recognizing when realignment is indicated (P3-P4).

6. Establish a formal curriculum and competencies for training the PNMPCs (P4).

7. Review the methods used to analyze databases to ensure accuracy of calculations of compliance (P4).

8. Review the existing OT/PT assessment format to address summary/analysis. As currently written these were not consistently sufficient to establish the rationale for the recommendations. The development of a framework that included more specific guidelines for therapists in their treatment of the analysis of findings and justification for supports and interventions in the PNM clinic and the written reports would be useful, particularly with the addition of new therapy clinicians. 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, services and interventions were indicated. These should then be listed as recommendations (P1).

9. Consider the establishment of therapy assistant positions for both OT and PT (P1).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SASSLC Dental Operating and Procedure Manual o SASSLC Health Services - Dental/Medical Sedation and Restraint, 9/15/10 o SASSLC Policy Dental Desensitization and Restraint o Facility census containing the date of last annual dental exam o SASSLC Policy and Procedure: Facility Operational Dental Services Policy, 5/1/11 o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams, utilization rates o Presentation Book, Dental o Dental records for the individuals listed in Section L o Desensitization plans for the following individuals: • Individual #88, Individual #127, Individual #109, Individual #44, Individual #240, Individual #41 o Emergency Treatment documentation for the following individuals: • Individual #98, Individual #`108, Individual #344, Individual #200, Individual #198, Individual #263 o PSP Addendums for the following individuals: • Individual #103, Individual #150, Individual #270, Individual #42 Interviews and Meetings Held: o James P. Fancher, DDS, Dental Services Director o Russell Redell, DDS, DADS Dental Services Coordinator o Amy Weimer, Dental Hygienist o Leroy Quintanilla, RDH o Lilani Muthali, MD, DADS Medical Services Coordinator o Carmen Mascarenhas, MD, Medical Director Observations Conducted: o Dental department o Informal observation of oral hygiene regimens in residences o Dental clinic
	Facility Self-Assessment: SASSLC submitted its self-assessment, the POI. It was updated 8/2/11.

	The POI did not actually indicate what activities the facility engaged in to conduct the self-assessment. The presentation book was reviewed with the dental director an state dental services coordinator during the onsite review. The facility rated itself noncompliant with both provision items. The POI indicated that only basic services were provided and there had been no progress made in the area of dental desensitization. An action plan included several steps that the facility was taking in order to move towards substantial compliance with the Settlement Agreement. The focus for Provision Q1 was improving preventive services and aspiration supports. The actions steps for Q2 centered around development of a desensitization program. The monitoring team found the facility noncompliant with both provision items. This was largely based on the lack of a facility clinic space to adequately provide comprehensive services and failure to adequately address missed appointments, refusals, and desensitization.
	Summary of Monitor's Assessment: Under the leadership of the dental director, the department continued to make advances in the provision of services. Clinic continued in home 637. The new clinic was scheduled to be completed by 2/29/12. In spite of the challenges of a very restricted physical space, the dental clinic staff had continued to enthusiastically provide a variety of basic dental services. The department was well-organized, generated electronic notes that contained good information, and maintained key data related to services. The dental director saw individuals in their homes when necessary and the hygienists provided regular in home training on oral care. Regular interactions in the homes allowed the clinic staff to identify and correct problems, such as a lack of toothbrushes in areas and toothbrushes that were clearly unopened and unused. The vigilance with regards to oral home care proved to be beneficial as the facility's aggregate oral hygiene ratings demonstrated marked improvement from September 2010. The clinic made good use of its time as demonstrated by high utilization rates. Nonetheless, 13% of all clinic appointments were failed with the majority of those attributed to missed appointments. Refusals represented a small percentage of failed appointments. Little progress had been made in the desensitization program. In fact, it was not clear that the six plans developed and submitted had been implemented. There was some success with implementation of various strategies to overcome barriers to treatment.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q1</td><td>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.</td><td>The facility began providing onsite services 9/1/10 in a transition clinic that operated five days a week. The staff was comprised of a full time dental director, one full time hygienist, and one part-time hygienist.

<u>Provision of Services</u>
The dental director reported that basic services were provided. This included routine exams, preventive care, restorative care, minor oral surgery, endodontics, and periodontal care. The facility maintained contracts with community dentists for provision of special services such as geriatric dentistry and dental care for the medically compromised. The facility focused on preventive services. The number of clinic visits is summarized below:
<table>
<tr><td colspan="8">Appointments 2011</td></tr>
<tr><td></td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>June</td><td>Total</td></tr>
<tr><td>Preventive</td><td>28</td><td>39</td><td>47</td><td>64</td><td>63</td><td>68</td><td>309</td></tr>
<tr><td>Restorations</td><td>3</td><td>4</td><td>7</td><td>2</td><td>4</td><td>5</td><td>25</td></tr>
<tr><td>Total Seen</td><td>93</td><td>62</td><td>110</td><td>94</td><td>107</td><td>87</td><td>553</td></tr>
</table>
<u>Emergency Care</u>
Emergency care was available during normal business hours. After business hours, the on-call physician had access to the dental director by phone. Guidance could be provided on treatment and individuals referred to the local emergency department, if necessary. Documents were reviewed for the six individuals. In each case, prompt care was provided and the individual was followed in clinic until there was resolution of the problem. In the case of Individual #108, transfer to an acute care facility was required due to bilateral fractures of the mandible. Upon return to the facility the individual was followed until resolution.

<u>Oral Hygiene</u>
The hygienists started home visits in the summer of 2010. Each hygienist visited the homes two days each week. Toothbrushing instruction for individuals and staff occurred four days a week.

The facility tracked oral hygiene ratings on a quarterly basis. Data were represented in graphs and provided to the PSTs. The facility's aggregate hygiene ratings are summarized in the table below:
<table>
<tr><td colspan="4">Oral Hygiene Ratings</td></tr>
<tr><td>Quarter</td><td>Poor %</td><td>Good %</td><td>Fair %</td></tr>
<tr><td>12/31/10</td><td>62</td><td>31</td><td>7</td></tr>
<tr><td>3/31/11</td><td>48</td><td>42</td><td>10</td></tr>
<tr><td>6/30/11</td><td>39</td><td>43</td><td>18</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		These data indicated significant improvement in the oral hygiene status of the individuals supported by the facility. Individuals at risk for aspiration were assessed for the additional needs, such as suction toothbrushing and mechanical toothbrushes. In addition to orientation training, direct care professionals received training on the special supports required for those at risk for aspiration. Fifteen individuals participated in the suctioning toothbrushing program. The dental director reported regular communication with the QMRPs who were required to provide strategies to improve oral hygiene for those with poor ratings. Unfortunately, it was reported that the response to and implementation of recommendations regarding care was poor. Examples of two training objectives were provided. Individual #311 had an objective implemented to accept toothbrushing. The implementation date was 2/16/11. There was no update on progress included in the document. Individual #18 had a training objective implemented to accept toothbrushing. The implementation date was 2/7/11 with a completion date of 5/7/11.	
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	<u>Policies and Procedures</u> The dental policy manual was developed and implemented in 2010. This comprehensive policy included the organization of the dental services and the provision of care. It also included policies related to restraint and sedation, infection control, and radiology safety. <u>Annual Assessments</u> In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months and the date of previous annual assessment was requested. Data collected prior to the opening of the clinic were not used. The facility provided a list of individuals due for annual exams. The list contained 111 individuals: • 72 of 111 (64%) had an annual exam performed • 52 of 72 (72%) had the annual exam completed o 52 of 111 (47%) of individuals completed the annual exams Sixty four percent of individuals had and exam while only 47% actually completed the exams. Failure to complete the exams was usually due to the inability to cooperate. The exact reason for 64 % of individuals having the exam scheduled and attempted was not presented. Compliance with completion of annual exams will be explored further at the next visit.	Noncompliance

#	Provision	Assessment of Status	Compliance
	medications and dental restraints.	Dental Records Dental records consisted of initial/annual exams, oral hygiene evaluations, dental progress/treatment records, and entries into the integrated progress notes. A newly implemented standardized annual dental summary was developed as a tool to share information with the PSTs. This document presented a concise summary for review and included risk assessment, treatment provided, oral hygiene ratings, self-care assessments, present conditions, needs, behavioral assessment, and recommendations. The integrated progress notes included pointer notes that directed the reader to the dental treatment records contained within the integrated record. The documentation within the treatment record was electronically generated. The notes were dated, timed, and signed. The information was presented in SOAP format and consistently provided excellent documentation of services provided. Failed Appointments The clinic schedule was usually distributed one week in advance of clinic. Each morning, the nursing staff was reminded of the clinic schedule. Data was collected on failed appointments and distributed each month to the QMRPs, residential staff and the residential supervisors.	

Dental Clinic Appointment Data 2011

	Jan	Feb	Mar	Apr	May	June	Total
Missed	18	10	9	9	17	11	74
Refusals	7	4	3	3	5	5	27
No Shows	9	4	6	6	12	6	43
Total Failed Appointments	32	16	18	18	34	22	144
Total Appointments	93	62	110	94	107	87	553
Utilization Rate	85.7%	89.1%	92.9%	91.7%	86.0%	89.3%	--

Missed appointments represented 51% of all failed appointments. The two most frequent explanations provided for missed appointments were off campus appointments and activities and staffing issues. The dental director calculated the utilization rates as a measure of efficiency. Consistent rates greater 85% represented good use of clinic hours. Even with high utilization rates, 26% of total appointments for the first half of the year were considered failed appointments.

The dental director reported that he had frequent communication with various members of the team, particularly the QMRPs. He considered the responses to issues, such as failed appointments, to be infrequent. The POI documented that progress was made in

#	Provision	Assessment of Status	Compliance
		sharing of information across the organization, but implementation of recommendations to PSTs was not consistent. Documentation of interventions to address failed appointments was requested. Three emails, dated in June 2011, from the dental director were provided. One response was noted from the QMRP related to scheduling. One email included no response from the QMRP. The third email included a response from the QMRP stating the two individuals had BSPs for refusals that would be followed and assessed. Another individual was determined to have an isolated incidence of refusal. The PSP addendums for four individuals were provided to the monitoring team for review. Three of the PSP addendums indicated that appropriate BSPs were in place. One indicated that the refusal was an isolated incident. <u>Restraints</u> The facility resumed the use of oral sedation in December 2010. The use of sedation and restraints was tracked and monitored by the restraint reduction committee. A summary is presented below.	

	Jan	Feb	Mar	Apr	May	June
Pretreatment sedation	9	7	8	8	9	11
Percentage of individuals requiring sedation	9.7	11.2	7.2	8.5	11.2	12.6

Prior to receipt of sedation, the dental director sent a standard letter to the team. A package including the standard letter, consults from physicians, psychiatrist, and clinical pharmacist were sent to the QMRP in order to obtain consent from the LAR and HRC approval. Each individual was required to have a desensitization plan included in the active treatment program. Recommendations for special program objectives were provided.

The director of psychology reported that 63 desensitization plans were developed. Upon further discussion it was determined that approximately six plans had been developed, but a number of strategies and interventions had been implemented to assist in providing treatment to individuals who refused treatment or required sedation.

The desensitization plans for the individuals listed in the Documents Reviewed section were submitted to the monitoring team. The plans provided were identical, contained no implementation dates or other data, and were unsigned. The only information entered was the name of the individual. It did not appear that the six plans reported to have been

#	Provision	Assessment of Status	Compliance
		developed were actually implemented. The POI indicated that desensitization plans had rarely been developed. Several PSPs documented training objectives related to oral care and some measure of success was noted with these objectives. The review of PSPs found that every PSP included an action plan related to toothbrushing. The facility should consider ways of incorporating procedures to reduce the need for sedation, including, but not limited to desensitization programming as it develops the teaching SPOs for these action plans. In other words, there were opportunities every day to work with individuals on their becoming more comfortable with dental procedures.	

Recommendations:

1. The facility should continue with plans to open a full clinic. This is required in order to provide more comprehensive services (Q1).

2. Efforts related to providing special supports to individuals at risk for aspiration should continue. The facility should ensure that all individuals who could benefit from suction toothbrushing receive this support (Q1).

3. The facility must hold the PSTs accountable for responding to recommendations related to oral care at home. Strategies and interventions should be developed when those needs are identified by the dental clinic. A formal process should be developed and implemented to achieve this goal (Q1).

4. The PSTs must develop strategies and interventions to overcome barriers to treatment. These strategies should be individualized. When there is a lack of response to strategies, the PSTs must ensure that appropriate actions such as assessment, development and implementation of desensitization plans occurs (Q2).

5. Desensitization plans should be regularly evaluated for effectiveness. When there is a failure to progress, the PSTs should intervene and consider alternative strategies (Q2).

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 SASSL Organizational Chart o Individuals Served- Alphabetical list o Admissions list o Budgeted, Filled and Unfilled Positions by Job Code (6/30/11) o AAC Services Policy #16 (10/07/09) o Facility Communication Services 300-50A (4/28/11) o Section R Presentation Book and POI o Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication Guidelines o Continuing Education documentation submitted o Current list of Speech staff o Comprehensive Communication Evaluation template o List of general use AAC devices at SASSLC o PNMPs submitted o List of Individuals with Behavioral Issues and Severe Language Deficits o List of Individuals with PBSPs and Replacement Behaviors Related to Communication o BSP Approval and Review Data (July 2011) o SLP Assessments for February – July 2011 PSP Meetings o Master Plan (8/17/11) o Communication and Hearing Equipment o Communication - Hearing - Environmental Control Equipment Observation Form o Completed Communication - Hearing - Environmental Control Equipment Observation Forms submitted o SPOs, PSPs, PSPAs, Assessments and related documentation for: Individual #31, Individual #112, Individual #170 and Individual #335 o Communication inservice documentation submitted for the past quarter o Communication evaluations and PSPs: • Individual #324, Individual #347, Individual #155, Individual #255, Individual #78, Individual #239, Individual #10, Individual #255, Individual #203, Individual #104, Individual #288, and Individual #56 o Information from the Active Record including: PSPs, all PSPAs, signature sheets, Integrated Risk Rating forms and Action Plans, PSP reviews by QMRP, PBSPs and addendums, Aspiration Pneumonia/Enteral Nutrition Evaluation and action plans, PNMT Evaluations and Action Plans, Annual Medical Summary and Physical, Active Medical Problem List, Hospital Summaries, Chest X-rays, GI Consults, Orthopedic consults, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report,

	Aspiration Triggers Data Sheets (1/1/11 to present), Habilitation Therapy tab (included Communication assessments and updates), Nutrition tab and PNMP tab for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. o PNMP section in Individual Notebooks for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. o Mealtime Observation/PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #164, Individual #122, Individual #108, Individual #91, Individual #165, Individual #200, Individual #265, Individual #300, Individual #32, Individual #199, Individual #311, Individual #37, Individual #151, Individual #197, Individual #248, Individual #238, Individual #227, Individual #138, Individual #8, Individual #94, Individual #170, Individual #234, Individual #19, Individual #254, Individual #106, Individual #93, and Individual #335. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MA, CCC-SLP Habilitation Therapies Director o Allison Block Trammell, MA, CCC-SLP o Ron Hoffmann, MS, CCC-SLP o Melissa Garcia, MA, CCC-SLP o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs o Workshop

	Facility Self-Assessment: SASSLC submitted its self-assessment for this provision (POI). In addition, the monitoring team requested that the Director review the Presentation Book onsite and a copy was submitted for review. The POI did not identify what activities were conducted for self-assessment, but rather included dated statements, or the status of a variety of tasks since the previous review in February 2011. The correlation of these tasks to each provision item was not always clear. Also, there was no mechanism to determine how the facility had determined noncompliance with each element in this provision. A blank Settlement Agreement Cross-Reference with ICF-MR Standards Section R-Communication self-audit tool and Guidelines were included in the Presentation Book**,** and completed audits for 12 individuals were submitted, done in May 2011 and June 2011. In the case of Individual #155, he was reviewed during both consecutive months. It was not clear how the sample was identified for these audits. Scores of 100% were reported for four of 13 indicators in June 2011. It did not appear that the audits were used to self-rate compliance. A list of 10 Action Steps was included in the POI, related to R3 only. It was reported that the Department was to pick one provision to focus on and submit the Action Steps for that provision. These actions were not all particularly pertinent to the provision and did not reflect a comprehensive strategic action plan developed to guide the department through the process of achieving substantial compliance across all provisions, nor were they clearly linked to content in previous reports or specific recommendations made by the monitoring team. Three of the 10 action steps were listed as completed. Projected completion dates were listed, but not actual dates of completion. Each of the other seven action step listed was identified as in process with completion dates ranging from 12/1/11 (fill SLP position) to 12/31/12 (assess all individuals per priority list. The evidence cited for the first action step (assess all individuals per priority list) was to include only Priority 1 and 2 individuals , while assessments for Priority 3 and 4 individuals would not be completed until 2013 for approximately 50. This approach appeared to merely document completion of tasks rather than to serve as a clear, well-outlined plan to direct focus, work products, and effort by staff. Action steps should be short-term, stated in measurable terms with timelines and evidence required to demonstrate completion of all interim steps. The monitoring team concurs with SASSLC self-assessment of noncompliance for each of the items in provision R.
	Summary of Monitor's Assessment: Though it had been reported that all individuals at Priority 1 had received a comprehensive assessment, only 13 had received one since 2010. Assessments prior to that time were not comprehensive per the current standards established in the Settlement Agreement. There were a number of these individuals who had not received a communication assessment in 20 or more years. Over 50 individuals identified as

	Priority 3 and 4 had not received an assessment in 10 or more years. The Master Plan for assessment for individuals at all priority levels extended well past the timelines in the Settlement Agreement. Approximately 62% of those at Priority 1 had been provided some type of system beyond a communication dictionary, but only 23% of those at Priority 2 had been provided a device. A list submitted identified a total of 83 individuals with one or more AAC systems and this represented a net increase from that documented during the previous review. The majority of the systems provided appeared to be individualized and potentially meaningful to the individual. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual was often not possible. The comprehensive assessments were more consistent across individuals, though the AAC section was extremely limited in content. Systems were selected based on very minimal evidence of consideration, or trials, of various options. The rationale and recommendations did not consistently reflect a careful and thoughtful consideration of AAC systems, skill acquisition potential, and the consideration of learning opportunities designed and directed by the speech language pathologists. As all individuals had yet to receive a current comprehensive assessment, it was not likely that all had been provided the communication supports they required. The clinicians reported that not all individuals had been provided these supports to date. In addition, many of those already issued were not consistently implemented throughout the environments frequented by the individual. AAC use was not consistently described or integrated into training objectives for the individuals reviewed with AAC. There was no description of expressive or receptive communication skills outlined in the PSPs for 36% of those reviewed and very minimal descriptions of either receptive or expressive communication were included in the PSPs for another 39% of those reviewed. By report, NEO staff training in the area of communication was largely lecture only with no opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. This was reflected in the observations of general interactions of staff with the individuals they served. While they were generally positive, 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. In addition, the monitoring team continued to note (as also noted in each of the previous reviews) that direct support staff in the homes very diligently and routinely provided instruction and language-based active treatment activities. Unfortunately, as identified in previous reports, these activities were most often not functional or meaningful to the individuals to whom they were provided. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. 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, there were two full time SLPs (Allison Block Trammel, CCC-SLP and Ron Hoffman, CCC-SLP) and one part time contract SLP (Melissa Garcia, MS, CCC/SLP). One other contract SLP began a nine month contract during the week of this review and another was interviewed and expressed interest in a contract position. There was one unfilled position for a speech language pathologist. There was one speech technician who also had general administrative duties for the Habilitation department. There were two contract audiologists. SASSLC provided license numbers for Ms. Trammel, Mr. Hoffman, and Ms. Garcia and continuing education for each clinician in the last 12 months. The status of licensure for each of these clinicians was verified online. The new contract SLP had not been employed at the time of the document request so the license number and continuing education information was not available. CVs were not submitted for any current speech staff. Evidence of attendance for communication-related continuing education since the previous review was not submitted though a variety of courses were listed for Allison Trammel (13 contact hours), Ron Hoffman (seven contact hours), and Melissa Garcia (none since November 2010). Attendance at additional AAC related continuing education was planned by report. **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.** The SASSLC Master Plan was requested. The document submitted was a list used to prioritize the completion of assessments. Each individual had been previously screened and ranked based on need for AAC from 1 (most needy) to 4. At the time of this review, it was reported that all individuals identified as Priority 1, and approximately 79% of those identified as Priority 2, had been provided a comprehensive communication assessment. No dates were included in the Plan, only the year of completion or year a comprehensive assessment was due. Another list identified the completion dates of assessments with the PSP dates. There were 73 comprehensive assessments or updates listed as completed since 1/18/11. Five had been completed on the day of the PSP or after the PSP date listed. Seven were still listed as pending after the date of the PSP identified.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Though it had been reported that all individuals at Priority 1 had received a comprehensive assessment, only 13 had received one since 2010. Assessments prior to that time could not be considered comprehensive, per the current standards established in the Settlement Agreement. • Though six of seven individuals with comprehensives in 2008 were scheduled for a subsequent comprehensive scheduled for this year (2011), none were listed as completed to date. The facility later reported that a total of 13 individuals with comprehensives in 2008 were awaiting a subsequent comprehensive in 2011. For 10 of these individuals, these comprehensives had not yet been completed because the PSP meeting was scheduled for a later month in the year (i.e., September through December). The PSP month for the other three individuals was in August, and the Master Plan did not yet reflect their completion and was not presented to the monitoring team. • Approximately 10 of 25 individuals with comprehensives in 2009 had received an annual update in 2011, six were due in 2011, and nine others were not scheduled for a new comprehensive until 2012. • Eight of the 12 individuals with comprehensives in 2010 were scheduled for an annual update, though only two were listed as completed. • Only 35% of the individuals who were Priority 2 had received a comprehensive since 2010. • There were 25 individuals who had not received a comprehensive assessment since before 2002 (1989-1999). See chart. • Each individual identified as Priority 2 with an assessment listed prior to 2009 (34) was scheduled for a new comprehensive assessment this year (2011), though none were listed as completed to date. • There were 57 individuals who had been identified at highest priority (Level 1 and 2) listed with comprehensive assessments due during the year 2011 though only 18 of these had been completed to date (Individual #136, Individual #38, Individual #256, Individual #78, Individual #198, Individual #284, Individual #327, Individual #30, Individual #73, Individual #248, Individual #288, Individual #104, Individual #9, Individual #165, Individual #189, Individual #208, Individual #10 and Individual #62). • Individual #173, Individual #56, Individual #170 (in process), and Individual #203 had received comprehensive assessments this year as new admissions. A total of 109 individuals were identified as needing a comprehensive assessment per the Master Plan as follows: • Priority 1 = 0 • Priority 2 = 30 • Priority 3 = 21	

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		• Priority 4 = 58 Per the POI action steps, SASSLC planned to assess all individuals per the established priority list (Master Plan). The start date was 11/1/10 with a projected completion date of 12/31/12 for all level 1 and 2 assessments. As stated above there were likely a number of the assessments completed prior to 2010 that would not be considered to be comprehensive and as such there were approximately 106 assessments that would need to be reviewed and redone as needed prior to 12/31/12 to meet this deadline. In addition, this action step did not consider the additional 98 individuals who were identified as Priority 3 or 4 who had received an assessment prior to 2010 and would also require review and reassessment as indicated. The Master Plan indicated that these individuals would receive comprehensive assessments in 2011 (6), 2012 (7), 2013 (38) and 2014 (15). This schedule was well outside the SA provision timelines to ensure that all individuals had received a comprehensive communication assessment. A list submitted identified approximately 83 individuals with one or more AAC systems that had been provided as follows: • Communication Books (14) • Picture Boards (14) • Laptray Pictures (2) • Voice Output Communication Aids(VOCA) (23) • Picture Wallets (5) • Communication Posters and Wall Pictures (3) • Tactile Activity Board (1) • Cheap Talk 4 (3) • Cheap Talk 8 (1) • 32 message communicator (1) • Small Talk (1) • Twin Talk (1) • GUS Laptop Computer with head switch activation (1) • Electronic communication device attached to wheelchair (2) • Sequencer Devices (2) • Picture Folders (12) • Object Rings (6) • Picture Rings (3) • Object Board (1) • Placemats (1) • Picture Schedule (2) These systems were varied and appeared to be individualized. Many were designed to	

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		be available to individuals across environments or a device was available in multiple environments. For example: • Individual #95: Picture schedule in her bedroom and a picture schedule ring at work. • Individual #287: Sequencer device at Sensory Skills Program and another at home. • Individual #335: Electronic communication device attached to his wheelchair and a three button VOCA device at work. There were 64 individuals who had an AAC system in addition to a communication dictionary and 80 individuals with a dictionary only. This was a net increase from that documented during the previous review. Approximately 62% of those at Priority 1 had been provided some type of system beyond a communication dictionary, but only 23% of those at Priority 2 had been provided a device. There were a variety of communication boards and single message wall switches installed in several homes (e.g., Homes 665, 668, 670, 671, 672, 673, 674 and 766) and the workshop. The majority of the community devices were in working order, however, a number of those intended for individual use were not operational (e.g., Individual #31). Records of 27 individuals were requested. There were communication evaluations contained in the record for 23 of them, though the assessments submitted for 12 individuals were not current within the last 12 months (i.e., Individual #265 (9/8/89), Individual #300 (7/18/89 and 3/4/09), Individual #333 (2/9/09), Individual #248 6/889), Individual #238 (5/3/01), Individual #227 (2/27/95 and 8/16/00), Individual #94 (6/14/01), Individual #234 (11/29/89 and 11/19/09), Individual #19 (7/7/89), Individual #254 (11/2/95), Individual #106 (12/7/89) and Individual #93 (7/21/09)). Communication assessments were not submitted for Individual #335, Individual #8, Individual #138, and Individual #197. Assessments submitted for Individual #170 and Individual #108 were incomplete. The report dated 8/8/11 for Individual #170 was an addendum to a Comprehensive Communication Evaluation dated 4/28/11. The report for Individual #108 was missing pages. Assessments of 39 individuals were reviewed. This included individuals participating in direct speech therapy, the five most current assessments for each clinician, and additional randomly chosen ones. Of these, 95% (37 of 39) indicated that the individuals presented with significant communication deficits. Two individuals (Individual #155 and Individual #225) were reported to be verbal with effective expressive and receptive communication skills. There were 20 Comprehensive Communication Evaluations and	

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		six Interim communication Updates current within the last 12 months. The format of the updates was inconsistent with the template submitted. The comprehensive assessments were more consistent across individuals, though the AAC section was extremely limited in content. Systems were selected based on very minimal evidence of consideration, or trials, of various options. For example • In the case of Individual #37, she was assessed for an environmental control switch to activate a vibrating pillow placed in her lap. It was determined that she activated this with minimal prompting. It was stated that she already had this available to her and that a training objective be developed by the PST. It was not clear why additional options, particularly those that were more communication-based were not evaluated. As she already demonstrated the ability to activate the switch with the vibrating pillow, it was unclear why an alternate training objective was not presented for further skill acquisition. • In the case of Individual #165, he was evaluated for use of Picture Key Ring (4/5/11). By report, he showed an interest in the pictures on the ring and attempted to point to them. It was recommended that the PST provide this and consider a language objective. Individual #165 was not evaluated by this clinician related to any other systems. No training objectives were recommended for development or implementation by speech for either of these individuals. Individual #165's PSP (5/5/11) included no communication objectives, but rather only an objective that he should point at pictures of currency with physical prompts and that he would engage in an activity for one minute with partial physical prompts. A picture ring was listed for him in the list of AAC provided but it was not clear how he would learn to use it functionally without specific learning objectives. As all individuals had yet to receive a current comprehensive assessment, it was not likely that all had been provided the communication supports they required. Further, the clinicians reported that not all individuals had been provided these supports to date.	
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	**All individuals in need of AAC are identified as being in need of AAC.** The most current assessments were essentially unchanged in format or content since the previous review. As stated above, the AAC and environmental access sections were very limited and in many cases did not reflect thorough review of possible options for assistive technology or skill acquisition programming. The rationale and recommendations did not consistently reflect a careful and thoughtful consideration of AAC systems, skill acquisition potential, and the consideration of learning opportunities designed and directed by the speech language pathologists. Some examples are below.	Noncompliance

#	Provision	Assessment of Status	Compliance
	systems, including systems involving behavioral supports or interventions.	• It was reported (6/7/10) that Individual #151 had a program in place in the sensory stimulation day program. He was to activate a switch with physical assistance three of four trials per month for three consecutive months. There was no indication that this was observed by the clinician. The only recommendation was that this activity should continue using a variety of sounds and to resume a message recorded by the individual's father. There was no evidence that the speech clinician would be involved in the design or review of Individual #151's participation in this program. This device was not listed as provided per the list of AAC submitted. The PSP submitted as present in his individual record was not current within the last 12 months (6/21/10). At that time it was documented that the PST agreed he should be provided a sensory training objective to target expansion of his environmental/sensory awareness skills, though there was no communication objective identified. Observations by the monitoring team during this (and the previous onsite review) revealed that, generally, these devices were presented by an instructor at only one time during the day program session and were not available to the user at any other time. This, as well as the design and implementation of the program, were unlikely to ensure that progress would be made in Individual #151's communication skills. There was no evidence that the clinician intended to provide technical support to day program staff or annual reassessment to review this individual's progress with this. He was not listed for a subsequent comprehensive assessment until 2013. • Individual #225 was described as functionally verbal (6/3/11), but demonstrated outbursts of frustration and required prompting to remain alert and attentive to tasks. It was further reported that her language age scores had diminished since an assessment in 2006. Speech intervention or further assessment was not recommended, though a monthly calendar or daily routine calendar were suggested to assist with transitions. These were not listed as provided per the list of AAC submitted. There was no evidence in the evaluation report that this clinician intended to review this individual's status in a subsequent assessment and she was not listed for a subsequent comprehensive assessment until 2014. No PSP was submitted as requested. **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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		The current comprehensive communication assessment format generally addressed both verbal and nonverbal skills, and expressive and receptive language skills. Each of the assessments had recommendations related to whether direct therapy or AAC was indicated. The recommendations provided typically addressed staff strategies to use or enhance existing skills, but recommendations related to acquisition of new skills were limited based on the assessments reviewed. PSPs, PSPAs, assessments, SPOs and documentation were requested for the following individuals identified as currently participating in direct speech therapy (Individual #112, Individual #31, Individual #170, and Individual #335). Documentation and integration into the PSP was inconsistent. Examples include the following: • Individual #112: The most current assessment submitted was dated 9/2/10, despite her ongoing participation in direct communication services. Per this report, she had been participating in direct therapy for some time, though this was not specifically identified by the clinician. Individual #112 had been using her current AAC system since 1998, though she had not received a comprehensive assessment since 1989. The assessment did not delineate her progress, but rather only her status with a statement that she continued to make steady progress. Recommendations included that she would continue with direct therapy but did not identify specific goals or outcomes. The SPO submitted as most current was dated 9/8/10 and listed this objective: "Individual #112, when using her new GUS communication system, will communicate at least 5 sentences from 3 specific menu pages for 80% accuracy for two consecutive months." A clear statement of her baseline performance was not stated. Progress notes from 3/1/11 to the 7/29/11 were submitted. By report, her computer was not working and no data were documented from 3/1/11 to 6/30/11. Documentation indicated that she had attended one session during July 2011 with progress reported. However, the recommendation was to continue in her current program as soon as her computer was repaired. Her PSP dated 9/7/10 referenced a speech evaluation dated 8/6/09 rather than the more current comprehensive. There were Action Steps in her PSP related to use of her AAC system to report how she was feeling as well as two outcomes for speech intervention. The objectives listed in her SPO and PSP were not consistent. Training was to occur daily per the PSP Action Plan #4. • Individual #31: Specific objectives, as well as a description of his progress over the last year, were clearly documented in the comprehensive communication evaluation dated 2/16/11. There was an SPO and progress notes from April 2011 to July 2011 that clearly identified his baseline status and specifics related to his progress across each of six objectives. This direct service and integrated	

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		use of his system was noted in his PSP dated 2/14/11. • Individual #335: The most current assessment submitted was an update dated 10/11/10. There was no evidence that he had participated in direct intervention since 2008. Individual #335 used existing AAC systems since 2000, but a Dynavox Mighty Mo had been obtained for him. Direct intervention was recommended to assist him in using this new device. Specific goals were not outlined in this assessment. An SPO submitted as most current was dated 4/28/11 and listed four objectives. It was not clear why it took over six months to implement this. Progress notes submitted from April 2011 to July 2011 denoted his status and progress specific to these objectives. Other than having access to his AAC and an objective related to medication administration, his PSP dated 10/19/10, did not reflect direct communication interventions. There was no PSPA reflecting the addition of this service to his plan. • Individual #170: The most current assessment submitted was a comprehensive evaluation dated 4/28/11 and addendum dated 8/8/11. There was no evidence that he had previously participated in direct intervention related to communication. Individual #170 was nonverbal and had not used AAC systems prior to his admission to SASSLC on 4/14/11. Direct intervention was not recommended, but rather extended assessment to determine if AAC use would be of benefit. Per the addendum, he was seen in his home on four other occasions by the clinician. Direct intervention was not indicated, per this addendum. Recommendations included that he would be provided an object ring corresponding to activities and consistent exposure to voice output devices. By report, he routinely held stuffed animals in his hands (related to previous behavior plans to prevent SIB), precluding the use of his hands for communicative purposes. His PSP dated 5/13/11, included a psychology training objective that he was to activate a communication device to indicate that he wanted to eat. There was no evidence of collaboration related to the communication programming intended for Individual #170. Specific skill acquisition outcomes were not delineated in most of the other assessments reviewed and specific measurable goals were recommended for PST implementation for three others (see below). **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.** As stated above, there were only four individuals listed as receiving direct speech services and the documentation for each of those were requested for review. Current communication assessments for each were submitted as follows:	

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		• Individual #335: Interim Communication Update (10/11/10) • Individual #170: Comprehensive Communication Evaluation (4/28/11) • Individual #112: Comprehensive Communication Evaluation (9/2/10) • Individual #31: Comprehensive Communication Evaluation (2/16/11) With the exception of Individual #170 each was scheduled for annual interim updates. He was scheduled only for a subsequent comprehensive assessment in 2014 despite specific recommendations for AAC. Individual #335 was scheduled for a repeat comprehensive assessment later this year. As the only update submitted was for Individual #335, it was not possible to determine if the clinicians consistently provided these on an annual basis. There were approximately 159 individuals identified as Priority 1 and 2, or most likely to benefit from AAC, yet less than 2% of these individuals participated in direct communication supports. • Only 58% of those identified as Priority 1 and 22% of those at Priority 2 were provided some type of AAC system. • Approximately 32% of those at Priority 2 were scheduled for an annual update and all the others were scheduled for assessments every three years. • There were a number of these individuals (15) who had not received a communication assessment in 20 or more years. While each was scheduled for an assessment during 2011, there were nearly 37 other individuals at all priority levels also scheduled for assessments and approximately 36 scheduled for updates during the remaining four months of this year. • Over 50 individuals identified as Priority 3 and 4 had not received an assessment in 10 or more years. There were 21 individuals at these levels listed with AAC. While most of these individuals had received an update or comprehensive assessment this year, nine more were still due in 2011 and Individual #294 was not scheduled for a comprehensive assessment until 2012. She was listed with a communication wallet per the list provided. **Standard: Programs, goals and objectives related to the acquisition or improvement of speech or language are written by the SLP.** The only goals and objectives written by SLPs were those addressed through direct communication services for Individual #112, Individual #335, and Individual #31. These were integrated into the PSPs for Individual #112 and Individual #31. In the case of Individual #335, the action steps included only that he would have access to his AAC but not that he would gain skills in this area. There was, however, a step	

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		under the outcome "I will enjoy my leisure/recreation time" that included him independently approaching the nurse and pointing to a picture of a pill on his communication board to indicate that it was time for his medication. There were recommended objectives in the assessments for three other individuals including Individual #37 (7/8/11), Individual #239 (11/8/10), and Individual #10 (5/9/11). It was expected, however, that the other PST members would design and implement these programs without assistance from the SLP. SLP modeling, coaching, support, training, and monitoring did not appear likely. Individual #10 was listed as scheduled for an annual interim assessment and subsequent comprehensive evaluation in 2014. She was listed with a picture schedule at work. Individual #239 was not scheduled for an interim assessment or comprehensive until 2013 and Individual #37 was not likely to receive a subsequent assessment until 2014, however, as neither was listed with AAC. **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. Communication programs are integrated into the PBSP as indicated.** Of the 26 current assessments reviewed, 15 were identified with behavioral issues requiring a PBSP. A list submitted identified 88 individuals with behavioral concerns and coexisting severe language deficits. There were an additional four individuals for whom assessments were submitted that identified significant communication deficits and the implementation of BSPs, though they were not included on the list submitted (Individual #203, Individual #56, Individual #335 and Individual #324). Additionally, three other individuals were listed with behavioral concerns and significant communication deficits (Individual #93, Individual #234 and Individual #227). Each had PBSPs contained in his or her individual record. The only assessments in their individual records, however, were not current. For example: • The most current assessment submitted for Individual #227 was an update that had been completed 11 years ago. • Individual #93 had been provided an update on 7/21/09, but was listed with a comprehensive evaluation in 2009 and subsequent updates in the interim, none of which were in his individual record. • Individual #234 was listed with comprehensive evaluation in 2008 and subsequent updates in the interim, none of which were present in her individual record. • Each of these individuals had been provided AAC, yet their assessments had not	

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		been provided as needed. In the sample of 27 individuals for whom individual records were submitted, there were 14 individuals listed with PBSPs per the list submitted by psychology. None of the assessments reviewed (0 %) reflected appropriate integration of the communication program with the PBSP to address communication related behavior concerns. The clinicians had been attending the Behavior Support Committee meetings per the POI, but by report, actual collaboration was difficult to accomplish due to the format and lack of focused discussion in these meetings. By report, collaboration occurred more consistently during discussion during the PST meetings, however, evidence of this was not noted in the PSPs reviewed. The PSP included text from the communication assessment, but little documentation of how these supports were integrated. There was no policy related to the identification of behavioral challenges and related communication deficits. Lists were submitted, as requested, of individuals with communication-related replacement behaviors in their PBSPs (46) and also for individuals who had behavioral concerns and severe communication/language deficits (73). The assessment used for those who received behavioral supports (89) was the same used for other individuals living at SASSLC. Only 42% of those individuals with a BSP had a communication assessment completed since 12/14/10, and many of these could not be considered comprehensive, particularly if completed prior to March 2011. Compliance in this area would not be possible by merely describing the PBSP in a section of the communication assessment. Collaboration between SLPs and psychology related to assessment and analysis of associated communication and behavioral concerns, as well as in the development and implementation of related training objectives, is required. **Standard: Communication programs were integrated into the BSP as indicated.** PBSPs were submitted for 15 of 27 individuals included in the sample reviewed, though only 11 were current. Eight of these individuals were identified with severe language deficits, though only two had communication-related replacement behaviors included in their PBSPs. Less than 50% had a communication assessment current within the last 12 months. Without a current comprehensive assessment, accurate and appropriate information related to communication may be unavailable for effective integration into a behavior plan. **Standard: Policy existed that outlined assessment schedule and staff responsibilities.** The current state policy referenced a "Communication Master Plan" that was intended to	

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		prioritize assessments and services based on need. A separate list was submitted in response to a request for assessments and the dates of completion. The Master Plan as outlined in the policy was intended to prioritize those individuals who would most benefit from AAC devices or equipment. There was a new facility policy (4/28/11) that outlined a general communication assessment schedule (every three years) and established specific staff responsibilities.	
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: Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.** Of the 36 PSPs submitted for review, five were not current within the last 12 months (Individual #238, Individual #93, Individual #8, Individual #164, and Individual #151). AAC use was not consistently described or integrated into training objectives for each of the 14 individuals with AAC for whom PSPs were submitted. Some examples included: Individual #199, Individual #138, Individual #91, Individual #234, Individual #56, Individual #155, and Individual #104. **Standard: The PSP contains information regarding how the person communicates and strategies staff may utilize to enhance communication.** • There was no description of expressive or receptive communication skills outlined in the PSPs for 36% of those reviewed. • Very minimal descriptions of either receptive or expressive communication were included in the PSPs for 39% of those reviewed. • There was no current PSP in the individual records for Individual #93, Individual #238, Individual #151, Individual #164, and Individual #8. **Standard: Communication information is not only present in the PSP but integrated into the daily schedule** As stated above, adequate information related to communication was not present in the majority of the PSPs reviewed. There were brief statements related to communication in the PNMPs, but there was no evidence that this was integrated throughout the day. This also did not include strategies for use by staff in order to be an optimal communication partner with the individuals they supported. By report, AAC systems provided to individuals were not consistently implemented throughout the day or across settings. **Standard: AAC devices are portable and functional in a variety of settings.**	Noncompliance

#	Provision	Assessment of Status	Compliance
		The majority of systems provided were intended to be functional and many were portable for use across a variety of settings. In some cases, duplicate communication boards and message switches were provided in multiple settings in which the individuals participated. As described above, however, there continued to be systems provided that were presented to individuals only during a training session and then were unavailable to the users at other times throughout their day. **Standard: AAC devices are individualized and meaningful to the individual.** The majority of the systems provided appeared to be individualized and potentially meaningful to the individual. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual was often not possible. During observation in a work area, two 3-message switches were available to Individual #335 and Individual #31. However, these were not utilized as intended because the direct support staff anticipated needs for more work (and other needs) throughout the day. When interviewed, staff were not able to discuss the appropriate implementation of these devices. A sign language board in the same area was reported to be used by the individual to point to something she wanted, rather than as intended to serve as a reference for staff related to work-related signs. **Standard: Staff are trained in the use of the AAC.** Direct support staff did not appear to be knowledgeable regarding communication programs. No communication systems were observed being used. Though the majority of the general use devices were working when tested, a number of those provided to individuals were not available for use (Individual #155 and Individual #31). Documentation of communication training provided to staff was requested for the previous quarter. Training sheets were submitted reflecting training for five individuals as well as three more general inservice trainings related to basic sign language, general use AAC devices, and tactile sign strategies. There was no evidence that any of these were competency-based training sessions. In some cases, the training sheets merely listed the recommendations from the communication assessment as the information trained. The training sheets should outline the information content needed by staff as well as the actual skills expected to be performed by staff. An indication that staff appropriately performed the skills taught should be documented. By report, NEO staff training in the area of communication was largely lecture only with no opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners.	

#	Provision	Assessment of Status	Compliance
		Standard: Communication strategies/devices are implemented and used. While the general interactions of staff with the individuals they served were generally positive, 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. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be made a priority. 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 are available in common areas.** A number of general-use devices were available in the homes (e.g., Homes 665, 668, 670, 671, 672, 673, and 674) and the DC area. As stated above, the majority of these were operational when tested. These non-portable devices may be useful as a backup or as extra systems for individuals, but should not be used as the primary augmentative or alternative means of communication for any individual. Further, none were observed in use during the onsite review and inconsistent use by staff was reported by the clinicians. 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. As stated above, there appeared to be insufficient time devoted to hands-on training, modeling, and reinforcement of the appropriate implementation of communication supports of any kind, including AAC. There was no evidence of formal communication programs submitted and limited SLP support was available to ensure sufficient supports for appropriate and routine implementation of the recommendations addressed in the communication assessments. For example, the monitoring team continued to note (as also noted in each of the previous reviews) that direct support staff in the homes very diligently and routinely provided instruction and language-based active treatment activities. Unfortunately, as identified in previous reports, these activities were most often not functional or meaningful to the individuals to whom they were provided. Last time, a discussion related to cream cheese was noted for a group of individuals who received enteral nutrition. During this onsite review, a discussion related to cucumbers was noted for a group of individuals who most likely did not eat cucumbers. As observed during the previous review and again during this review, individuals in the sensory programming area were transferred to a recliner and the instructor moved from	

#	Provision	Assessment of Status	Compliance
		individual to individual, presenting an activity for a minute or so. The position of many was not optimal to promote visual or physical participation. The sensory activities were very sparse and brief and would likely be ineffective in producing desired outcomes.	
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: Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.** There were no policies related to a monitoring system for AAC. A form for monitoring communication, hearing, and environmental control had been developed. For each of the 27 individuals included in the sample, monitoring forms for the last three months (June, July, and August 2011) were requested. A total of 10 forms were submitted for five individuals (Individual #335, Individual #199, Individual #91, Individual #93, and Individual #165), one of which had been completed in April 2011. These forms were completed largely by speech technicians (70%) and, as such, it was not possible to determine the effectiveness of the devices for these individuals. There was no analysis of the monitoring data or process to inform and direct staff training or system change. The same monitoring form was used when a problem was reported by the home as in the form completed by Allison Trammel for Individual #335 on 5/3/11. Use of the forms in this manner and the inclusion of this type of intervention in the analysis of findings would not be indicated because it would skew the results. **Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.** The monitoring was reported to be completed in the home and workshop areas. The completed forms were based on observations in the living area of homes (3), bedroom (1), dining room (1), Forever Young program (2), and unspecified areas (3). Six of the forms identified the activity observed as leisure and one was completed during a meal. Two others did not specify the activity and, in fact, the form completed for Individual #91 documented that this was not applicable as he was not present. In this case, a VOCA was reviewed and determined to need batteries that were replaced at that time. On 5/26/11 it was reported by the monitor on 5/26/11 and 6/30/11 that the device for Individual #93 was not located. In the first case, the observer action was to conduct the observation at another time. There was no evidence that this was reported to anyone else at that time. During the observation the following month the observer action was to notify the SLP. Thus, it was likely that he did not have access to his device for over a month. **Validation checks are built into the monitoring process and conducted by the**	Noncompliance

#	Provision	Assessment of Status	Compliance
		plan's author. There was no evidence of validation monitoring conducted with the speech tech at the time of this review. PNMPCs had not yet been trained to conduct this monitoring.	

Recommendations:

1. Establish a clearly outlined strategic plan to direct the activities of the speech clinicians that will focus on those actions necessary to make progress toward and achieve substantial compliance with each item of this provision. The development of the POI should be clearly related to activities conducted to assess status based on chart review, observations, training drills, and so forth, and the actual implementation of actions in the strategic plan with documentary evidence. These should be reported in the POI and serve as the foundation for the assignment of compliance or noncompliance status by the facility (R1-4).

2. Review the current format and content of NEO staff training. Revise as indicated to ensure that the focus is for new staff to develop skills as effective communication partners. This should by interactive and dynamic with opportunities for role playing and practice. One hour of training in this area is insufficient to address this critical area for supports and services. Staff cannot learn what they need to in such a short time (R1).

3. Review existing comprehensive assessments for those who were identified as Priority 1 and 2 who were evaluated prior to 2010 to determine if these assessments met the standard as outlined per the SA. Also careful consideration of the development of specific guidelines is indicated to promote improvement and consistency in the AAC portion of the assessment format (R2).

4. 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 (R3).

5. PNMPs should include descriptions of expressive communication as well as strategies for use by staff (R3).

6. Initiate meaningful collaboration with psychology in order to develop a plan that ensure appropriate, integrated and comprehensive assessment, program development, staff training and monitoring for individuals with communication deficits and related behavioral concerns (R2).

7. There is an urgent 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. A program of this nature could be especially effective if implemented with OT and PT and/or psychology (R1).

8. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSPs and in the PNMPs (R3-R4).

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 #271, Individual #168, Individual #279, Individual #159, Individual #259, Individual #308, Individual #198, Individual #219, Individual #90, Individual #9, Individual #177, Individual #272, Individual #141, Individual #306, Individual #128, Individual #160, Individual #218 o Specific Program Objectives (SPOs) for: • Individual #177, Individual #141, Individual #306, Individual #160, Individual #135, Individual #287, Individual #280, Individual #105, Individual #304, Individual #276, Individual #240, Individual #315, Individual #229, Individual #81, Individual 105 o SPO data for: • Individual #135, Individual #287, Individual #280, Individual #105, Individual #304, Individual #276, Individual #277, Individual #240, Individual #315, Individual #229 o Quarterly reviews of SPO progress for: • Individual #177, Individual #128, Individual #306, Individual #98, Individual #135, Individual #287, Individual #280, Individual #105, Individual #304, Individual #276, Individual #277, Individual #240, Individual #315, Individual #229 o Dental Desensitization Plans for: • Individual #284, Individual #88, Individual #127, Individual #108, Individual #41, Individual #288, Individual #43, Individual #330, Individual #240, Individual #90 o Vocational Assessment, undated o A summary of community outings, undated o A list of all instances of skill training in the community, undated o Listing of on-off-campus day and work program sites, undated o Section S Presentation Book o SASSLC Plan of Improvement, dated 8/2/11 o A list of individuals with dental desensitization plans, undated o List of individuals under age 22 and the school each attended o Charting point system for public school teacher made by SASSLC psychologist o PSP, ARD/IEP, and IEP progress notes for: • Individual #271, Individual #168, Individual #279 o PSP and ARD/IEP showing that the PSP contained a training objective similar to a SAISD objective • Individual #208, Individual #232

	Interviews and Meetings Held: o Gina Dobberstein, Active Treatment Coordinator o Mark Boozer, Associate Psychologist o Andrea Blue and Eric Saenz, QMRPs 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 submitted its Plan of Improvement (POI), dated 8/02/11. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the Active Treatment Coordinator identified what tasks have been completed and the status of each provision item. The POI did not indicate how the findings from any activities of the self-assessment were used to determine the self-rating of each provision item. 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. 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 throughout the facility, and because it will likely take some time for SASSLC to make these changes, the monitoring team recommend that the facility establish, and focus their activities, on selected short-term goals. The specific provision items the monitoring team suggests that facility focus on in the next six months are summarized below, and discussed in detail in this section of the report.
	Summary of Monitor's Assessment: 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, the monitoring team noted several improvements since the last review. These include: • A reorganization of staff responsible for writing, implementing, and monitoring skill acquisition plans. • New procedure for the monitoring of skill acquisition plans.. • Expansion of SPO training methodology. • New individual engagement form. • Began list to document training in the community. • Progress in obtaining extended school year services for some of the individuals. The monitoring team believes that the facility should focus on the following over the next six months: • Expand new format to all SPOs written at SASSLC. • Ensure that the rationale for each SPO clearly states how acquiring this skill is related to the individual's needs/preference. • Ensure that all SPOs include specific activities that staff could engage in to promote meaningfully maintenance and generalization. • Establish a measure of treatment integrity of SPO. • Graph SPO outcomes to ensure that the continuation, modification, and discontinuation of SPOs are the result of data-based decisions.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, 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. There had been many potentially important changes recently initiated that have not yet been fully implemented and, therefore, not fully evaluated for this report. Accordingly, this item continues to be rated as being in noncompliance. <u>Skill Acquisition Programming</u> Personal Support Plans (PSPs) reviewed indicated that all individuals at SASSLC had multiple skill acquisition plans. Skill acquisition plans at SASSLC consisted of training objectives, and were referred to as specific program objectives (SPOs). At the time of the onsite review SPOs were written and monitored by the qualified mental retardation professional (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	Noncompliance

#	Provision	Assessment of Status	Compliance
		promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and/or represent a documented need. Just prior to the previous review (February 2011), SASSLC modified the training sheet/format to include a rationale for each specific acquisition plan. The monitoring team reviewed the SPOs in the new format that were available and were encouraged by what was found. At the time of this onsite review, however, most of the residential SPOs were still using the old format. The SPOs for nine of the 13 individual SPOs reviewed were in the new format, and the rationale for seven of those nine new-format SPOs (78%) did include a rationale based individual need and/or preference. For example: • Individual #287's SPO for pressing a switch to turn on a tape recorder with a message from his mother, included the rationale that communication assessments indicated that he would benefit from learning to use switches to improve his ability to communicate. Additionally, the rationale stated that Individual #287 enjoyed listening to messages from his mother. • Individual #276's SPO for exercising included the rationale that she wanted to be healthier and lose weight. On the other hand, the monitoring team also reviewed SPOs where the rationale, although stated, was unclear. For example: • Individual #315's vocational SPO stated "As discussed by the PST and identified in the vocational assessment to encourage [him] to be more independent." It is recommended that all SPOs at the facility (including residential SPOs) use the new modified training sheet. Additionally, SASSLC should ensure that the rationale for each SPO clearly states how acquiring this skill is related in the individual's needs/preference. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response	

#	Provision	Assessment of Status	Compliance
		• Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology In the last report, the facility attempted to ensure the above components were included in each SPO by including specific teaching cues, instructions, consequences for correct response, consequences for incorrect response, and a plan for skill maintenance and generalization on the training sheet. The monitoring team was encouraged by the facility's attempts to, and progress in, including all of the above components in every SPO. The monitoring team noted, however, that many of the plans for maintenance and generalization appeared vague, and would not likely result in the maintenance or generalization of the new skill. For example: • Individual #315's vocational SPO's plan for generalization and maintenance stated, "Independence will be encouraged in all areas throughout the day including home/work/leisure." On the other hand, the following example was more specific and included specific activities that staff should engage in to promote generalization and maintenance: • Individual #81's learning to release a maraca into a container SPO's plan for generalization and maintenance stated, "This skill can be used at his home, as he often plays the maraca during leisure time. This skill can also be used in teaching him to put up other items such as clothes or other daily use items." It is recommended that all SPOs include specific activities that staff could engage in to promote meaningfully maintenance and generalization. Finally, the training methodology for SPOs reviewed consisted of forward chaining (e.g., Individual #315) and general shaping procedures (Individual #280). The facility began using the Murdoch Center Program Library Curriculum for training methodology for the majority of the skill acquisition plans. At the time of the onsite review, staff were being trained to use the new training methodology. The facility had attempted to improve the overall quality of the skill acquisition plans by forming a team of professionals that will be responsible for writing SPOs. This reorganization potentially can result in a substantial improvement of the quality of the SPOs at SASSLC because it shifts the task of writing skill acquisition plans from a group that was burdened with many responsibilities in the facility (i.e., QMRPs), to a group that will be selected because of their experience and interest in writing skill acquisition plans. The monitoring team looks forward to the opportunity to evaluate the effect of this reorganization on the quality of SPOs during the next review.	

#	Provision	Assessment of Status	Compliance
		Desensitization skill acquisition At the last review it was recommended that the psychology department begin to write desensitization plans designed to teach individuals to tolerate medical and/or dental procedures. A list of dental desensitization plans developed indicated that 63 dental desensitization plans were developed. However the directors of psychology and dentistry indicated that the number of current dental desensitization written by the psychology department was substantially less than 63. Review of 10 of those plans revealed that six of them (Individual #88, Individual #127, Individual #108, Individual #41, Individual #43and Individual #240) were identical. It is recommended that individualized dental desensitization plans be developed and incorporated into the new SPO format. 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 in future site visits. Replacement/Alternative behaviors from PBSPs as skill acquisition As discussed in the last report, SASSLC included replacement behaviors in each PBSP. There were descriptions of teaching conditions (see K9), however, the format was not consistent and the quality and detail of the training varied greatly. Replacement behavior training procedures, like those for the dental desensitization plans, should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. Communication and language skill acquisition The monitoring team encountered some skill acquisition programs targeting the enhancement or establishment of communication and language skills. The facility reported that in the SPO reorganization described above, that speech pathologists will have a more active role in the development of communication skill acquisition plans. It is recommended that the facility expand the number of communication SPOs for individuals with communication needs. Service objective programming 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). Engagement in Activities 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	

#	Provision	Assessment of Status	Compliance
		individual engagement. As described in past reports, engagement of individuals 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 home and day program is listed in the table below. The monitoring team continues to be encouraged by the overall quality of the activities, the generally positive and caring interactions between staff and individuals, and the clear commitment to individual engagement at SASSLC. The monitoring team was also encouraged by the large numbers of individuals that were observed in activities outside of the home. For example, all the individuals in Home 673 were out of the home at approximately 6:30 pm in community activities or at the Development Center on campus. 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 668 the staff were engaging individuals in a lively conversation about favorite foods. 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 61%, a continued improvement over the last three reviews (i.e., 42%, 44%, and 59%). 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 modified their engagement tool just prior to onsite review. It is now recommended that they establish specific engagement goals in each home and day program site.	

#	Provision	Assessment of Status	Compliance
		Engagement Observations: Location / Engaged / Staff-to-individual ratio Home 665 2/2 3:2 Home 665 3/6 4:6 Home 665 3/6 4:6 Home 668 5/10 2:10 Home 670 6/14 3:14 Home 671 4/5 2:5 Home 671 6/6 4:6 Home 671 2/3 1:3 Home 766 0/5 3:5 Home 766 1/1 1:1 Home 766 1/6 1:6 Home 766 4/6 2:6 Home 665 2/2 4:2 Home 665 1/5 3:5 Home 672 1 /3 1:3 Home 672 1/3 1:3 Vocational Workshop 8/11 3:11 Vocational Workshop 9/10 4:10 Vocational Workshop 10/10 4:10 Home 668 2/6 2:6 Vocational Classroom 4/6 2:6 Vocational Classroom 2/3 2:3 Educational Services SASSLC continued to have a positive working relationship with the San Antonio Independent School District (SAISD). As a result, individuals were attending school and SASSLC and SAISD staff appeared to be collaborating and communicating. Mark Boozer, the SASSLC psychologist for most of the 17 SASSLC individuals who attended SAISD (three high schools, two vocational programs, and one middle school) reported to the monitoring team that there was open communication, that the QMRP from SASSLC attended most ARD/IEP meetings, and that SAISD teachers attended SASSLC PSP meetings. Moreover, SASSLC had assigned staff to do vocational planning with SAISD. This was great to see. Since the last onsite review, continued progress had been made in a number of areas that	

#	Provision	Assessment of Status	Compliance
		were discussed in the previous monitoring report. First, extended school year (summer school) services were provided to three SASSLC students for the first time. This likely would not have happened without SASSLC collaboration with SAISD. Moreover, summer school lasted for a majority of the summer, that is, through mid-August, almost until the beginning of the new regular school year. The psychologist and QMRPs should continue to pursue extended school year for those students who qualify for it. Second, SASSLC was beginning to incorporate SAISD ARD/IEP objectives into the annual PSP training objectives. Two examples were provided to the monitoring team, one for Individual #208 who had an objective for washing his arm in both settings, and one for Individual #232 who had a food preparation objective for both settings. This was a great start and, for the next onsite monitoring review, SASSLC should show that this occurred, at least once, for every student; or if not, that the PST considered the ARD/IEP objectives when developing the set of PSP objectives. In addition, SASSLC should continue to develop its communication with the public school staff. For example, there might be a daily school note from the classroom to the home, and a daily note from the home to the classroom each morning. Finally, the ARD/IEP progress reports provided almost no useful information to the PST. The progress reports for all of the individuals reviewed merely had a "W" for every objective. The "W" indicated "work in progress." SASSLC should obtain additional information so that SASSLC staff might support or help progress to occur. The progress report results should be shared with the PST, however, an entire PSPA meeting will usually not be necessary.	
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. Overall, however, more work is needed to achieve substantial compliance for this item. At the time of the onsite review, the facility was using the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. DADS was 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. Finally, while the PSP attempted to identify individual preferences, no evidence of	Noncompliance

#	Provision	Assessment of Status	Compliance
		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.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	SASSLC has begun to reorganize responsibility for who writes, monitors, and implements skill acquisition plans. The monitoring team was encouraged by these plans and expects to see improvements in areas of integrity of implementation and the practicality and function of SPOs during the next onsite review. This item, however, continues to be rated as being in noncompliance because the effects these changes could not be evaluated during this review. QMRPs at SASSLC summarized SPO data monthly and presented those data at quarterly meetings. Reviews of SPO data revealed that skill acquisition plans were producing meaningful behavior change for some individuals (e.g., putting down his cup for Individual #287). Many other SP0s, however, indicated no improvements (e.g., working for 20 minutes for Individual #135, beginning work following the sign for work for Individual #105) without any indication of a modification of the plan, retraining of staff, etc. Additionally, the monitoring team found it time consuming to evaluate if individuals' SPOs were progressing. Many of the quarterly reports (e.g., Individual #280) simply indicated if progress was maintained or progressing. This required reviewing the raw data to determine if the individual was maintaining mastery of the skill or maintaining poor performance. The facility's reorganization plan noted above also included a component to improve the monitoring of SPO progress. In addition to a new skill acquisition monitoring form, all SPOs at SASSLC will be monitored by the active treatment coordinators (rather than QMRPs). It is anticipated that this reorganization will allow more time devoted to the important role of monitoring SPOs. Subsequent monitoring 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 ability to evaluate the effectiveness of the plan. Additionally, it is recommended that these graphed data summaries of individual SPO progress be used to make data based decisions concerning the continuation,	Noncompliance

#	Provision	Assessment of Status	Compliance
		discontinuation, or modification of skill acquisition plans. As discussed in S1, the skill acquisition plans appeared practical and functional for some individuals (e.g., Individual #287 activating a speech output device, and Individual #280 requesting his snack by using a voice output device), but not for others (e.g., Individual #135 SPO of working for 20 minutes). The facility should ensure that SPOs are consistently practical and functional. The final phase of the SPO reorganization is to have the majority of skill acquisition plans implemented by 12 training specialists specifically trained to implement SPOs. Because this phase of the reorganization had not yet begun at the time of the onsite review, the monitoring team did not observe the implementation of SPOs for this review. Observations of SPO data sheets not completed as scheduled (e.g., Individual #3) and conversations with staff indicating confusion with training procedures (none of the DCPs working with Individual #135 could correctly explain what a partial physical prompt was-the prompt level specified on her work for 20 minutes work SPO) suggested that problems similar to those identified in previous reports with the integrity of the implementation of the SPOs at SASSLC continued. These issues indirectly indicated problems with the integrity of the implementation of SPOs. The only way to ensure that SPOs are conducted as written is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SPOs are conducted as written. A reasonable starting point would be to conduct an integrity check on the implementation of one SPO in each residence/day program each week (similar to the schedule the facility does for engagement). Then, minimal integrity levels would be established (80% is typical) and staff would be retrained if they did not achieve these levels. The literature on treatment integrity suggests that in order to achieve and maintain acceptable levels of treatment integrity, integrity checks and staff feedback need to be ongoing. The monitoring team was encouraged by the facility's attempt to address problems with the writing, monitoring, and implementing of SPOs with their reorganization plan, and looks forward to seeing substantial improvements in this provision in the next review.	
	(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 training in the community. More work, however, is necessary to achieve substantial compliance. The facility provided the monitoring team with a newly developed list of skill training	Noncompliance

#	Provision	Assessment of Status	Compliance
		excursions in the community. There was, however, no way evaluate which of these represented specific SPO training, verses general skill training opportunities, such as dinning out in community. It is recommended that SPO training activities in community be separately recorded so that community training trends could be better tracked, and increased across the facility. At the time of the review, four individuals at SASSLC worked in the community. Three individuals worked on maintaining rest areas for the department of transportation, and one individual worked at a restaurant in the community. Three individuals were reported to work in the community during the last onsite review. 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. It is recommended that all SPOs at the facility use the new modified training sheet (S1).
2. SASSLC should ensure that the rationale for each SPO clearly states how acquiring this skill is related in the individual's needs/preference (S1).
3. It is recommended that all SPOs include specific activities that staff could engage in to promote meaningfully maintenance and generalization (S1).
4. It is recommended that individualized dental desensitization plans be developed by the psychology department and incorporated into the new SPO format (S1).
5. Replacement behavior training procedures, like those for the dental desensitization plans, should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above (S1).
6. The facility should collect engagement data in each setting and establish specific engagement goals in each home and day program site (S1).
7. Continue to work on extended school year (S1).
8. Include SAISD ARD/IEP objectives in the SASSLC PSP (S1).
9. Create and use a daily communication note between SASSLC and SAISD staff (S1).
10. Try to get ARD/IEP progress reports that contain useful information. Share the content of the progress reports with the PST members (S1).

11. It is recommended that SPO data be graphed so as to improve the 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 (S3).

12. The facility should ensure that SPOs are consistently practical and functional (S3).

13. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written (S3).

14. SPO training activities in community should be separately recorded (S3).

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, and attachments o Organizational chart, undated, but current o SASSLC policy lists, 8/1/11 o List of typical meetings that occurred at SASSLC o SASSLC POI, 8/2/11 o SASSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/15/11 o Community Placement Report, 2/1/11 through 8/16/11 o List of individuals who were referred for placement and had been placed since last onsite review (5 individuals) o List of individuals who were referred for placement and had not yet been placed (5 individuals) , as of 8/19/11 o Individuals on the referral list for more than 180 days (3 of the 5 individuals), and required PSPAs o List of individuals who requested placement, but weren't referred, (7 individuals), as of 8/19/11 o List of individuals who requested placement, but weren't referred solely due to LAR preference, (3 individuals), as of 8/19/11 o List of rescinded referrals (2 individuals) and PSPA notes regarding each rescinding o List of individuals returned to facility after community placement (1 individual, but returned to community), and PSPA o List of alleged offenders (4 individuals) o List of individuals discharged under alternate discharge procedures (no individuals) o List of individuals who have died after moving from the facility to the community since 7/1/09 (no individuals) o Weekly enrollment report prepared by APC, four, 7/22/11 through 8/12/11 o Document describing how PSP assessments will, in the future, indicate the professional's determination regarding community placement, and the type of discussion expected to occur during the PST meeting. o Description of how the facility assessed an individual for placement (the PSP policy) o List of all individuals at the facility, indicating the PST's recommendation, if any, for movement to the community o Documentation regarding central office training for all APCs and PMMs from all SSLCs, 4/6/11 o Documentation of PMM and APC's training for SASSLC QMRPs, 3/17/11 o Documentation of training by MRA for PST members, 5/18/11

	o Minutes from SASSLC and MRA quarterly meeting, 4/19/11 o CLOIP and permanency plan tracking 2/11 through 6/11 o Four completed CLOIP worksheets o Self-advocacy materials used that were related to community living, 4/28/11 o List of individual and staff visits to community providers, 2/11 through 7/11 o Review by state office of the living options discussion portion of 5 PSPs o Completed self-monitoring tools by SASSLC staff for 3 living options discussions and 1 CLDP o Blank checklist tool used by APC regarding assessment submissions for CLDP o List of individuals who had a CLDP completed since the last review (5 individuals) o DADS central office written feedback on CLDPs (Individual #211) o PMM one-page tracking sheet o PSPs for: • Individual #10, Individual #310, Individual #18, Individual #57, Individual #78, Individual #313, Individual #73, Individual #342, Individual #141, Individual #110, Individual #39, Individual #45, Individual #284, Individual #275 o CLDPs for: • Individual #211, Individual #269, Individual #275 o In-process CLDPs for: • Individual #103, Individual #92, Individual #276 o Pre-move site review checklists for: • Individual #107, Individual #269, Individual #1 o Post move monitoring checklists conducted since last onsite review for: • Individual #192: 90-day • Individual #107: 7-day, 45-day, 90-day • Individual #211: 7-day, 45-day • Individual #269: 7-day, 45-day • Individual #1: 7-day, 45-day • Individual #275: 7-day, 45-day <u>Interviews and Meetings Held</u>: o Carol Young, Admissions and Placement Coordinator o Anna Cruz, Post Move Monitor o Ralph Henry, Facility Director o Donnie Wilson, DADS central office most integrated setting practices coordinator, and Jim Sibley, DADS consultant for the PSP process o Center for Health Care Services, Home Program Administrator, Carl Heinzman o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs

	Observations Conducted: o PSP Meeting for: • Individual #205, Individual #286 o In-process CLDP meeting for: • Individual #92, Individual #276 o Community group home visit for: • Individual #275 o Many residences and days programs at SASSLC
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. In addition, during the onsite review, the APC reviewed the presentation book for this provision and discussed the POI at length with the monitoring team. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the APC wrote a sentence or two about what tasks had been completed and/or the status of each provision item. In future POIs, the facility should describe what actions it took, such as observation, interview, and review of a sample of documents. These are the types of activities taken by the monitoring team as part of this compliance review. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The APC self-rated the facility as being in substantial compliance with five provision items: T1c2, T1c3, T1g, T1h, and T2a. The monitoring team was in agreement with four of these self-ratings; a rating of noncompliance was given for T1g based on the absence of a facility assessment of obstacles. It was unclear from discussions with the APC and from a review of the POI how SASSLC came to any of the self-ratings in the POI. The action steps included in the POI were written to guide the department in achieving substantial compliance. The action steps, however, did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). Only two action steps were included, one for implementation of the new PSP/LOD and CLDP processes, and one for ensuring all required assessments were submitted as part of the CLDP. These were both relevant, however, there were many other provision items and actions that required attention if the overall provision was to reach substantial compliance.

	Summary of Monitor's Assessment SASSLC continued to make progress, albeit it very slowly, towards meeting provision T of the Settlement Agreement. The slow progress was evident in the few individuals referred and placed in the community. The monitoring team recommends that the facility's QAQI Council consider initiating a performance improvement team regarding most integrated setting practices and the components of this entire provision T, especially focused on referrals for placement and identification of suitable providers for the individuals at SASSLC. The monitoring team also recommends that the department's data be summarized and graphed every six months, and that the data be incorporated into the facility's QA program. The opinions of the professionals on the PST were often not adequately incorporated into discussion, documentation, and decision-making as required. Professionals need to provide their opinions regarding community placement and these opinions need to be explicit in the written PSP document. Another revision to the PSP process was recently initiated under the guidance of three DADS consultants. The consultants will need to work closely with the DADS coordinator of most integrated setting practices to ensure that the requirements of provision T are included, such as the LOD. In the PSP meetings observed by the monitoring team, much time was spent talking about information that PST members were well aware of rather than using the time to discuss goals and needs. In the written PSPs reviewed by the monitoring team, there was wide variability in the amount of information included in the PSPs within each subsection of the LOD. Obstacles to referral and placement were not adequately identified or addressed in the PSPs in any type of consistent manner across the facility. A plan to address the obstacle was not explicitly noted in most cases. PSTs may need to describe reasons for not making a referral separately from obstacles to making a placement happen (e.g., provider capability). A number of activities were occurring to educate individuals and their LARs, however, this needs to be individualized and incorporated into the PSP. The system for community tours needed to be more organized. The new CLDP process was being used, including the initiation of the CLDP at the time of referral. The list of essential and nonessential supports in the CLDP focused primarily on the provision if inservices and the scheduling of appointments. There were few supports that were directly related to actions that were to occur day to day for each individual, such as implementation of preferred activities, supports, and services. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. PSTs need to become more involved in the referral process and in the selection of providers. This should include visits to all homes and day programs that are being considered and teaching the individual how to make a decision. The monitoring team continued to be concerned about the way individuals' preferences and decisions were assessed at SASSLC. PST members should be assertive in finding a good provider and in

	intervening if it appears an individual may be selecting a provider that will ultimately be unable to meet his or her needs and preferences. Most individuals do not have the experience or capacity to fully assess the competency of providers and their ability to provide what the individual wants and needs over a long period of time. Post move monitoring (T2a) was rated as being in substantial compliance. The post move monitoring conducted post move monitoring as required and followed up on supports that were not being implemented. In order to meet the overall intention of post move monitoring, she will also need to intervene when the overall quality of the home, day site, activity program, or medical needs are not being addressed adequately.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Overall, SASSLC continued to make progress, albeit it slowly, towards meeting provision T of the Settlement Agreement. The activities in which the facility will need to engage in order to meet all of the items of this provision will involve many different departments of the facility (e.g., admissions and placement, QMRPs, unit directors, clinicians and therapists). Therefore, the monitoring team recommends that the facility's QAQI Council consider initiating a facility-wide performance improvement team regarding this provision, with a particular emphasis on (a) referrals for placement and (b) identifying providers who are most suitable for supporting SASSLC individuals. Referral and placement activities continued to be overseen by Carol Young, the Admissions and Placement Coordinator (APC). She continued to be assisted by Anna Cruz, the Post Move Monitor (PMM). Ms. Young remained energetic and consumer-directed. The monitoring team continued to be impressed with her interaction style with staff, clinicians, individuals, and family members; and with her skill at leading and participating in team discussions regarding the placement process. The specific numbers of individuals who were placed and who were in the referral and placement process remained low, given the size of the facility. Below are some specific numbers regarding the referral and placement process. • 5 individuals were placed in the community since the last onsite review (less than 2%). This compared to 1 placement during the six months prior to the previous review, 3 placements in the six months prior to that, and 5 placements in the six months prior to the baseline review. Thus, the number of placements were low and relatively consistent.	Noncompliance

		• 5 individuals were on the active referral list as of 8/19/11 (less than 2%). This compared with 9 individuals, 4 individuals, and 3 individuals who were on the active referral list over the last three six month periods, respectively. o 3 of the 5 individuals had been on the referral list for more than 180 days. • 7 individuals were described as having requested placement, but were not referred. For 3 of these individuals, the LAR's preference was to not have the individual referred. Behavioral and psychiatric problems were the reason 2 others were not referred. The other 2 individuals were not referred, but were listed as exploring community options. o A facility review of each individual who requested placement, but was not referred (other than those for whom LAR preference was the sole reason) needs to occur. Lufkin SSLC had implemented this process and that might serve as a model for SASSLC. It was called the "Placement Appeal Process" at Lufkin SSLC and is described in the April 2011 monitoring report for that facility. • 3 individuals were described as not referred due solely to LAR preference. o The data for this category need to be gathered more accurately. This should be a list of individuals who would have been referred for placement but were not, solely due to LAR preference. This list should include <u>not only</u> those individuals who themselves requested referral, but those individuals who were not able to express themselves. This is a different list than the one described in the bullet immediately above, however, some names might appear on both lists. o There were many individuals at SASSLC who were likely to be on this list. • 1 individual was re-admitted to the facility after a failed community placement due to behavior problems. The admission was considered a respite admission (i.e., short term) and the facility successfully worked with the individual, his PST and the community provider, and he returned to the provider after about six weeks back at the facility. At the time of the onsite review, he had been back in the community for about two weeks. The PMM had re-started the 90-day post move monitoring period. • The referrals of 2 individuals were rescinded since the last review. At the time of the last onsite review, 3 referrals had been rescinded, and all had been re-instated. Some detail regarding the 2 recent rescindings are provided below: o Individual #201's referral was rescinded after she returned from an attempted overnight visit to a potential provider in June 2011. Serious behavioral outbursts occurred. Since then, she stated that she no longer wanted to move to a group home. Based on her behavioral presentation and verbal statements, and discussion among the PST, it appeared that a	

		rescinding of her referral was an appropriate step for the PST. o Individual #160's PST met on 4/4/11 to discuss her clearly presented verbal statements that she did not wish to move, that she wanted to stay at SASSLC, and that she no longer wanted to be referred. The PSPA noted that, even so, the individual might still visit possible group homes and that the individual was now more knowledgeable about community options. • 0 individuals were discharged under alternate discharge procedures (see section T4 below). • 0 individuals had died since being placed since the last onsite review. Moreover, the APC reported that no individuals had died since being placed in the community since the beginning of the Settlement Agreement, 7/1/09. The above data should be summarized and graphed every six months. Each of the above eight bullets should be graphed separately. The monitoring team recommends creating simple line graphs with one data point representing six months of data (preferably to coincide with the onsite reviews, that is, February-July and August-January). These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). The monitoring team is available to help the facility create this graphic presentation prior to the next onsite review. In addition, the APC should do a review of every rescinded referral and every case when an individual returned to the facility, even if for a respite. Perhaps a thorough review (i.e., treating it as a type of sentinel event for the admissions and placement department) might lead to changes in these processes for some, or if not all, individuals at SASSLC. <u>Determinations of professionals</u> This provision item requires that actions to encourage and assist individuals to move to the most integrated settings are consistent with the determinations of professionals that community placement is appropriate. This is an activity that should occur during the annual PSP meeting and be documented in the written PSP. In the PSPs listed above under Documents Reviewed, 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 on this important matter. In most of the PSPs, there was a sentence stating the PST determined the most integrated setting to be the individual's current home. In only a few cases was a rationale provided (e.g., Individual #73) and in no cases were the determinations and opinions of the professional members of the PST indicated. Many examples were provided in the previous monitoring report. Similar examples were found during this review, but are not listed again.	

		One of the 14 individuals whose PSP was reviewed had already been referred (Individual #275). In the other 13, the MRA CLOIP's opinion either was not noted, or if noted, indicated the CLOIP's agreement with the LAR or PST that SASSLC was the most integrated setting. The facility will need to 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. It appeared that the upcoming work on again revising the PSP process (see T1b1 below and section F above) will include the incorporation of professional's determinations within the PSP meeting, PSP document, and within the assessment written by each professional member of the PST. This was discussed in a meeting with the DADS central office coordinator for most integrated setting practices, the DADS consultant for PSPs, the APC and PMM, and the monitoring team during the onsite review. It was also indicated in a document related to the conduct of the PSP process that was given to the monitoring team. <u>Preferences of individuals</u> The preferences of individuals appeared to be important to SASSLC PST members. In the previous monitoring report the monitoring team recommended that the facility work on improving the way in which it determined and documented the preferences of individuals for possibly living in the community. It did not, however, appear that any action was taken to address this since the last onsite review. Indications that individuals were happy and satisfied at SASSLC (which was good to see) should not be taken as an indication that community referral would not be of interest and preference to the individual if he or she was to learn more, and/or be exposed to possible options in new ways. Many examples were provided in the previous report and a few additional examples and comments are provided below. • Individual #275 chose a home in the community after visiting only one home as part of the referral and placement process, though he had visited a few homes through the facility's general tour process (see T1b2 below). Further, few, if any, PST members visited the home before it was chosen. It appeared to the monitoring team that the individual's decision, although clearly stated by him, might not have been as informed as it should have been, especially for an individual with developmental disabilities and limited experience. That is, he might have benefited from seeing additional homes that might have been available specifically for him. His PST might have considered ways to accomplish this. • Individual #10's PSP noted that after visiting her family at their home for three hours, she usually stood by the car indicating that she wanted to go back to the	

		facility. The PST took this to indicate that she preferred to not move to the community whereas there were many other possible reasons for this. • The PSP for Individual #39 stated that she was knowledgeable about options, but had not made any request for placement. Her mother who was her LAR did not want to pursue referral, but the assessment of the individual's preference was: "After extensive conversations with [the individual] she has not given any indication that she would prefer any other location than SASSLC. Therefore, the team will not be pursing an alternate location at this time." • On the other hand, the PST for Individual #92 appeared to be proceeding very cautiously since the time of the last onsite review (his case was one of the examples cited by the monitoring team) to ensure that his living arrangement was one that would have all of the supports and services that he preferred and needed. PSTs need to become more involved in the referral process and in the selection of providers. This should include visits to all homes and day programs that are being considered and teaching the individual how to make a decision. PST members should be assertive in finding a good provider and in intervening if it appears an individual may be selecting a provider that will ultimately be unable to meet his or her needs and preferences. Most individuals do not have the experience or capacity to fully assess the competency of providers and their ability to provide what the individual wants and needs over a long period of time. The APC and PMM were very knowledgeable about the community provider system. They knew the most about the competence and capacity of providers. They should have a way to provide this information to PSTs, families, and individuals. Further, the facility might consider assigning a staff member (perhaps the PMM) to visit all of the local community providers and assess their services, quality of their homes, activities that are available to individuals, work and employment opportunities, and so forth. This information may then be very useful to PSTs, individuals, and family members/LARs. <u>Preferences of LARs and family members</u> SASSLC attempted to obtain the preferences of LARs and family members and to take these preferences into consideration. Most of the PSPs reviewed were for individuals who had an LAR. In all cases, the LAR was very happy with SASSLC services and indicated a clear and strong preference for the individual to remain at SASSLC. This was also evident in the PSP meetings observed during the onsite review, the family satisfaction survey, and a meeting the monitoring team had with the LAR of one individual. <u>Senior management</u> The APC continued to complete a weekly enrollment report. It was submitted to senior	

		management each week. Senior management, however, would benefit from more detail regarding the status of each referral. To that end, the monitoring team recommends that the APC model the weekly report on that of the Lufkin SSLC, called "Weekly Admission, Inquiries, and Referrals Update."	
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. The state policy regarding most integrated setting practices was numbered 018.1, dated 3/31/10. The APC reported that the facility followed the state's policy. The facility did not have any additional facility-specific policies. A revised state policy was in draft format. The Monitoring Panel had the opportunity to review this draft revised policy and submitted a set of comments to DADS separately from this report. The new policy contained improvements from the previous version as well as more detail for PSTs. Once finalized and disseminated, SASSLC will need to incorporate these revised policies, practices, and forms into its facility-specific policies. Implementation of the new state policy and the updating of facility policies to make them in line with the new state policy will lead SASSLC towards substantial compliance with this provision item.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	This 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. DADS and the SSLCs were embarking on another revision to the PSP process. This was the third (or so) revision to the process since the initiation of the Settlement Agreement, however, this was not unexpected because revisions to such a major part of service provision often require repeated revisions, modifications, or even overhauls. The monitoring team wishes to acknowledge DADS' efforts to continue to work to improve the PSP process so that it meets the needs of the individuals while continuing to progress towards meeting substantial compliance with the Settlement Agreement. To this end, DADS recently brought in three consultants to work on developing a new PSP format, new expectations, and updated training for staff. The consultants will learn about the current system, develop a new PSP document format, revise the way the meeting is conducted, and provide training to staff. Moreover, the consultants were working with the DADS central office coordinator of most integrated setting practices to ensure that the many requirements of provision T would be addressed.	Noncompliance

		All three of the annual PSP meetings held during the week of the onsite review were observed by the monitoring team. In addition to attending PSP meetings, 14 recently completed PSP documents were reviewed (listed above in the Documents Reviewed list). The total sample included individuals representing different levels of referral for placement, ages, need for extensive supports, language abilities, medical needs, and family involvement. These 14 were chosen by SASSLC, and sampled from each of the homes on campus. <u>Protections, Services, and Supports</u> The discussion about the ideal optimistic vision should focus on the components of an environment that would best (a) suit the needs and preferences of the individual, (b) ensure safety, and (c) provide adequate skill development and maintenance, and quality of life activities, such as leisure and recreation activities. The revised (but not yet finalized or disseminated) state policy included a more structured way of addressing the living options discussion (LOD) portion of the PSP meeting, both in the meeting and in the written document. Further, it separated the discussion of addressing the individual's preferences (which were derived from the PFA and discussed earlier during the PSP meeting) and the individual's needed supports and services (which were derived from assessments and discussed later at the PSP meeting during the LOD). The revised LOD will help ensure that the PST properly and fully considers an (a) optimistic living vision, (b) all aspects of supports and services, and (c) preferences. In order to accomplish this, the APC and the QMRP coordinator will need to work together. The monitoring team observed all three annual PSP meetings held during the week of the onsite review. The QMRPs observed were working hard to follow the required format, address all topics that were required, and facilitate the meeting. Clearly, more work, practice, and feedback will be needed as the next revision to the PSP process is developed and implemented. Overall, the meetings were well-attended and most, if not all, participants participated at some point during the meeting. The content, however, was primarily a description of characteristics and behaviors of the individual that were already known to all members of the PST. The monitoring team hopes that the new PSP process will help PSTs to use their limited and valuable time together to plan for the individual's future, and to address any relevant problems the individual is facing at that time. For Individual #205, the PST left little time for discussion of community living options, though there was some discussion following up to last year's recommendation that she and her mother visit some community group homes and day programs. Individual #286 stated very clearly	

		and repeatedly that he wanted to go home to live with his mother. This led to interesting discussion about his problem behaviors when at home and ways that the psychologist and PST could support his mother. The standardized format of the PSP meeting, however, required the QMRP to ask questions that did not seem relevant to this case, such as about group homes or foster care. Additional comments regarding the PSP meetings will not be presented here because the process is scheduled to change and, therefore, will be reviewed during the next onsite review. The set of 14 written PSPs reviewed were from February 2011 through June 2011. Comments on these 14 PSPs are below: • There were differences in format, outline, and sections and subsections. • There were differences in length of narrative; one was less than two pages long. • Some had a good opening paragraph that described characteristics of an optimal living arrangement for the individual. • One PSP (Individual #78), had a four-page addendum called "Living Options." It contained similar information as in the PSP and some information in the section called essential/nonessential supports. • There were differences in the amount of detail included in sections: o Some sections were only a sentence or two in length o Some PSPs included a table/chart about risk levels in the medical section while others included descriptions of risk levels in paragraph format, and some PSPS contained little mention of risk. o Some sections included information seemingly cut and pasted from a professional's assessment o Some PSPs had a section titled Quality of Life • Some sections contained good descriptive paragraphs, such as: o Individual #10, regarding her day sensory awareness program o Individual #310, regarding speech and language o Individual #18, regarding his 24 hour nursing care, g-tube, positioning needs, seizures, recurrent pneumonia, osteoporosis, heart disease, and extensive therapies Further, few PSP objectives for learning new skills (called training objectives) addressed relevant community living skills (also see sections F and S of this report). The number of training objectives ranged from four to eight for each individual, indicating that some work was being done to teach skills to individuals. Most disappointing, however, was that no training objectives were specially chosen to help prepare Individual #275 for what was then his upcoming move to the community. The PST should have focused upon skills that might be useful and helpful to him in his new home and work settings. Individual #275 was referred in November 2010, his PSP occurred in April 2011, and he	

		moved in July 2011. For Individual #269, however, the team initiated a pedestrian safety training objective after his referral and in anticipation of his move. <u>Obstacles to Movement</u> 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. 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 to be more successful in identifying and addressing obstacles. It may be that PSTs will need to differentiate between: • Reasons not to refer: these are limited and are described in the new policy on most integrated setting practices (e.g., LAR preference, individual preference, MRA not present at meeting, legal restrictions, no citizenship, severe medical requiring daily physician monitoring, severe behavioral health instability), and • Obstacles to referral: which come from the 12 obstacles chart. Some examples from the set of PSPs reviewed indicated that PSTs did not follow the state's 12 obstacles chart or differentiate between characteristics of the individuals and their need for support. Below are what was written in the PSPs as obstacles: • Individual #10: Autism, Tourette's, need for staff, need for a strict daily routine • Individual #310: Adjusting to new situations, autism, refuses work, SIB, pica • Individual #73: Mother's reluctance, runs a lot and group homes are small, no pedestrian skills • Individual #342: A new medical condition of detached retina and cataracts which had led to SIB and aggression. This appeared to be a reasonable obstacle until his condition can be treated. • Individual #39: The obstacles section of the PSP stated not applicable. As PSTs begin to define what supports are necessary to meet these needs, the discussion will likely become more centered upon what it is that the providers of community services will need to provide in order for the individual's placement to be successful, fulfilling, and long-term.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families	SASSLC made continued progress on this provision item, that is, the APC and PMM had taken specific actions based upon the previous monitoring report. SASSLC had only just begun to address education of individuals and their families on an individual basis. This was due to the PSP template requiring a comment about the	Noncompliance

	or guardians to enable them to make informed choices.	education of the individual and LAR, however, as exemplified in each of the written PSPs reviews, the PSP provided very little information and no details. Some PSPs described what the individual had done, whereas others described what the individual might do during the upcoming year. Some PSPs stated that living options would be presented only when they became available in the community, others only referred to possible attendance at the next provider fair. • The next step is for the PST to specifically report on (a) the activities of the previous year and (b) make a plan for the upcoming year. The annual provider fair had not occurred during the past six months; it was scheduled for October 2011. It appeared that the APC was working with local providers and the MRAs in planning the event. Further, the APC was following guidance from state office regarding implementing some best practices from other SSLCs. • The fair will be reviewed during the next onsite review. SASSLC continued to maintain a good relationship with the local MRAs. Quarterly meetings were held in January 2011 and April 2011. Minutes from the April 2011 meeting indicated a relevant and appropriate agenda of topics. There were two trainings for facility staff, one on 3/17/11 regarding the PSP and living options discussion, and one on 5/18/11 regarding the role of the MRA local authority. In addition, the APC attended recent self-advocacy meetings to talk about community living options. A Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) continued to be in place for all individuals. It was implemented by the CLOIP worker from the contracted MRA. Taking individuals, staff, and PST members to visit community provider day and residential sites is a good way for everyone to learn more about the community options that are available. Tours were occurring at SASSLC and were commented upon during the last onsite review, however, none of the four recommendations of the monitoring team were addressed. Further, very few individuals participated in tours: • March 2011: 6 individuals • April 2011: 3 individuals • May 2011: 2 individuals • June 2011: 3 individuals • July 2011: 1 individual The monitoring teams and DADS central office are working towards agreement on the	

		specific criterion for this provision item. Once established, it will provide more specific direction to the APC and the facility regarding achieving substantial compliance. Finally, the APC might keep a log or perhaps create a brief monthly update of activities in each of the above topic areas taken to address this provision item (i.e., individual PSPs, provider fair, MRA collaboration, education of staff, education of individuals, tours).	
	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 individuals were assessed by following the state's most integrated setting practices policy. In addition, a listing was given to the monitoring team showing every individual and whether the PST referred the individual for community. The monitoring teams have been discussing this provision item at length with DADS, especially regarding whether the determinations of professionals in their discipline-specific assessments, a well-conducted living options discussion, and similarly well-done documentation in the written PSP, would meet the requirements for this provision item. This question will be resolved by the time of the next onsite review at SASSLC.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	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. The revised policy and practices also required more involvement of the PST throughout the referral and placement process, including: • Initiation of the CLDP document at the time of referral. Rather than waiting until right before the individual moved, the CLDP document was to be created at the time of referral with an expectation that its contents would be developed and completed over the months during which referral and placement activities occurred. The APC and the QMRP were the primary writers of the CLDP. At this time, both the APC and QMRP worked on separate copies of the CLDP and the APC had to spend time putting the two together into a single document. The APC should explore ways for both of them to work off of the same document, perhaps through some type of shared file. Three of these in-process CLDPs were reviewed and, as somewhat expected, they contained only minimal information. • PST members were to visit group homes and be more active in supporting the individual to choose a home and provider that would best support his or her preferences and needs. This had not yet begun. This is a very important part of	Noncompliance

		the new process and it will be important for the APC to ensure that PST members understand the critical role they play in helping individuals, whom they cared for, and cared about, find the right placement. • PST meetings were to occur after every post move monitoring visit, even if there were no problematic issues. This was not yet occurring regularly.	
	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.	Three completed CLDPs were reviewed by the monitoring team. The CLDP document contained a number of sections that referred to actions and responsibilities of the facility, as well as those of the MRA and community provider. The APC expected that implementation of the new CLDP policy, utilization of QA processes, and greater involvement of the PST to bring the facility closer to substantial compliance with this provision item. In each CLDP, the APC wrote details about the entire referral process. They were interesting and allowed the reader to understand the process each individual experienced. For example, the involvement of Individual #269's father and extended family, the reason for only doing one pre-placement visit for Individual #269, and the expressions of preference of Individual #275 were made very clear to the reader. SASSLC continued to hold in-process CLDP meetings (though the facility referred to them as pre-CLDP meetings). Two were attended by the monitoring team and both demonstrated an individualization of the use of these meetings. • One was for Individual #92 and was a continuation of the series of meetings attended by the monitoring team during the previous onsite review. The meeting topic was the continued preparation of the individual for his move, and continued completion of the CLDP. The PST, following the excellent suggestion from the APC, scheduled a subsequent meeting to solely focus upon creating the list of essential and nonessential supports. The monitoring team asked if SASSLC PST members had seen the home. Most had not and a tour was therefore going to be scheduled. It was surprising that, at this late point, almost no PST members had seen the home (this was also noted as a problem in the placement of Individual #275). • The other meeting was for Individual #276. She had been requesting a referral for some time and had made great progress the past six months in her skill development and behavior improvement. The meeting was a very positive gathering of her PST and a referral for placement was made. The actions required by the three CLDPs were primarily around inservicing of staff and setting up of appointments. These were important to have included, however: • The inservice requirements should also specify what the expectations were with regard to the competency of the community provider staff in implementing the programs.	Noncompliance

		• Actual implementation of these supports by staff should be required. • Also see comments in T1e below. Further, the CLDPs did not describe the need for collaboration between staff at SASSLC and staff, consultants, or clinicians in the community. For example, it would be expected that clinical staff at SASSLC would be responsible for sharing information and answering questions through face-to-face or telephone contact with their counterparts in the community. In none of the plans reviewed was this included as a requirement. This appeared particularly pertinent given Individual #211's complicated needs, and Individual #269 and Individual #275's needs for an active and stimulating daily life. The APC reported that DADS central office was conducting reviews of each of SASSLC's CDLPs. The monitoring team reviewed this feedback for one of the completed CLDPs (Individual #211). The central office feedback was not available for the other two CLDPs. There were three reviews done by state office of this one CLDP. The comments addressed all aspects of the CLDP, were excellent, and should continue. State office should consider developing a metric to determine if facilities are making progress, that is, whether the feedback from state office is helping to reduce errors and improve content of the CLDPs.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities.	Substantial Compliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The CLDPs contained evidence of individual review and LAR review. This was also evident during observations of PSP meetings, and the in-process CLDP meetings.	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. A checklist of assessments was part of the new style CLDP and should help the APC to meet this provision's requirement. The APC was just beginning to use this checklist to monitor the dates of completion of the assessments. The move date of each of the three individuals reviewed was extended from the originally planned date and that resulted in some assessments turning out to be more	Noncompliance

		than 45 days prior to the transition by a few days for Individual #211. For the other two individuals, the APC held an additional CLDP meeting to update the assessments and include the new date within the CLDP. Given that the Settlement Agreement is clear about the 45-day requirement, the APC should ensure that an update is provided and dated within 45 days of the individual's move. It is likely the facility will meet substantial compliance with this provision during the next onsite review.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	SASSLC continued to struggle with creating an adequate list of well-written essential and nonessential supports. The monitoring team met with the APC and PMM and discussed this topic at length during the onsite review. Some of the information discussed is presented below in hopes that its inclusion in this report will be beneficial to the facility. The creation of the list of essential and nonessential supports provides the PST with the opportunity to ensure that the new provider provides the individual with all of the aspects of service and support that the PST deems necessary. PST members should never lose sight of their responsibility and opportunity, that is, that this is their chance to ensure that the individual gets what he or she needs and wants. Many PST members have, for many years, cared for, and cared deeply about, the individuals who are transitioning. They should take this opportunity to increase the likelihood of their individual's success at his or her new home. There are three components to a proper list of essential and nonessential supports. • First, the CLDP needs to include supports from a wide range of possible supports. This is an area where many CLDPs end up with an abundance of inservicing and appointment-setting supports, but few supports that focus on what is most important to the individual (e.g., activities, foods, relationships). The list of supports should come from the o individual's personal preferences and interests, o family members and LARs, o written assessments and updates from PST members (i.e., needed services for health, safety, and skill development), o other documents, such as the PSP and PSPAs, and o discussion at PST meetings. • Second, supports, both essential and nonessential, need to be described in adequate detail, using observable, measureable, and verifiable terminology. The wording must provide the facility, the receiving provider, and the post move monitor with adequate guidance regarding the provision and monitoring of each support. • Third, the way in which provision of the support is to be verified must be provided. The CLDP needs to specify what should be observed by the post move	Noncompliance

		monitor (e.g., checklists indicating staff behavior, paperwork, items, interactions with staff) and at what criterion (e.g., twice per week). The specification of what the CLDP refers to as "evidence" will result in specific actions required by the provider so that the PMM can adequately determine whether the support was being provided. The facility might also note that it remains available, perhaps even on an on-call basis, for any questions the provider might have regarding any support. The monitoring team reviewed the three completed CLDPs. Below are comments on the essential/nonessential supports sections. • The lists of essential and nonessential supports contained requirements for staff inservicing in PBSPs, PNMPs, safety issues, and so forth.. o It would seem that the facility would want there to be a competency-based component to the inservicing. This should be considered for future CLDPs. o In some cases, the CLDP indicated that staff had been trained, however, these trainings were dated four or five months prior to the individual's move. This was not sufficient and training needed to be redone even if for the same staff, and even if these staff had continued to get to know the individual during pre-placement visits. • Although inservicing is very important, requiring <u>only</u> the documentation of the inservicing of staff and/or <u>only</u> the presence of the BSP or PNMP document is insufficient. o The required essential/nonessential supports should also list out those actions that the provider must <u>implement</u> to satisfy the post move monitor that these supports were being provided. o The APC and PST should list, perhaps in bullet-style format, some specific details required to be covered during each of these inservices. By providing this detail, the APC and PST can ensure that certain important information is included in the inservice. ▪ Some, if not all, of these bulleted items could then also be listed as essential or nonessential supports. o For Individual #211, 16 of 21 supports were for staff training, equipment, or appointments. o For Individual #269: 22 of 28 supports were for staff training, equipment, or appointments. o For Individual #275, 16 of 19 supports were for staff training, equipment, or appointments. • For essential/nonessential supports that are the scheduling of appointments, the APC and PST should consider bulleting out a number of important points to be reviewed during the appointments. This can provide the PMM with specific detail for her post move monitoring.	

		• There were few supports that were directly related to the individual's preferred actions that were to occur each day for each individual. The PSTs (under the guidance of the APC and PMM) really need to consider the most important aspects of the individual's life, that is, his or her preferences, support needs, and safety concerns. It appeared to the monitoring team that important aspects of each individual's life were not included in the list of essential and nonessential supports. o There were no supports related to preferred activities, food, or relationships for Individual #211, only one for Individual #269 (visit with family), and only two for Individual #275 (participate in activities, call his friends at SASSLC). These two, however, were not adequately defined or implemented by the provider. o For Individual #275, as noted immediately above, one support was a general statement about participating in activities, but it contained little detail of where, how often, and so forth, thereby failing to give the provider an explicit expectation or the PMM enough detail to adequately monitor. His CLDP noted that he liked to be outside, go on walks, and have a productive job; that he was an active person who enjoyed a variety of activities, such as swimming, basketball, going to movies, going out to eat, shopping and other activities; that is, he liked to keep busy. Observation by the monitoring team at Individual #275's home (see T2b below) showed that in the first two weeks of August 2011, he'd only been out twice, once to McDonalds and a movie, and once to Long John Silver's. This was hardly what the PST would have expected or wanted. • None of the plans identified crisis intervention plans, and/or how the current methods for dealing with crises at the facility needed to be modified in a community setting. This might be especially important for someone like Individual #211 who had a history of failed placements and multiple psychiatric hospitalizations. • Generally, day and vocational supports were not well defined. For example, work was described as very important for Individual #275, yet the CLDP support only called for a day habilitation program. It should have contained much more detail about what he should be doing, how much he should be working, what types of activities, whether pay was important to him, and so forth. • Evidence of provider provision of the supports was not adequately described in the CLDP. Evidence for many supports was listed as "consult," "observation," or "inservice documentation." The facility had begun using a form entitled "Pre-Move Site Review," which was a part of the revised CLDP process. Four were reviewed and indicated that the essential supports (i.e., those required to be in place) were addressed. All of the essential supports,	

		however, were inservicing or the presence of adaptive equipment items (for one individual). The PMM, however, included some detail as she answered the series of questions regarding home environment, day program, and activities.	
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.	DADS had developed three self-monitoring tools for the SSLCs to use to self-monitor performance related to most integrated setting practices. These reviewed the living options discussion at the annual PSP meeting, the CLDP document, and the post move monitoring documents. Implementation of these tools was barely occurring at SASSLC (only two living option discussions and one CLDP were self-monitored). State office also did reviews of the living option discussion portion of the written PSP for three May 2011 PSPs. It did not seem that anything was done with the results of any of these reviews The monitoring team recommends that the APC take a close look at all three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of the self-monitoring are adequate, and that the criterion for scoring appears to be valid. Proper, reliable, and valid (i.e., correct content) self-monitoring will be required if SASSLC is to achieve and maintain substantial compliance with all of section T. There were other monitoring tools implemented for the PSP meeting, such as regarding the overall PSP meeting, and the QMRP's facilitation skills. Sometimes there was more than one observer, each monitoring a different aspect of the same meeting. The facility should work towards a single observer being capable of observing all that needs to be observed and monitored during the PSP meeting. In addition to the implementation of self-monitoring, data from the referral and placement activities at SASSLC should be submitted to and incorporated into the QA program at the facility (see section E above and T1a above). Certainly, a variety of data can be collected and reported by the APC that would be of interest to the facility's QA department and to its senior management team. Examples were provided in the previous monitoring report.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a	At the facility level, SASSLC was not in compliance with this provision item. SASSLC was not gathering relevant information regarding obstacles across the facility. SASSLC was not analyzing information related to identified obstacles to individuals' movement to more integrated settings. Further, as indicated in this provision item, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. The proposed statewide obstacles report was described in the previous monitoring	Noncompliance

	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.	report for SASSLC. As of the time of this review, it had not yet been issued and, therefore, the same comments from the previous monitoring report continued to be relevant and are not repeated here.	
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,	The monitoring team was given a document titled "Community Placement Report." It was updated 8/16/11. Although not yet included, the facility and state's intention was to include, in future Community Placement Reports, a list of those individuals who would be referred by the 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.	Substantial Compliance

	medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	SASSLC was implementing the post move monitoring process. Post move monitoring was conducted by the post-move monitor (PMM), Anna Cruz. Due to Ms. Cruz's efforts, the post move monitoring process at SASSLC continued to improve since the last onsite review. Ms. Cruz had a very personable style and followed through on items that were not met. On the other hand, when she sees some aspects of the individual's living or work arrangement that are not satisfactory, even if they were not specifically identified in the list of essential and nonessential supports, such as the cleanliness of the home and/or the lack of activities (as was the case during the home visit described in T2b below), she should realize that she is fully empowered to act, and that she should act in an assertive manner. The 12 post move monitoring forms reviewed were 100% of the required post move monitoring forms required to be completed during this monitoring period. According to the documentation reviewed, it appeared that all 12: • occurred within the required timelines, • were completed on a proper form as per Appendix C; moreover, the PMM specifically noted whether each support was met or not met, even though the form did not require it (hopefully, future revisions of the form will require a yes/no or met/not met indication), and • included visits to both the day and residential sites when the individual was present (this sometimes required the PMM to make multiple trips to the home or day program). The monitoring team was pleased to see that the PMM followed up on supports that were not in place and/or were rated as not met. In the post move monitoring forms, she indicated what follow-up actions had occurred, including the date and details. Examples	Substantial Compliance

		are her follow-up on: • a questionable diagnosis (Individual #192) • failure to use a weight and diet chart, including requiring the provider to contact her later that night with their evidence (Individual #107) • absence of a new behavior support plan (Individual #107) • improper or absent dining safety and proper food texture (Individual #269) • absence of wheelchair and adaptive equipment (Individual #211) In addition, on a couple of occasions, the PMM met with the SASSLC PST to inform members of problems (e.g., absence of a BSP) and/or to get guidance on how to proceed with her post move monitoring (e.g., regarding whether a communication book should continue to be required). The PMM created a one-page tracking list to monitor required deadlines for all post move monitoring. It fit onto one page because so few individuals had been placed. A rating of substantial compliance was given, however, for the next onsite review, the facility needs to show that a PST meeting was held following every post move monitoring visit, even if there were no serious issues.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team had the opportunity to accompany the PMM and APC on a post move monitoring visit to the home of Individual #275 for the 45-day review. The purpose of this visit was to see the post-move monitoring process, see the community home, 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 arrangements for this visit to occur. Further, subsequent to the onsite review the PMM sent the completed post move monitoring form to the monitoring team. The post move monitoring turned out to consist of, what could be considered, three components. First was a visit to the offices of the provider agency (for review of some of the required documents), second was a visit to the home, and third was a visit to the day program. The monitoring team was present for the first two of these three components. The PMM assessed each support one by one, asked relevant questions, asked for documentation to be sent if it wasn't available, and engaged in appropriate and professional interactions with the managers and staff of the provider, Center for Health Care Services. Note that the purpose of this provision item is for the monitoring team to evaluate the accuracy of the facility's monitoring. The monitoring team was somewhat alarmed by	Noncompliance

		the quality of the home and breadth of services being provided, even though the PMM was able to indicate that supports were being provided. The PMM is the eyes and ears of the PST and as such must not hesitate to speak up when she feels that the quality of services are not adequate. The PMM must be capable of, saying "this is not acceptable." First, the house was small, sparsely furnished, and looked like a workplace rather than a home. For example, the kitchen was plastered with department of labor posters, a bulletin board, and a time-clock. The air conditioning was not working properly, the backyard had junk in it, and there were few decorations in the home. The post move monitoring form only indicated that the air conditioning was not working and would be fixed, but did not reflect the overall condition of the home. Second, although interesting and varied activities were deemed to be very important for the individual, little seemed to be going on in the home or in the community for him, according to the log and staff description. When the PMM asked if he liked living there, Individual #275 said, "I kind of want to go back." Certainly more discussion was required between the individual, PMM, and perhaps the PST and provider, but it may be very likely that the environment and activity schedule were not turning out to be as attractive as perhaps they appeared to be during the provider search. The post move monitoring form indicated that the PMM looked at additional outing records and based on that review determined that additional outings had occurred, but even so, the number of outings was few. This also speaks to the need for the facility to help individuals make choices that will be in their best interest in the long term (see T1a above). This means that SASSLC staff (e.g., APC, PMM, clinicians, direct care staff) who are knowledgeable about community providers should share this information so that individuals are most likely to be served by those providers most competent to do so. Moreover, additional involvement of PST members must occur, including visits to the home (with or without the individual present), so that the decision making and transition processes can address what PST members see as potential problems in service provision for the individual. It is the monitoring team's understanding that no PST members saw this house and program, only the individual and his advocate. Further, if the PMM is unable to adequately determine the presence of a support based upon the way the evidence is described in the CLDP, she has the responsibility to look for further evidence and/or go back to the PST with questions and suggestions. For example, more observations of implementation could occur, staff could be interviewed further (this occurred regarding food textures and diet for another individual), requiring the provider to initiate and complete some sort of checklist indicating staff implementation, and/or other types of checks of staff and provider competence.	

T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination	There were no discharges during this review period that met the criteria for this provision item.	Not rated

	subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

1. Create a performance improvement team for the provision items of T1, especially regarding referrals and identifying providers who are most suitable for supporting SASSLC individuals. (T1a).

2. Create facility policies to be in line with the updated DADS policy (T1b).

3. Implement a process of review for each individual (who does not have an LAR who is opposed to placement) who has requested placement, but has not been referred (e.g., Placement Appeal) (T1a).

4. Identify those individuals who would have been referred except for the preference choice of the LAR; this list should include not only those who themselves requested referral, but those individuals who themselves cannot express a preference but whose PSTs would otherwise have referred. Add this list to the Community Placement Report (T1a, T1h).

5. Ensure that professional determinations are explicitly included in the PSP meeting, and that these professional determinations are clearly indicated in the PSP document. Professional determination is separate from both the preference of the individual, the LAR, and the opinion of the PST as a whole (T1a, T1b1).

6. Do a thorough review of every rescinded referral, return to the facility (even if for a respite), or failed placement as if it were a "sentinel event" for the admissions and placement department (T1a).

7. Effectively help individuals to choose community residential and day programs. Help them to avoid choosing providers whom the PST feels will not adequately meet their preferences or needs. This may involve teaching decision making skills to individuals, more involvement by the PST, and sharing of the APC and PMM's knowledge and experience regarding the competency providers (T1b1, T1c, T1c1).

8. Ensure that PST members see the homes and day programs that are being considered for individuals who are referred (T1c1, T2b).

9. Implement an effective and efficient LOD; ensure that there is collaboration between the consultants who are developing the next revision of the PSP process and the central office coordinator for most integrated setting practices (T1b1).

10. Create more consistency in amount of information included in the LOD sub-section of the written PSP. Consider the comments and examples presented above (T1b1).

11. Chose training objectives that will help individuals who are referred learn relevant skills (T1b1).

12. Identify and address obstacles to referral and to placement at an individual level (T1b1).

13. Identify and address obstacles to referral and placement across all individuals at the facility by conducting a comprehensive assessment and analyzing the information (T1g).

14. Assess content and scoring criterion for the three self-assessment tools being used for this provision; implement them in a reliable and consistent manner; and utilize the results (T1b1).

15. In the PSP, describe what activities were taken over the past year, and what activities are to be taken during the upcoming year, to educate the individual and/or his or her LAR regarding community placement (T1b2).

16. Implement a system to better manage the community tours of residential and day providers (T1b2).

17. Summarize and graph all relevant data from the Admission and Placement department's activities (T1a, T1f).

18. Include Admission and Placement data in the facility's QA program (T1a, T1f).

19. Consider doing a more detailed weekly report from the APC for senior management (T1a).

20. Develop a way for the APC and QMRP to work on a single version of the CLDP (T1c).

21. Ensure all assessments are updated within 45 days of the day the individual moved (T1d).

22. Address the many comments in T1e above regarding the determination and definition of essential and nonessential supports, including, but not limited to:
    a. Ensure essential and nonessential supports specifically include the individual's most important preferences and the most important supports and services noted by the PST (T1e).
    b. When an inservice is listed as a support, it should also include competency outcomes (T1e).
    c. The topics of inservices and appointments should be considered to be included in the list of essential or nonessential supports (T1e).
    d. Include a crisis plan for those individuals for whom that might be appropriate (T1e).
    e. Include supports to be provided during work/day programming rather than only indicating enrollment in a program (T1e).

23. Post move monitor must report on all problems regarding an individual's residential and day conditions (T2b).

24. Conduct a PST meeting following each post move monitoring visit (T2a).

25. DADS CLDP reviews might be done at various stages of CLDP development, not only immediately prior to the move date. In addition, consider creating a metric to measure the quality of the CLDPs (T1c1).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DRAFT DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SASSLC Plan of Improvement updated 8/2/11 o SASSLC Procedure: Consent Process dated 4/1/09 o Human Rights Committee Minutes for the past six months o The facilities list of individuals without LARs o Personal Support Plans: • Individual #27, Individual #161, Individual #67, Individual #191, Individual #102, Individual #66, Individual #37, Individual #114, Individual #184, Individual #81, Individual #31, Individual #36, and Individual #13 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 Gevona Hicks, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Morning Unit Meeting 8/16/11 o Incident Management Review Team Meeting 8/16/11 o Annual PSP meetings for Individual #205 and Individual #286
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. In addition, during the onsite review, the HRO reviewed the presentation book for this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, the comments section of each item of the provision included a statement regarding what tasks had been completed or were pending. The POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The facility assigned a noncompliance rating to both of the provision items in section U. It was unclear from a review of the POI how SASSLC came to this self-rating. Nevertheless, the monitoring team was in agreement with these self-ratings.

	The action steps included in the POI were restatements of the requirements of this provision. The facility was still waiting on approval of the state policy regarding consent and guardianship.
	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. Some positive steps that the facility had taken in regards to consent and guardianship issues included: • The facility had established a guardianship committee. • The facility had updated a list of individuals and their guardianship status. • The Human Rights Officer had created a Guardianship Process folder in the facility shared drive to serve as a central location for guardianship information. • Information on guardianship was presented at a meeting for families. • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had provided training to the Self Advocacy group comprised of individuals residing at the facility. • The Human Rights Officer had made contact with advocacy and guardianship agencies in the area. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. While the facility maintained a list of individuals needing an LAR, the list was not prioritized and not all PSTs were adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. The facility reported little activity or planning to solicit guardians for those determined to be in need. 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. Some PSTs were holding minimal discussions around the need for guardians in reference to the capacity for individuals to make decisions and give consent.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year,	SASSLC did not have a policy in place for developing and maintaining a list of individuals lacking both a 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	address this provision, but had not yet released it to the SSLCs for implementation. The facility's POI indicated that it planned to take action in these areas once the policy is finalized. The facility had a list of 146 individuals at the facility that did not have an LAR. This list was not prioritized by need. Twenty-three individuals on the list had been referred for advocates. No new guardians had been obtained for individuals since the last monitoring visit. PSTs were not assessing individual's ability to make informed decisions. There was no evidence in any of the PSPs reviewed that teams were discussing the need for guardianship in relation to the individual's ability to make decisions or give informed consent. PSTs need to hold more thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. The facility is not yet 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 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.	SASSLC was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific policies to address consent and guardianship. The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. The facility did have some rights protections in place including an assistant independent 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 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.	Noncompliance

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).

2. 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 (U2).

3. Continue to teach individuals to problem-solve, make decisions, and advocate for themselves (U1, U2).

4. 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 (U2).

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10 o Organizational chart, undated, but current o SASSLC policy lists, 8/1/11 o List of typical meetings that occurred at SASSLC o SASSLC POI, 8/2/11 o SASSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/15/11 o List of all staff responsible for management of unified records o Tables of contents active records and individual notebooks, dated 2/4/11 o Table of contents for the master record, dated 3/28/11 o Description of quality assurance auditing process o List of all individuals chosen for recordkeeping audits, five each month, January 2011 - June 2011 o 10 completed audits May 2011 and June 2011; included the state self-assessment form and the facility's table of contents/guidelines form o 10 audit follow-up tracking sheets and supporting documentation for the 10 completed audits from May 2011 and June 2011 o Emails showing distribution of the results of each of the five audits each month, January 2011 through June 2011 o Training documentation for senior clinical staff regarding signatures and record entries, 6/21/11 o A spreadsheet that tracked the status of state and facility policies for each provision of the Settlement Agreement o Email regarding state office expectations for facility-specific policies, from central office SSLC director of operations, Donna Jesse, 3/15/11 o SASSLC description of how it addressed provision item V4 o Questions and answers regarding auditing and interviewing for this provision, from Becky McPherson to the SSLCs, dated 4/19/11 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 #344, Individual #205, Individual #276, Individual #286, Individual #60, Individual #287, Individual #129, Individual #268, Individual #92 o Review of master records of: • Individual #89, Individual #124 Interviews and Meetings Held: o Noemi Cardenas, Unified Records Coordinator o Janet Prince Page, RHIT, Coordinator of Medical Records

	o Home records clerks (eight) o Numerous staff and clinicians during observations in residences <u>Observations Conducted</u>: o Records storage areas in residences o Overflow and master records storage area
	Facility Self-Assessment: SASSLC submitted its self-assessment, called the POI. It was updated on 8/2/11. In addition, during the onsite review, the Coordinator of Medical Records and the Unified Records Coordinator reviewed the presentation book for this provision. They had done a very nice job of organizing the presentation book and aligning documentation with each of the items of this provision. The POI did not indicate what activities the facility engaged in to conduct the self-assessment for this provision. Instead, in the comments section of each item of the provision, the CRM and URC wrote a sentence or two about what tasks were completed and/or the status of each provision item. Although this was helpful to the monitoring team, the monitoring team would prefer to have an understanding of the self-assessment process used by the recordkeeping department. For instance, 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. Further, the POI did not indicate how the findings from any activities of self-assessment were used to determine the self-rating of each provision item. The CRM and URC self-rated the facility as being in substantial compliance with provision item V1 and in noncompliance with the other three provisions. The monitoring team agreed with the three items self-rated as being in noncompliance, but did not agree with a rating of substantial compliance for V1. That being said, the monitoring team believes that SASSLC was very close to achieving substantial compliance as evidenced by the relatively modest actions that will need to be taken by the URC. The action steps included in the POI were written to guide the department in achieving substantial compliance. The nine action steps were all relevant to improving recordkeeping practices, however, they did not address all of the concerns of the monitoring team (i.e., did not address all of the recommendations of the monitoring team). A set of actions, such as those described in this monitoring report, should be set out as actions. Certainly, these steps will take time to complete; the facility should set realistic timelines, not just for initial implementation of an action, but a timeline that will indicate the stable and regular implementation of each of these actions.

	Summary of Monitor's Assessment: SASSLC demonstrated continued progress towards meeting substantial compliance with this provision. Recordkeeping activities continued to be managed primarily by the experienced and competent Unified Records Coordinator. Further, the facility had an active and engaging group of home record clerks who appeared to understand their jobs very well. The monitoring team recommends that the recordkeeping department begin to collect data on its own performance. To do so, the CMR and URC should list out the metrics that would be beneficial for their ongoing management of recordkeeping activities as well as be of interest to the facility. The active records reviewed by the monitoring team were very neat and organized. Future activities should focus on content, legibility, and signatures of both the observation notes and IPNs. The URC will need to determine what medical consultations had occurred so that she can determine if a consultation note was present. Individual notebooks were in place and available for each individual. Across the facility, they varied in condition, indicating that they were being used by staff. Because the individual notebooks were carried throughout the day, SASSLC should assess whether everything in the individual notebooks is useful to staff. The master records were very organized, very neat, and easy to review. Now that SASSLC had master records and a checklist table of contents, the next step was for the facility to determine what to do about the many items that were missing. The requirement to have, and manage, state and facility-policies was not yet being done at SASSLC. The conduct and organization of the five monthly reviews of the unified record continued to be done in an excellent manner by the URC. Five reviews were done each month, as required. The content, findings, and results of the reviews using the URC's table of contents/guidelines were much more relevant than the statewide self-monitoring tool. The monitoring team recommends that data from the table of contents/guidelines review be what is submitted to the QA department for tracking, trending, analysis, and sharing with QAQI Council. To address the facility's use of the unified records to make treatment and care decisions, the URC had done two activities. First, she did a brief interview of a PST member each month and, second, she looked at the IPNs to see if there were entries from different disciplines. Although these were good steps, more activities will need to be undertaken. Direction will likely be provided by state office in the near future.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	SASSLC demonstrated continued progress towards meeting substantial compliance with this provision item. The Unified Records Coordinator (URC) continued to lead the facility towards substantial compliance, which is likely to be obtained for this provision item in the near future. The DADS statewide policy remained in effect. Regarding facility-specific policy, nothing new or updated was submitted by the facility. In the previous monitoring report, however, it was noted that a facility-specific policy was written and was submitted to DADS central office for review and approval. At the time of this review, nothing new had happened with this, thus, it was unclear if a facility-specific policy was in effect for recordkeeping. Recordkeeping activities continued to be managed primarily by the experienced and competent Unified Records Coordinator, Noemi Cardenas, and the Coordinator of Medical Records, Janet Prince-Page. They were both very serious about their jobs, were committed to having acceptable unified records, and worked hard to do so. The URC and the CMR were responsive to the comments and recommendations in the previous monitoring report, such as including more detail regarding what should be in the consents section of the active record. The monitoring team recommends that the recordkeeping department begin to collect data on its own performance. To do so, the CMR and URC should list out the metrics that would be beneficial for their ongoing management of recordkeeping activities as well as be of interest to the facility. Examples include, but are not limited to: • Score on self-assessment tool • Number of records reviewed per month • Average number of items that required correction per individual unified record • Number of incomplete corrections after a specified period of time (e.g., one month) These data should then be incorporated into the facility's QA program. <u>Active records</u> The active records reviewed by the monitoring team were very neat and organized. A number were reviewed as indicated in Documents Reviewed, above. It was easy to find where items were supposed to be located. The SPO section included an SPO for each objective as per, and in the same order as, written in the annual PSP. Now that the active records were in place and staff were familiar with them, the URC should address the following.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Continue to address problems in observation notes regarding signatures and full names for reach entry. • Continue to work on improved IPNs, including entry legible content and signatures, and inclusion of credentials. This issue had not gone undetected: the URC noted it in every record audit (and did follow-up, see V3 below), and a training session was held for senior clinical/discipline staff on 6/21/11. Effects of these actions were not yet evident. • Determine what medical consultation documentation should be in each active record because these varied from individual to individual (e.g., cardiac, podiatry, vision). The monitoring team suggests that the URC find out if the facility's medical department keeps a list of these consultations and, if so, whether a copy can be obtained every month for use during record audits. <u>Individual notebooks</u> The DADS central office coordinator for recordkeeping practices sent a request for each SSLC to pick one of four individual notebook options. SASSLC chose the option to keep the individual notebooks as they had been using them. This appeared to be a good resolution to the question about individual notebooks raised during the previous onsite review. The facility, however, will need to demonstrate that data and information are accurately and reliably recorded. The monitoring team believes that this was also a requirement of DADS central office (also see section K above). SASSLC should be prepared to discuss this during the next onsite review. Individual notebooks were in place and available for each individual. Across the facility, they varied in condition, indicating that they were being used by staff (e.g., Individual #268, Individual #129). Because the individual notebooks were carried throughout the day, SASSLC should assess whether everything in the individual notebooks is useful to staff. Sections or information that are not, should be removed (e.g., perhaps the daily schedule of activities because most of them merely contained lists of broad categories of activities and didn't provide the direct care staff with any meaningful direction). <u>Master records</u> The recordkeeping staff had created a master record file for every individual. This was an accomplishment since the last onsite review and included the creation of a table of contents for the master record. Master records were reviewed for seven individuals, including some who were recently admitted and some who were residents at SASSLC for many years	

#	Provision	Assessment of Status	Compliance
		The master records were very organized, very neat, and easy to review. Now that SASSLC had master records and a checklist table of contents, it was evident that many items on the list were not available. The next step is for the facility to determine what to do about the many items that were missing (e.g., determination of mental retardation, birth certificate). The recordkeeping staff should have some sort of procedure or rubric to follow so that they are ensuring that they are doing follow-up on any documents that should be located. Perhaps state office can provide some guidance to the CMR and URC. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review. <u>Record Clerks</u> The monitoring team had the opportunity to meet with the group of eight record clerks. The facility was fortunate to have such a dedicated and experienced group. Their efforts were also contributing to SASSLC's continued progress. The record clerks had many responsibilities, including filing all kinds of documents, purging the records, mending active records and individual notebooks, and ensuring blank forms were available for all staff and clinicians. In addition, they completed injury reports and tracked down documents for unified record as needed (which was most every day).	
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. The notes in the POI indicated that the facility was only addressing this provision item as it related to policy and procedure for recordkeeping. This was incorrect; this provision item refers to all of the provisions of the Settlement Agreement. The monitoring team was very pleased to see that state office was requiring an organized and systematic way of managing facility-specific policies, that is, state office: • Required a facility-specific policy (or policies) for every Settlement Agreement provision • Required each facility-specific policy to be in line with the contents of the state policy • Required the facility to submit each facility-specific policy for approval • Provided feedback on the content of each facility-specific policy • Detailed these expectations in an email memo from the DADS SSLC director of operations, dated 3/15/11.	Noncompliance

#	Provision	Assessment of Status	Compliance
		These specific steps were not yet being implemented at SASSLC for the facility-specific policies. At SASSLC, there was a one-page spreadsheet showing one line for each provision. Each line noted the state office policy with the most recent revision date, and whether or not SASSLC had a facility-specific policy. None of this was dated, so it was not clear how up-to-date it was. Further, the SASSLC status column was not correct and did not accurately reflect the status of SASSLC facility-specific policies (e.g., recordkeeping, quality assurance, integrated clinical services). Some facilities have created a second spreadsheet to detail the status of each facility-specific policy. SASSLC should consider doing the same. Further, at SASSLC it was not clear (to the monitoring team) who, if anyone, was managing this provision item. At some facilities it is the QA director. At other facilities it is the Coordinator of Medical Records or the URC.	
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 conduct and organization of the five monthly reviews of the unified record continued to be done in an excellent manner by the URC. Five reviews were done each month, as required. Individuals were selected in a systematic random manner, excluded were any individuals whose annual PSP was in the previous three months (because many documents would not yet be in the active record). The URC's monthly review was thorough. It looked at all three components of the unified record (an improvement from the time of the previous monitoring review). The review form was typically 12 pages long: three pages were the statewide self-monitoring tool, seven pages were the detailed table of contents and guidelines for the active record and individual notebook, one page was for the master record, and one page for comments. The review tool had two columns for every item on the TOC: (a) document present?", and (b) guidelines followed?" The master record review page, however, only had a place to indicate whether or not the item was present in the master record. The results of the self-monitoring tool were sent to the QA department. Many of the items of the self-monitoring tool, however, were broad or vague. The self-assessment tool alone was insufficient (not much useful detail), and the results were almost identical across all individual reviews (not due to the URC not doing the review properly, but rather, due to the inadequacy of the tool). The content, findings, and results of the reviews using the table of contents/guidelines were much more relevant than the self-monitoring tool. The monitoring team recommends that data from the table of contents/guidelines review be what is submitted to the QA department for tracking, trending, analysis, and sharing with QAQI Council.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Once a review was completed, the URC had a very good, very detailed, and consistently implemented process for contacting the responsible staff and then for following up on each of these. The URC should do 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. Even if the state office does not collect the results of the detailed table of contents/guidelines review, the information should be tracked and trended over time and included in SASSLC's QA program. The information should include, for example, number of reviews conducted, number of items that needed correction, and number of outstanding corrections (see V1 above).	
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.	Continued progress was demonstrated by the URC and CMR, however, more work will need to be done to determine the full set of activities the facility needs to engage in to demonstrate that records are being used as required by this provision item. Recently, the monitoring teams presented, to DADS and DOJ, a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item. Even so, the recordkeeping staff had implemented some processes towards this end. First, the URC conducted one post-PSP interview with one PST member each month using the new questionnaire form developed by central office. The results of these were not summarized or used by the facility in any way. Further, only talking with one PST member each month might not provide enough information for any generalizations to be made about the use of records. Second, the URC made a notation while doing her monthly record reviews as to whether the content of the IPNs indicated that the unified record was used as per this provision item. Usually, it was scored as "yes," however, there was no criterion or rationale presented to the monitoring team as to how this determination was made, other than perhaps seeing if some of the disciplines had made entries over the past month's period of time. 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 facility to address in meeting the requirements of this provision item. • Active records and individual notebooks were present at PST meetings, such as annual PSPs, PSPAs, and in-process CLDP meetings (e.g., Individual #276, Individual #92, Individual #205). In one meeting, the nursing staff checked an individual's medical notations during a discussion of the relationship between	Noncompliance

#	Provision	Assessment of Status	Compliance
		medical conditions and behavior problems. • In all four observed psychiatric clinic encounters, the individuals record was available and the physician was actively reviewing documents. • Medical providers made entries in the records. These were not seen in response to some issues such as consults and QDRRs. • Since the prior monitoring review, the legibility of nurses' notes, signatures, and credentials had not improved. In addition, there were numerous nurses' notes that followed no format (SOAP or otherwise). In addition, there were many notes that were uninformative, cryptic phrases that failed to constitute an assessment or evaluation of any sort. For example, individuals were noted to have eaten "fairly well" or "with no problems." Others who had problems with skin integrity were noted as "picking less than last quarter" or having "a little bit of drainage." Nurses' notes were out of date/time order either on the same IPN or from one IPN page to the next. • Plans of care (HMPs and ACPs) were a hodge-podge of various and overlapping mini medical disorder stock care plans scattered throughout the IPNs. Current plans were mixed with outdated plans; and plans lacked information and/or evidence of resolution/discontinuation, which made it difficult, if not impossible, to discern what interventions the nurses and direct care staff members were expected to implement and evaluate. • The staff reported that the individual books were helpful. The monitoring team observed staff using the individual books, however the majority were locked in a room and did not appear to be useful for recording behavior/incidents in a timely manner. • There was a reference in the PNMT meeting that the oral intake record for Individual #39 was locked up and not available for staff use. This was unacceptable and particularly problematic in that she was being followed to address weight loss and the amounts and kinds of foods she ate were critical to problem solving this issue.	

Recommendations:

1. Resolve the status of facility-specific policies for recordkeeping (V1).
2. The recordkeeping department should collect data on its own performance (V1, V3).
3. Incorporate data into SASSLC QA program (V1, V3).
4. Continue to address problems in observation notes regarding signatures and full names for reach entry (V1).

5. Continue to work on improved IPNs, including entry legible content and signatures, and inclusion of credentials (V1).

6. Determine what medical consultation documentation should be in each active record (V1).

7. Ensure that data and information are accurately and reliably recorded in the individual notebook. Demonstrate this to the monitoring team during the next onsite review (V1).

8. Assess whether everything in the individual notebooks is useful to staff. Sections or information that are not, should be removed (V1).

9. Determine what to do about items that are missing from the master record (V1).

10. Manage the status of state and facility policies for each of the provisions of the Settlement Agreement. Consider making a second spreadsheet that details SASSLC's facility-specific policies. Determine who at SASSLC is responsible for this provision item (V2).

11. Follow the steps outlined by DADS central office regarding facility-specific policies (V2).

12. Report on the results of the table of contents/guidelines review to the SASSLC QA department (V3).

13. Implement all procedures to address V4 when disseminated from state office (V4).

14. Summarize and use the information collected from the post-PSP meeting PST interviews (V4).

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AACAP	American Academy of Child and Adolescent Psychiatry
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
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
AEB	As Evidenced By
AED	Anti Epileptic Drugs
AED	Automatic Electronic Defibrillators
AFB	Acid Fast Bacillus
AFO	Ankle Foot Orthosis
AICD	Automated Implantable Cardioverter Defibrillator
AIMS	Abnormal Involuntary Movement Scale
ALT	Alanine Aminotransferase
AMA	Annual Medical Assessment
ANC	Absolute Neutrophil Count
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
ARDS	Acute respiratory distress syndrome
ASA	Aspirin
ASAP	As Soon As Possible
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology

BBS	Bilateral Breath Sounds
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BP	Blood Pressure
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CANRS	Client Abuse and Neglect Registry System
CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
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
CMS	Circulation, Movement, and Sensation

CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic obstructive pulmonary disease
COTA	Certified Occupational Therapy Assistant
CPEU	Continuing Professional Education Units
CPK	Creatinine Kinase
CPR	Cardio Pulmonary Resuscitation
CPS	Child Protective Services
CR	Controlled Release
CRA	Comprehensive Residential Assessment
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CTA	Clear To Auscultation
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebrovascular Accident
CXR	Chest X-ray
D&C	Dilation and Curettage
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DBT	Dialectical Behavior Therapy
DC	Discontinue
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
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Doctor of Osteopathy
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

DX	Diagnosis
e.g.	exempli gratia (For Example)
EBWR	Estimated Body Weight Range
EEG	Electroencephalogram
EES	erythromycin ethyl succinate
EGD	Esophagogastroduodenoscopy
EKG	Electrocardiogram
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, and Thank
EMR	Employee Misconduct Registry
EMS	Emergency Medical Service
ENT	Ear, Nose, Throat
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FNP	Family Nurse Practitioner
FOB	Fecal Occult Blood
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Gram
GYN	Gynecology
H	Hour
HB/HCT	Hemoglobin/Hematocrit
HCG	Health Care Guidelines
HCL	Hydrochloric
HCS	Home and Community-Based Services
HCTZ	Hydrochlorothiazide
HCTZ KCL	Hydrochlorothiazide Potassium Chloride

HDL	High Density Lipoprotein
HHN	Hand Held Nebulizer
HHSC	Texas Health and Human Services Commission
HIP	Health Information Program
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human immunodeficiency virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IEP	Individual Education Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development
IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPN	Integrated Progress Note
ISP	Individual Support Plan
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left

L	Liter
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MED	Masters, Education
Meq	Milli-equivalent
MeqL	Milli-equivalent per liter
MERC	Medication Error Review Committee
MG	Milligrams
MH	Mental Health
MI	Myocardial Infarction
MISD	Mexia Independent School District
MISYS	A System for Laboratory Inquiry
ML	Milliliter
MOM	Milk of Magnesia
MOSES	Monitoring of Side Effects Scale
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus

MS	Master of Science
MSN	Master of Science, Nursing
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
MVI	Multi Vitamin
N/V	No Vomiting
NA	Not Applicable
NA	Sodium
NAN	No Action Necessary
NANDA	North American Nursing Diagnosis Association
NAR	Nurse Aide Registry
NC	Nasal Cannula
NCC	No Client Contact
NCP	Nursing Care Plan
NEO	New Employee Orientation
NGA	New Generation Antipsychotics
NL	Nutritional
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
O2SAT	Oxygen Saturation
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
PEG	Percutaneous Endoscopic Gastrostomy
PEPRC	Psychology External Peer Review Committee
PERL	Pupils Equal and Reactive to Light
PET	Performance Evaluation Team

PFA	Personal Focus Assessment
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
Pharm.D.	Doctorate, Pharmacy
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
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
POX	Pulse Oximetry
POX	Pulse Oxygen
PPD	Purified Protein Derivative (Mantoux Text)
PPI	Protein Pump Inhibitor
PR	Peer Review
PRC	Pre Peer Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
PVD	Peripheral Vascular Disease
Q	At
QA	Quality Assurance
QAQI	Quality Assurance Quality Improvement
QAQIC	Quality Assurance Quality Improvement Council
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement

QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNP	Registered Nurse Practitioner
RPH	Registered Pharmacist
RR	Respiratory Rate
RTA	Rehabilitation Therapy Assessment
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPCI	Safety Plan for Crisis Intervention
SPI	Single Patient Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
STAT	Immediately (statim)
STD	Sexually Transmitted Disease
STEPP	Specialized Teaching and Education for People with Paraphilias
STOP	Specialized Treatment of Pedophilias
T	Temperature
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia

TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TT	Treatment Therapist
UA	Urinalysis
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States
USPSTF	United States Preventive Services Task Force
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VPA	Valproic Acid
VS	Vital Signs
WBC	White Blood Count
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WT	Weight
XR	Extended Release
YO	Year Old