United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: February 13 – February 17, 2012

Date of Report: April 9, 2012

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Background

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

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

In order to conduct reviews of each of the areas of the Settlement Agreement, each Monitor 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 onsite. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

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

(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.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the

provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

Executive Summary

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 again extremely supportive of the monitoring team's activities throughout the week of the onsite review. The new Settlement Agreement Coordinator, Andy Rodriguez, did an excellent job in this, his first onsite review in this role at SASSLC.

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. Further, many positive interactions were observed between staff and the individuals at SASSLC during the many hours of observation conducted by the monitoring team. 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, below are comments on a few general topics regarding service operations at the facility and one item about this report.

- Attention to Settlement Agreement: Facility staff and management were very aware of the Settlement Agreement. There was frequent reference to Settlement Agreement provision and provision items, often by provision item letter and number.

- Integration of clinical services: Numerous efforts to this end were observed by the monitoring team. The medical director had done a very nice job of moving the facility forward. The monitoring team would also like to see the facility director more involved in the facility's work towards this.

- New ISP Process: The facility, under the direction of the active and energetic QDDP coordinator, had made some steps forward with this new process.

- ISP terminology: DADS and the SSLCs changed the wording of many documents, meetings, and processes to Individual Support Plan (ISP). This was a change from the previous Personal Support Plan (PSP). Also, the Personal Support Team (PST) name was changed to the Interdisciplinary Team (IDT). This report uses the new terminology and refers to all documents with the new terminology.

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

- Between 8/25/11 and 2/3/12, 131 restraints occurred. Of these, 89 were programmatic restraints and 42 were emergency restraints. Of these 131, 99 were physical hold restraints, 2 were mechanical restraints (unknown type and wristlets for self injurious behavior), and 30 were chemical restraints. Twelve individuals were the subject of restraints.
- During observation at the facility, it was found that some mechanical restraints being used to address self-injurious behavior were classified as medical restraints by the facility and, therefore, were not routinely reviewed by IDTs, addressed in behavior support plans, or reported in terms of restraints at the facility. These included mittens, wrist ties downs, helmets, and abdominal binders. This needs to be corrected.
- Action taken since the last monitoring visit included nurses were inserviced on nursing services regarding restraints, and restraint monitors had been inserviced on restraints. In addition, the facility began a self-assessment process using the statewide section C audit tool, and a template was developed to be used by IDTs for determining the need for medical and dental desensitization plans.

Abuse, Neglect, and Incident Management

- DFPS confirmed two allegations of physical abuse and 25 allegations of neglect from 8/3/11 through 12/26/11 (less than five months). DFPS investigated a total of 193 allegations of abuse, neglect, or exploitation. This included 68 allegations of physical abuse, 26 allegations of emotional/verbal abuse, and 99 allegations of neglect. This was an increase in reported allegations from the previous monitoring visit, however, the number of confirmed allegations was the same. There were an additional 38 serious incidents at the facility that did not involve allegations of abuse or neglect.
- Through the week of the onsite review, there had been a total of 782 injuries for the fiscal year 2012 (since 9/1/11). This was an increase from the same period for FY 2011. Of the 782 injuries in FYI 2012, 25 of those were serious injuries involving fractures or sutures compared to 11 for the same period in FYI 2011.
- Some positive steps taken to address incidents at SASSLC were:

    - SASSLC had created an AOD position to provide administrative presence and oversight during off-hours, weekends, and holidays.
    - The Abuse and Neglect Coordinator and the QA Program Auditor had inserviced the AODs on incident management policies and reporting guidelines.
- There continued to be a high number of incidents and injuries 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 and take action to reduce the number of incidents and injuries.

Quality Assurance

- SASSLC had a new director of quality assurance. As a result, it was not surprising that there was little progress made. The new director was knowledgeable of the facility, and was very motivated to create a comprehensive QA program. Support and collaboration from the facility director, state office quality assurance coordinator, and the new SAC at SASSLC should be provided to the new director.
- Revisions to the state's QA policy were completed and included more detail and direction than did the previous policy. Training and orientation to this new policy and its requirements were needed.
- Some progress had been made in creating a listing/inventory of all data collected at SASSLC.
- Data were not yet being appropriately reviewed and summarized (e.g., graphed) for all of data on the QA matrix.
- The work of the QA nurses was exceptional and can provide a model for other departments at SASSLC. They created an organized system to implement, assess, and follow-up on the findings from all 12 of the nursing tools.
- A QA report was completed each month. The January 2012 report, created by the new QA director, was the best of those reviewed by the monitoring team. The report, however, still needed a lot of work and improvement.
- QAQI Council had met intermittently over the past six months. The facility director should take a stronger lead role in the meeting.
- A systematic, organized way of managing corrective actions, and corrective action plans, was not yet in place.

Integrated Protections, Services, Treatment, and Support

- SASSLC received technical assistance from the DADS ISP consultants in January 2012 and began implementation of the new ISP process on 2/1/12. Only two ISPs had been developed since training occurred. These two ISPs showed improvement in including supports and services in a manner that would guide staff implementing plans.
- Three annual IDT meetings were observed by the monitoring team. In these meetings, the QDDPs attempted to ensure that all necessary information was covered. Meetings attended were lengthy (three hours) and somewhat fragmented in discussing risks and supports. Teams, however, engaged in better discussion in the meetings observed than during previous onsite reviews.

- There was minimal progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want.
- 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 were still needed.
- The facility had begun to use state developed audit tools to review both meeting facilitation and the ISP development process, but had not yet evaluated the outcome of those audits.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- It was clear that these important provisions were taken seriously and a great deal of effort had been devoted to moving towards substantial compliance, especially for provision G. SASSLC was also positioned to move forward on provision H.
- State office developed a draft procedure to address the requirements of provision G and provision H. In January 2012, the facility formally adopted a procedure related to the integration of clinical services.
- New committees such as the Medication Variance Review Committee and Pneumonia Review Committee were multidisciplinary in approach.
- Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted.
- The medical director and medical compliance nurse understood that provision H reflected a means of ensuring that all of the elements of clinical care were appropriately coordinated and monitored. To that end, they drafted a facility-specific procedure that described how the clinical disciplines captured and monitored the delivery of care. This represented a good effort by the facility, but more importantly, indicated that this important provision was being taken seriously.
- Since many of the activities in this provision were related to the determination of quality, it will be important for the quality assurance department to work collaboratively with the areas of clinical services.

At-Risk Individuals

- SASSLC had taken minimal steps towards compliance with this provision including:
  - A DADS consultant provided training to the facility on the new ISP Process and Risk Identification.
  - The QDDP Coordinator and QA Nurse provided training on the new risk identification process to RNCMs.
  - Teams began implementing the new risk identification process as of 2/1/12.
- The monitoring team met with some IDT team members who were involved in the at-risk process. Team members agreed that the facility was in the initial stages of implementing the new risk identification process.

- The monitoring team did not find that IDTs were consistently completing assessments prior to the IDT meeting or updating assessments as needed.

Psychiatric Care and Services

- The facility lead psychiatrist implemented policy and procedures geared toward meeting generally accepted professional standards of care in psychiatry. The new practices were expanded to include all facility homes.
- Observations of psychiatric clinic 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.
- The clinical staff 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.
- 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.

Psychological Care and Services

- In the last six months, there was progress in a few areas. One psychologist became a certified applied behavior analyst, there was an increase in the percentage of functional assessments for individuals with PBSPs, there were improvements in the quality of functional assessments, and there was an introduction of a simplified PBSP format.
- On the other hand, a lot of work needed to be done. For example, the psychology department needed to establish internal and external peer review, ensure the routine use of the graphing of data in intervals necessary to make treatment decisions, increase the percentage of functional assessments that included all the necessary assessment components, and collect interobserver agreement data, establish target levels, and ensure that staff achieve those levels.

Medical Care

- Continued progress was noted in the provision of medical services. Much progress was seen in the development and implementation of systems and processes. Improvement was observed in preventive services, such as vaccinations and breast cancer screening. In other areas, such as colorectal cancer screening, compliance remained low. The format of several required assessments improved the overall usefulness and quality.
- Many individuals who needed screening for osteoporosis, such as those who used high risk AEDs, had not been tested, and the medical director had addressed this by implementing osteoporosis clinical guidelines.

- Many individuals were diagnosed with pneumonia, but the facility's data related to pneumonia were not accurate. It appeared that the Pneumonia Review Committee was not an effective means of reviewing pneumonia. There were no formal written criteria for the process. Some individuals with serious respiratory issues were not included in the pneumonia listing and some had the pneumonia incorrectly categorized.
- The facility had adopted the standard that no small bowel feeding was permitted in the facility. This was contradictory to state issued guidelines that recommended consideration of small bowel feedings for those with recurrent aspiration. Individuals who had J-tubes inserted in the hospital were sent to live in other types of long term care facilities.
- Neurology services were primarily provided on campus. Clinic was conducted monthly for approximately two and a half hours. This seemed inadequate for providing services for the number of individuals diagnosed with seizure disorders. The neurological care was not comprehensive.
- Ten percent of individuals living at the facility had active DNR orders and the rationale for many of those orders was not clear. Many individuals had this status for years.
- External reviews were completed and progress was noted in the nonessential elements of care. Mortality reviews continued to be completed per state guidelines. One of five reviews generated recommendations. Quality nursing reviews indicated a continued pattern with regards to nursing care and one corrective action plan was provided.

<u>Nursing Care</u>

- With the leadership and hard work of the Chief Nurse Executive, the nursing department achieved additional structural and procedural improvements, filled vacant leadership positions, and established a manageable and reasonable allocation and assignment of individuals to RN case managers. Old nursing policies were revised and lines of communication within the department and outside the department were opened, developed, and nurtured. There continued to be improvements in the collaboration and communication between nurses and QDDPs, and the CNE and QDDP Coordinator worked together to address barriers.
- Onsite review activities and the review of the documents, however, revealed a continued and pervasive pattern of problems in nursing practices across all aspects of care.
- Nurses failed to perform timely, complete, accurate assessments and failed to develop acute and chronic health management plans to address individuals' health problems. Nurses failed to implement basic infection control procedures as simple and as basic as proper hand washing. Nurses were not knowledgeable of the health problems, needs, and/or reasons for prescribed medications and treatments of the individuals assigned to them. Nurses failed to properly perform procedures, such as catheterization, management of gastrostomy tubes, and oral and enteral administration of medications. Nurses also failed to ensure that the basic health care needs of medically fragile and vulnerable individuals were met.

Pharmacy Services and Safe Medication Practices

- The provision of pharmacy services and safe medication practices demonstrated a mix of continued progress, lack of progress, and even regression. Many issues that were noted in the August 2011 and previous reports had not been addressed. At SASSLC, pharmacy was supervised by the CNE. None of the other SSLCS placed pharmacy under the supervision of nursing and such an arrangement is not standard practice. This also resulted in the medical director having a diminished role in pharmacy services.
- The facility had to work with the limitations that resulted from the use of an outsourced pharmacy. These were not insurmountable limitations, but there was very little demonstrated effort to overcome them, particularly with regards to provision N1.
- A small number of single patient interventions were documented, however, this was clearly inadequate both in content and number. There were discussions, just prior to and during the onsite review, regarding potential solutions to the barriers of having an outsourced pharmacy.
- Clinical pharmacists continued to complete QDRRs. These were completed thoroughly and in a timely manner. Physicians acknowledged the recommendations included in the QDRRs. Record reviews appeared to indicate that appropriate actions were taken on the part of the physicians.
- The MOSES and DISCUS evaluations were completed by the psychiatrists. In most instances, the forms were adequately completed.
- Adverse drug reactions were completed by the clinical pharmacists and reported in the Pharmacy and Therapeutics Committee meetings. All of the reporting appeared to be completed by the pharmacy staff.
- Two DUEs were completed since the last visit. The prescribers of medications reviewed by the DUEs did not participate in the meetings where the information was presented.
- Medication variances were reported, but the processes at the facility had changed to the extent that dispensing variances were reported as zero. Given the history of dispensing variances, a sudden drop to zero was a clear indication that the facility was not able to provide accurate and reliable data.

Physical and Nutritional Management

- There was a fully-constituted PNMT, including a full time nurse. The dietitian was an exceptional addition to the team and will likely provide information and analysis that was, until now, missing from the team and the facility. They had met consistently each weekly. A meeting observed during this review showed some improvement since the last review, and the team did a particularly good job with addressing concerns with a parent who attended.

- The PNMT decided to initiate review of all individuals with aspiration pneumonia, but other key clinical indicators should also be examined, including bacterial/non-classified pneumonia or significant or consistent weight loss.
- Only two comprehensive assessments had been completed and these appeared to be more of an extensive record review rather than an actual assessment of the individuals' current status and issues. The action plans were not well organized and it was difficult to discern actions taken, completed, and assessed for their effectiveness.
- Mealtimes and snacks were observed in a number of homes. Observations in home 670 were disappointing because there were implementation and texture errors. Performance in home 674, however, was exceptional and there were some noted improvement in homes 671 and 668. The key to success in some areas appeared to be related to the quality of the supervisors. The successful supervisors were actively involved, were coaching and monitoring staff, and knew what should be done and how to do it.
- Positioning overall was improved. Staff did not understand the relationship of individual risks and triggers to their duties and responsibilities. Some staff were better able to answer questions about implementation of the plans and this was noted to be an improvement over previous reviews.

Physical and Occupational Therapy

- The therapists appeared to be knowledgeable and enthusiastic, however, they were contracted therapists and there was a great concern for continuity.
- There was a sound assessment template with guidelines for the comprehensive assessment. The assessments definitely continued to improve. The OT and PT clinicians conducted their annual assessments together and the SLPs had begun to participate in the assessment process, too.
- The PNMPs had improvements in many areas. Positioning, in general, appeared to be improved, though attention to personal body mechanics used by staff continued to need improvement. Review of gait belt use was also indicated. A number of individuals with gait belts did not appear to require them and/or they were not used correctly.
- Some staff were more confident in their responses to the monitoring team's questions and appeared to have a better understanding of why they were doing what they were doing in relationship to the PNMP.
- There continued to be a limited number of individuals participating in direct PT and there were none receiving direct OT services. The PT interventions were generally well documented, though there were some who had not received a recent assessment. Measurable objectives were noted for each, though the data collected did not always clearly relate.

Dental Services

- Continued progress was noted in the provision of dental services. The new clinic was originally scheduled to open by 2/29/12. That completion date was moved back by approximately six weeks. The monitoring team toured the new clinic space. Much thought and detailed planning had gone into its development. The physical space was generous and the framework had been established to provide full services including the use of TIVA.
- Records continued to be produced electronically and contained good information that was easily understood and informative for the IDTs. A new document was emailed daily to clinical and residential staff that summarized the clinic's activities of the day, including missed appointments, who received treatment, sedation used, effectiveness of the sedation, and other relevant information. The medical staff found this to be very helpful information.
- Individuals were seen in their homes when necessary, but the hygienist was no longer visiting homes to provide instruction to the individuals and staff on toothbrushing and oral care. This was unfortunate because the increased presence of the clinic staff in the homes likely contributed to the significant overall improvement in oral hygiene ratings.
- One disturbing finding noted during the conduct of this review was the delay in treatment that was caused by a lack of consent for use of sedation and consent for treatment. This appeared to be attributed to issues related to the HRC process as well as some individuals lacking a legally authorized representative. It appeared to have been addressed.
- The dental director reported that implementation of dental recommendations was poor. He also pointed out that assessments for the appropriateness of desensitization plans was slow.

Communication

- Progress with completion of communication assessments per the Master Plan was reasonable. More than half of the individuals had received a comprehensive assessment, but a number would not receive one until 2013.
- There was evidence of a concerted effort to establish training objectives related to communication. In some cases, these were directed by the speech therapist as well as collaboration with the home and day program staff. The SLPS are commended for making strides in this area.
- Consistency of the implementation of AAC and communication plans, however, continued to be problematic. Documentation was absent and there was limited integration in the ISPs. A new training module had been initiated in one home.
- Clinical staff had limited time for inserting themselves in the environments and daily routines of individuals, however, this will be key to effective assessments, the selection of meaningful and useful communication supports, the development of communication programs, and to provide modeling of how to be an effective communication partner. An effort to this end was the OT/PT/SLP consultation activities initiated in January

2012. Therapy teams were going to day program areas to observe and make recommendations as to how the activities may be enhanced.

Habilitation, Training, Education, and Skill Acquisition Programs

- Although no items of this provision were found to be in substantial compliance, the monitoring team noted improvements since the last review. These included the development of an interdisciplinary workgroup to identify a plan for achieving compliance with this provision item and the initiation of a pilot program to evaluate the effects of the new SAP format, skill acquisition monitoring tool, and the use of an active treatment specialist in two homes. In addition, the facility established an active treatment meeting to review engagement data, and discuss plans to improve engagement in treatment areas that fall below expectations. The staff also began tracking the implementation of skill acquisition plans in the community.
- The monitoring team suggests that the facility focus on expanding the new SAP format to all SAPs, and graphing SAP data to increase the likelihood that the continuation, modification, or discontinuation of SAPs are the result of data based decisions. A major project will be to ensure that the SAPs are implemented with integrity and that there are increases in the implementation of SAPs in the community.

Most Integrated Setting Practices

- State office was planning to hire a new APC and PMM. The previous APC retired and the previous PMM resigned.
- The specific numbers of individuals who were placed was at annual rate of less than 2 percent (2 placements in six months, census of 276). Two individuals were placed in the community since the last review. Of note was that both individuals were highly involved in their own transitions and had complicated behavioral issues.
- Ten individuals were on the active referral list. This was the largest number of individuals on the active referral list since the initiation of the Settlement Agreement.
- Some, but not all, ISP assessments included the professional's determination and opinion regarding referral. Review of written ISPs, and observation of an ISP meeting, indicated that the professionals' determinations were discussed during the annual ISP meetings.
- CLDPs specified actions to be taken and showed involvement of the individuals and LARs. The CLDPs identified the need for training for community provider staff, but very little detail was provided regarding this training.
- More ENE supports were included that related to individual's overall preferences as well as the needs of the individuals, and there were ENE supports that were individualized. Much improvement, however, was still needed. For instance, the supports did not adequately address the individuals' complicated behavioral and psychiatric histories, psychiatric diagnoses, and various psychotropic medications. Further, there was little planning for problems that might arise after the newness of the transition had worn off, especially given the psychiatric histories and diagnoses of both individuals (e.g., BPD).

- SASSLC did not maintain substantial compliance with provision T2a. This was due to the absence of a thoroughness of post move monitoring as evidenced in the reports, lack of follow-up in cases where the PMM indicated that further monitoring was needed, and due to the absence of post move monitoring IDT meetings for six of the eight post move monitoring visits.
- The monitoring team visited the two individuals who had moved since the last onsite review. Both individuals were happy in their new homes.

Consent

- IDTs were not adequately addressing the need for a LAR or advocate. At the HRC meeting observed, committee members engaged in limited discussion regarding the need for the proposed restrictions prior to giving approval. The HRC did not address individual's ability to give informed consent in regards for the need for guardianship when reviewing rights assessments.
- The facility had established a committee to develop an action plan, and to develop a process for integration of consent discussion within the ISP process. The facility also established a Guardianship Committee and developed a process of identifying and prioritizing a list of individuals that need guardianship at the facility.

Recordkeeping Practices

- There were continued improvements in recordkeeping activities and records management. Overall, the active records were organized and well maintained. There continued to be problems in all current documents being in the record, legibility of entries, and proper signatures. Some steps had been taken (e.g., green card in the individual notebook, yellow card for nurses, training for staff and clinicians). The IPNs had entries other than only handwritten notes, such as emails and typed notes.
- Overall, the individual notebooks were well organized and available. A master record was in place for every individual. They were put together nicely and in a consistent manner. There was still no satisfactory resolution as to what to do when items could not be located.
- The URC continued to conduct five thorough quality assurance audits each month of all three components of the record. She held a high and appropriate standard for physicians' orders, IPN entries, and observation notes.
- The URC should create a set of graphs as described in V3, and that these graphs should be included in the facility's QA program.

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

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy: Use of Restraints 001 o Restraint Documentation Guidelines for SSLCs dated November 2008 o SASSLC Draft Procedures Regarding the Use of Sedation and/or Restraint for Dental and/or Medical Treatment o SASSLC FY11 Trend Analysis Report o SASSLC Plan of Improvement o SASSLC Section C Presentation Book o Training Curriculum for RES0105 Restraint: Prevention and Rules for Use at MR Facilities o PMAB Training Curriculum 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 List of individuals with desensitization plans (7) o Dental desensitization plans for: • Individual #160, Individual #77, Individual #279, and Individual #114 o Restraint Reduction Committee meeting minutes for past six months o List of all individuals who had a Safety Plan for Crisis Intervention o Training transcripts for 24 SASSLC employees o Documentation for pretreatment medical sedation for: • Individual #105, Individual #248, Individual #241, Individual #302, Individual #256, Individual #235, Individual #250, Individual #156, Individual #181, and Individual #38 o PBSPs, Safety Plans, and ISPAs for: • Individual #148, Individual #85, and Individual #83

- A sample of restraint documentation including:

Individual	Date/Type P = Physical C = Chemical	Restraint Checklist and Face to Face Assessment	ISP ISPA	PBSP	Safety Plan
#83	10/21/11P	x x	11/7/11 8/23/11 (A) 8/9/11 (A) 7/27/11 (A) 7/7/11 (A) 6/28/11 (A) 6/28/11 (A)	11/7/11	10/3/11
	10/24/11P	x x			
	10/24/11C	x x			
	10/28/11 P	x x			
	10/29/11 P (x2)	x x			
	11/13/11 P (x2)	x x			
#85	8/29/11 P	x x	6/16/11 9/13/11(A) 9/21/11 (A) 9/2/11 (A) 9/13/11 (A)	6/16/11	9/14/11
	9/14/11 P	x x			
	9/15/11 C				
	11/08/11 C	x x			
#195	8/30/11 P	x x	9/20/11 8/8/11(A) 9/2/11 (A) 9/15/11 (A) 9/26/11 (A) 10/4/11 (A)	9/20/11	10/3/11
	9/16/11 C	x x			
	9/23/11 P (x3)				
#232	12/6/11 P (x2)	x x	10/21/11 11/29/11 (A)	10/19/11	10/19/11
#184	10/16/11 C	x x	7/14/11		
#148	10/5/11 C	x x	1/26/11 3/4/11 (A)	10/3/11	10/3/11
	12/11/11 P	x x			
#111	10/29/11 C	x x	11/16/10	11/18/11	11/18/11
	11/2/11 C	x x			

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

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Michelle Enderle-Rodriguez, Incident Management Coordinator
- Daisy Ellison, Psychology Coordinator
- Audrey Wilson, QDDP Coordinator
- Gevona Hicks, Human Rights Officer

	Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 2/14/12 o Incident Management Review Team Meeting 2/14/12 and 2/15/12 o Human Rights Committee Meeting 2/16/12 o Restraint Reduction Committee Meeting 2/15/12
	Facility Self-Assessment: SASSLC submitted its self-assessment. It was updated on 2/2/12. It 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 to correct 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 self-assessment 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, however, had not made much progress in addressing those issues. The facility rated itself as being in substantial compliance with item C2. The monitoring team did not find the facility in compliance with any of the provisions in Section C. The facility, however, 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. The facility had implemented an audit process using the tools developed by the state office to measure compliance with the Settlement Agreement. The findings from the facility's monthly audit process were not used to self-assess compliance.
	Summary of Monitor's Assessment: Based on information provided by the facility in a list of all restraints used for crisis intervention, between 8/25/11 and 2/3/12: • 131 restraints occurred. • Of these, 89 were programmatic restraints, • 42 were emergency restraints, • 99 were physical hold restraints, • 2 were mechanical restraints (unknown type and wristlets for self injurious behavior), and

	• 30 were chemical restraints. • 12 individuals were the subject of restraints. During observation at the facility, it was found that some mechanical restraints being used to address self-injurious behavior were classified as medical restraints by the facility and, therefore, were not routinely reviewed by IDTs, addressed in behavior support plans, or reported in terms of restraints at the facility. These included mittens, wrist ties downs, helmets, and abdominal binders. This needs to be corrected. According to the facility self-assessment, action taken by the facility to address compliance with section C since the last monitoring visit included: • Nurses had been inserviced on nursing services regarding restraints. • Restraint monitors had been inserviced on restraints. • The facility began a self-assessment process using the statewide Section C audit tool. • Restraint audits were being completed monthly using the Section C audit tool developed by the state office for a sample of restraints. • A template was developed to be used by IDTs for determining the need for medical and dental desensitization plans. Issues identified during the previous monitoring visit continued to be areas of concern regarding training, the documentation of events leading to restraint, monitoring by nursing staff, and review of restraints incidents. Progress had not been made towards meeting the requirements of Section C.

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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	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 16 physical and 8 chemical restraints for the seven individuals with the greatest number of restraints (out of a total number of 12 individuals who had been restrained). The individuals in this sample were Individual #83, Individual #85, Individual #195, Individual #148, Individual #111, Individual #184, and Individual #232. • Individual #83 had the greatest number of restraints, accounting for 31 (24%) of the 131 restraints for crisis intervention in the six months prior to the monitoring visit. • Individual #85 and Individual #195 had the second greatest number each with 25 (19%) of the restraints. • Individual #148 had 15, accounting for 11% of the total number of restraints. • Individual #111 had 11, accounting for 8% of the total number of restraints. • Individual #184 and #232 each had 7 restraints, accounting for 5%.	Noncompliance

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	accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Prone Restraint 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 a review of 16 physical restraint records for individuals in Sample #C.1 involving seven individuals, 0 (0%) showed use of prone restraint. Other Restraint Requirements 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. It was not evident from documentation reviewed that restraint was always used as a last resort measure or that the restraint method used was the least restrictive method of intervention Restraint records were reviewed for Sample #C.1 that included documentation for 24 restraints. The following are the results of this review: • In 24 of the 24 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In 6 of 24 (25%) restraints, staff documented events leading to the behavior that resulted in restraints. • Some example where staff adequately described events leading to the behavior: o The restraint checklist for Individual #85 dated 9/14/11 noted he became upset because he wanted to see his girlfriend and couldn't. o The restraint checklist for Individual #195 dated 9/23/11 indicated that she was upset with peers over the kind of music that they were listening to. o The checklist for Individual #232 dated 12/6/11 indicated that he became upset when staff told him that his shirt was not a school uniform. • 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 #83 on 10/24/11, staff documented "trying to UD. Sitting and kicking staff." There was no documentation of the events leading up to the restraint. o On the restraint checklist for Individual #83 dated 10/29/11 the description of events leading to the behavior noted "aggression,	

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		attempted UD after several restraints. " Staff did not document in what activity the individual was involved prior to the incident. o The restraint checklist for Individual #184 indicated "she is SIB-ing, attacking staff and peers." • In 23 of 24 the records (96%), 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. The exception was: o The chemical restraints for Individual #184 dated 10/16/11, which indicated that a chemical restraint was used when the individual did not respond to verbal prompts. • In 16 of 16 instances where physical restraint was used, documentation indicated that a horizontal restraint was used without an attempt to utilize a less restrictive physical hold. • In 8 of 24 (25%) instances of restraint, a chemical restraint was administered for crisis intervention. A total of 30 chemical restraints had been used in the six month period prior to the monitoring visit. 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. Observation in the residential settings, however, indicated that progress had been made on addressing environmental factors contributing to behavioral incidents. Based on observations in day programs, engaging individuals in more individualized and meaningful programming of interest would likely reduce behavioral incidence leading to restraints. During the monitoring visit, the monitoring team raised some concerns over individuals who were wearing protective equipment (abdominal binders, wrist tie downs, helmets, and mittens) for self injurious behaviors. IDTs were not addressing alternate strategies to reduce the use of protective equipment. The facility should ensure that these protective restraints are documented, monitored, and reviewed as are all restraints. Plans to reduce the behavior resulting in restraint should be addressed by the IDT. Facility policies identified a list of approved restraints techniques. Based on the review of documentation for 24 restraints, 24 (100%) were documented as approved restraints	

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		techniques. <u>Dental/Medical Restraint</u> The facility provided a list of pretreatment sedation and medical restraints between 8/1/11 and 12/15/11: • 49 individuals were the subject of pretreatment sedation or mechanical restraints during dental appointments. • 61 incidents of pretreatment sedation for dental appointments occurred. • 29 incidents of mechanical restraint for dental appointments occurred. Additionally, a list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there were four medical desensitization plans in place. The facility was still in the beginning stage of developing desensitization plans and/or strategies to minimize the use of medical and dental restraints. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, and all interventions attempted prior to restraint. Desensitization programs should be developed for those individuals requiring the use of pretreatment sedation for routine medical appointments. The long term use of mechanical restraints should be reviewed periodically by the IDT and strategies should be developed to reduce the amount of time in restraint. A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs. When restraint is used, staff should follow PMAB guidelines for applying the least restrictive restraint type necessary.	
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 for the seven individuals in Sample #C.1 were reviewed. Of these, six of the individuals had a Safety Plan for Crisis Intervention (SPCI) that gave direction for the use of restraint. The SPCI for Individual #85 did not include release criteria for physical restraints. Nine individuals at the facility had an SPCI in place at the time of the review. A sample of restraint documentation for 16 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. • Nine of 16 (56%) restraints reviewed indicated that the individual was released immediately when no longer a danger. • Three restraint checklists indicated that Individual #13 was released after the maximum allowed by her safety plan (five minutes). • The restraint checklist for Individual #85 dated 8/29/11 did not include a	Noncompliance

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		release code indicating his behavior at the time of release. • Six restraint checklist in the sample for Individual #83 indicated that she was released according to her safety plan. Her safety plan did not include criteria for release from a physical restraint. Restraints in the sample lasted from one minute to 10 minutes in duration. SPCIs should include specific behavioral indicators to identify when release from restraint should be attempted based on knowledge about that individual. Staff should document behavior at the time of release on the restraint checklist. The facility was not in substantial compliance with this item.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 24 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 • 19 of 24 (79%) had current training in RES0105 Restraint Prevention and Rules. • 15 of the 19 (79%) employees with current training completed the RES0105 refresher training within 12 months of the previous training. • 23 of 24 (96%) had completed PMAB training within the past twelve months. • 11 of the 23 (49%) completed PMAB refresher training within 12 months of previous restraint training. The facility remained out of substantial compliance with this provision item. Employees will need to complete training annually as required by the facility policy in order to gain substantial compliance.	Noncompliance
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.	Based on a review of 24 restraint records (Sample #C.1), 24 (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.	Noncompliance

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	No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The facility had not developed treatments or strategies for all individuals who required the use of restraint for routine medical care. According to a list provided to the monitoring team, desensitization programs had been developed for seven individuals who needed pretreatment sedation or restraint to have routine medical or dental care completed. A sample of four plans that had been implemented was submitted to the monitoring team for review. Three of the individuals in this sample were not included on the list of all individuals with plans in place. The four plans included individualized strategies for each person. The facility had created a "Do Not Restrain" list. There were 99 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. The list did not specify what types of restraints should not be used. Twenty-four individuals (25%) on this list had been the subject of restraint incidents according to documentation provided by the facility. For example, • Individual #256 – mechanical and chemical restraint for medical appointments on two separate dates. • Individual #181 - mechanical and/or chemical restraint for dental appointments on three dates in the past six months. • Individual #105 - mechanical, physical, and chemical restraint for medical and dental procedures on two dates • Individual #108 – mechanical and chemical for dental procedures on two dates • Individual #166 – mechanical and chemical for dental procedures on two dates. • Individual #184 – mechanical and chemical for dental procedures on two dates • Individual #77 – mechanical and chemical for dental procedures on two dates. • Other individuals appearing on both the "Do Not Restrain" list and list of individual's restrained for medical and/or dental appointments included: Individual #45, Individual #198, Individual #293, Individual #349, Individual #302, Individual #104, Individual #214, Individual #119, Individual #238, Individual #253, Individual #65, Individual #80, Individual #180, Individual #309, Individual #72, Individual #236, and Individual #247. IDTs should discuss the need for restraints during medical and dental procedures, and develop individual specific strategies to try to reduce or eliminate the need for restraint. The facility's "Do Not Restrain" list should specify which types of restraints should not be used due to the risk of harm. The facility was not in compliance with this provision.	

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C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	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 24 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 24 out of 24 incidents of restraint (100%), there was assessment by a restraint monitor. • In the 24 instances of restraint where there was a face-to-face assessment form completed, the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in 22 (92%) instances. Two assessment forms for Individual #83 dated 10/21/11 and 10/29/11 did not include the time that the restraint monitor arrived. Based on a review of 24 behavioral restraint records for restraints that occurred at the facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in nine (36%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #83 dated 10/21/11, 10/24/11 (x2), 10/29/11 (x2), 10/28/11, and 11/13/11 (x2). No documentation of monitoring was provided. The second page of the restraint checklist for restraints on 10/24/11 and 10/29/11 was a list of vital signs with no time given. It appeared that the second page was copied and used for all restraint incidents on these two days. o Individual #85 dated 8/29/11, and 9/14/11: no assessment was documented for either of these two restraints. A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Eight of 10 (80%) documented monitoring by a licensed health care professional at least every 30 minutes from the initiation of the restraint. The exceptions were instances of dental pretreatment sedation for Individual #235 dated 12/8/11 and Individual #Individual #105 dated 12/7/11. The facility remained out of compliance with this provision. Monitoring and post restraint review should be conducted and documented as required by state policy.	Noncompliance
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to	A sample of 24 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 24 (100%), continuous one-to-one supervision was indicated as having been	Noncompliance

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	exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	provided. • In 24 (100%), the date and time restraint was begun were indicated. • In 24 (100%), the location of the restraint was indicated. • In 24 (100%), information about what happened before, including the change in the behavior that led to the use of restraint, was indicated. Only six (25%) indicated what events were occurring that might have led to the behavior (see section C1). • In 24 (100%), the specific reasons for the use of the restraint were indicated. • In 24 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 24 (100%), the names of staff who applied/administered the restraint was recorded. • In 16 (100%) of 16 observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In 16 (100%) of 16 physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 18 (75%), 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. The exceptions were the restraints for Individual #85 dated 8/29/11 and 9/14/11 and for Individual #83 dated 9/16/11 and 9/23/11 (x3). • Based on the documentation reviewed, restraints did not appear to interfere with mealtimes or that any individual was denied the opportunity to use the toilet. The longest restraint in the sample was 10 minutes in duration. The facility reported that if any restraint interferes with mealtime or toilet use, it should be documented in the restraint form. In a sample of 24 records (Sample #C.1), restraint debriefing forms had been completed for 24 (100%). A sample of 10 restraint checklists for individuals receiving medical pretreatment sedation was reviewed to ensure one-to-one supervision was provided. One-to-one supervision was documented in all 10 (100%). The facility was not in substantial compliance with this provision. As noted in C1, 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. Results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects should be documented.	

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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 six individuals were placed in restraint (and/or received chemical restraint) more than three times in a rolling 30-day period. Three of these individuals (i.e., Individual #83, Individual #148, and Individual #85) were reviewed (50%) to determine if the requirements of the Settlement Agreement were met. PBSPs, safety plans, and individual support plan addendums (ISPAs) that occurred as a result of more than three restraints in a rolling 30-day period were also requested for all three individuals. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. This item was rated as being in noncompliance because none of the ISPA meeting minutes reviewed appeared to be specifically in response to more than three restraints in a rolling 30-day period, and none were organized so as to ensure that each of the issues below were discussed. This represents regression from the last report when all of the ISPA meeting minutes were organized around the categories listed below. Finally, in order to achieve compliance with this item, SASSLC needs to document that each individual's PBSP had been implemented with integrity, that specific procedures for training replacement behaviors for behaviors that provoke restraint had been developed, and that PBSPs had been revised when necessary (i.e., data-based decisions are apparent). None of the three ISPAs reviewed reflected a discussion of how an individual's adaptive skills, and biological and/or psychological factors that may have contributed to the behaviors that provoked restraint. As discussed in the last review, 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. The minutes from all ISPA meetings following more than three restraints in a rolling 30-day period should reflect a discussion of the potential role of adaptive skills, and biological, medical, and psychosocial issues, and if they are hypothesized to be relevant to the behaviors that provoke restraint, a plan to address them.	Noncompliance

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	(b) review possibly contributing environmental conditions;	None of the ISPA meeting minutes reviewed reflected a discussion of possible contributing environmental factors. Examples could include such things as noisy environments and suggestions for reducing noise to prevent the future probability of restraint. All ISPA minutes of meetings in response to more than three restraints in a 30-day period, 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 assessments of the behavior provoking restraints;	This item is concerned with a review of potential environmental antecedents to the behaviors that provoke restraint. None of the ISPA minutes reviewed reflected a discussion of potential environmental antecedents. Examples of possible environmental antecedents include things such as the cancelling of an outing or being told to wait. In order to achieve compliance with this provision item, ISPA minutes need to reflect a discussion of the effects of these types of variables on the individual's restraint, and (if they are hypothesized to affect restraints) a discussion of an action plan to eliminate these antecedents or reduce their effects on the dangerous behavior that provokes restraint.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. None of the ISPAs reviewed included a discussion of a variable or variables maintaining the dangerous behavior that provoked restraint. An example of what could be included here is an individual whose ISPA reflected a conversation that his or her physical aggression that often leads to restraint might be maintained by escape or avoidance of undesirable activities. The intervention, or action based on that hypothesis, could be to establish and reinforce a behavior a functional replacement behavior (see K9), such as communicating that the individual wants a break. All ISPAs should document a discussion of variables that may be maintaining the dangerous behavior that provoked restraint. This discussion should also include how these functions will be addressed (e.g., establishing and reinforcing replacement behaviors) 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	All three of the individuals reviewed (100%) had PBSPs to address the behaviors provoking restraint. The following was found: • Three (100%) were based on the individual's strengths; • Two (67%) of the PBSPs reviewed (Individual #148 was the exception) specified the objectively defined behavior to be treated that led to the use of the restraint	Noncompliance

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	be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	(see K9 for a discussion of operational definitions of target behaviors); • None (0%) of the PBSPs reviewed specified the alternative, positive and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and • All three of the PBSPs (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Two of the three PBSPs reviewed (67%) to weaken or reduce the behaviors that provoked restraint, however, were determined to be incomplete (i.e., Individual #83, and Individual #148) because they did not contain clear, precise interventions based on a functional assessment (see K9). The three Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In all three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In three (100%) of the four safety plans reviewed, 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.	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	Restraint incidents were reviewed daily in the Daily Unit meetings. Restraint incidents were also referred to the IDT for follow-up. See C7 for comments on review by the IDT. A sample of Face-to-Face Debriefing and Review Forms related to 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, Unit Psychologist, IMT, AOD, and	Noncompliance

#	Provision	Assessment of Status	Compliance
	days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	Psychology Director. • Eight (34%) restraints in the sample indicated review of the restraint by the AOD on the day of the restraint incident. • There was no indication that this review resulted in recommendations or additional staff training when warranted. For instance, the restraint checklist for individual #83 dated 10/29/11 was written over an already completed checklist from 10/24/11. The individual was not released according to criteria in her safety plan, which stated attempt release after five minutes. Staff documented a release code of J (met safety plan definition of calm and was released) after seven minutes. An assessment was not completed by nursing staff. The AOD did not note problems with the restraint or with documentation of the restraint. The facility did not adhere to restraint monitoring and review requirements for all protective mechanical restraints used for self-injurious behaviors, since some of these restraints were classified as medical restraint. The facility should ensure that these protective restraints are documented, monitored, and reviewed. For example, Individual #96 had his wrist tied down to prevent removing his tracheotomy. According to staff, his wrist had been tied down "for years." His wrist was only released for five minutes each hour. There was no plan in place to utilize those five minute periods for planned movement or exercise. There was no evidence that the team periodically reviewed this restraint or had attempted to develop strategies to allow for release from the restraint longer periods of his day. The team should meet with therapy and psychology staff to try to develop a plan to release his hand for activity, movement, or even massage for a period of time each day. Similarly, there were other individuals wearing mittens or helmets for a majority of their day. Teams should review all uses of mechanical restraints and document attempts at reducing the use of these restraints. 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 application, monitoring, or documentation. As noted throughout Section C, nursing assessments were not completed as required, yet, this was not noted in review of the restraint documentation.	

Recommendations:

1. The facility needs to ensure all restraints are documented and included in data collected and resulting trend reports in order to ensure adequate review has been completed (C1, C8).

2. The long term use of mechanical restraints should be reviewed periodically by the IST and strategies should be developed to reduce the amount of time in restraint. A schedule for monitoring the restraint and directions for the frequency of release from restraint should be included in ISPs (C1).

3. When restraint is used, staff should follow PMAB guidelines for applying the least restrictive restraint type necessary (C1).

4. 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).

5. The facility should ensure that protective restraints are documented, monitored, and reviewed. When applicable, plans to reduce the behavior resulting in restraint should be addressed by the IDT (C1).

6. 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).

7. SPCIs should specify specific behavioral indicators to identify when release from restraint should be attempted (C2, C4).

8. IDTs should discuss the need for restraints during medical and dental procedures and strategies should be developed to try to reduce or eliminate the need for restraint (C2, C4).

9. The facility's "Do Not Restrain" list should specify which types of restraints should not be used due to the risk of harm (C4).

10. Monitoring and post restraint review should be conducted and documented as required by state policy (C5).

11. Results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects should be documented (C6).

12. 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).

13. Continue to monitor restraints and retrain staff as necessary (C8).

14. 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:** <u>Documents Reviewed</u>: o Section D Presentation Book o SASSLC Plan of Improvement o DADS Policy: Incident Management #002.2, dated 6/18/10 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021 dated 6/18/10 o MH&MR Investigations Handbook Commencement Policy Effective 8/1/11 o Information used to educate individuals and their LAR on identifying/reporting unusual incidents o Incident Management Committee meeting minutes for each Monday of the past six months o Human Rights Committee meeting minutes for the past six months o Three most recent five-day status reports o Training transcripts for 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired in the past two months (48) o List of staff who failed to report abuse, neglect, or exploitation (0) o List of reporters that are known to be an individual or LAR (0) o Training and background checks for the last three employees hired o Training transcripts for facility investigators (7) o Training transcripts for DFPS investigators assigned to complete investigations at SASSLC o Abuse/Neglect/Exploitation QA Trend Reports o Injury Trend Reports 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 ISPs for: • Individual #83, Individual #160, Individual #55, Individual #72, Individual #96, Individual #106, Individual #150, Individual #194, Individual #232, Individual #127, Individual #32, and Individual #86. o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, BSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of all injuries for the past six months o List of all A/N/E allegations since 8/1/11 including case disposition o List of all investigations completed by the facility since 8/1/11 o List of employees reassigned due to ANE allegations

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

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#40278865	Neglect (3) Physical Abuse (1)	Confirmed (3) Inconclusive (1)	9/18/11 12:55 pm	9/19/11 4:12 pm	10/13/11
#40269362	Physical Abuse (2)	Unconfirmed (2)	9/9/11 5:10 pm	9/12/11 1:13 pm	9/21/11
#40275806	Physical Abuse	Unconfirmed	9/15/11 12:17 pm	9/16/11 3:47 pm	9/24/11
#40296823	Physical Abuse	Unfounded	10/3/11 4:16 pm	10/6/11 3:28 pm	10/17/11
#4032477	Physical Abuse	Confirmed	10/23/11 12:38 am	10/25/11 8:10 am	11/2/11
#40475724	Neglect (5)	Unconfirmed (3) Confirmed (2)	11/2/11 1:49 pm	11/4/11 10:45 am	11/12/11
#40572156	Physical Abuse (4)	Unconfirmed (3) Other (1)	11/13/11 7:42 pm	11/15/11 1:48 pm	11/22/11
#40682556	Neglect (4)	Confirmed (4)	11/26/11 4:33 am	11/28/11 3:2 am	12/6/11
#40791976	Physical Abuse	Unconfirmed	12/6/11 8:01 pm	12/7/11 3:45 pm	12/16/11
#40716744	Neglect (2) Physical Abuse (2)	Unconfirmed (2) Unconfirmed (2)	11/28/11 11:58 pm	11/29/11 11:12 am	12/8/11
#40828551	Neglect (1) Physical Abuse (1)	Confirmed (1) Unconfirmed (1)	12/9/11 4:04 pm	12/12/11 5:30 pm	12/22/11
#40954456	Emotional/Verbal Abuse	Unconfirmed (1)	12/23/11 4:17 pm	12/24/11 1:00 pm	1/3/12
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**		
#40310945	Neglect	Clinical Referral	10/14/11		
#40475431	Neglect	Administrative Referral	11/2/11		
#402599788	Neglect	Clinical Referral	10/5/11		

Sample D.3	Type of Incident	Date/Time of Incident	Director Notification		
#12-002	Encounter with Law Enforcement	9/2/11 5:15 pm	9/2/11 6:46 pm		
#012-009	Encounter with Law Enforcement	9/16/11 10:35 pm	9/17/11 4:09 am		
#12-012	Encounter with Law Enforcement	9/23/11 9:30 pm	9/23/11 8:30 pm		
#12-029	Encounter with Law Enforcement	11/14/11 2:00 pm	11/15/11 11:20am		
#12-030	Encounter with Law Enforcement	12/5/11 9:15 am	12/6/11 3:50 pm		
#12-033	Serious Injury	12/16/11 6:30pm	12/16/11 10:15 pm		
#12-034	Serious Injury	12/28/11 7:00 am	12/28/11 7:25 am		
#12-036	Serious Injury	12/31/11 6:50 pm	12/31/11 7:28 pm		

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Michelle Enderle-Rodriguez, Incident Management Coordinator
- Daisy Ellison, Psychology Coordinator
- Audrey Wilson, QDDP Coordinator
- Gevona Hicks, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Daily Unit Meeting 2/14/12
- Incident Management Review Team Meeting 2/14/12 and 2/15/12
- Human Rights Committee Meeting 2/16/12
- Annual IDT meeting for Individual #311 on 2/10/12
- Quarterly IDT meeting for Individual #111 on 2/15/12
- QDDP meeting on 2/15/12

Facility Self-Assessment:

SASSLC submitted its self-assessment. It was updated on 2/1/12. The facility indicated that it had begun using the statewide audit tools for Section D to assess compliance with the provisions of the Settlement Agreement.

	The self-assessment, however, did not indicate how the findings from any activities of the self-assessment were used to determine the self-rating of each provision item. Furthermore, findings from the self-assessment did not always agree with the compliance rating assigned by the facility. For example, the comment for D2b noted that of the four cases reviewed, there was an overall compliance rating of 100%, however, the compliance rating was "N" for noncompliance. The facility indicated that SASSLC was in substantial compliance with 14 of 22 provisions in section D of the Settlement Agreement. The monitoring team found that the facility was in compliance with 15 of 22 provisions. As discussed below, the monitoring team did not find evidence to support substantial compliance with provisions D1, D2a, D2c, D2d, D2e, D3g, and D4. The facility noted some processes that were in place to address certain provisions, but did not indicate if those processes were audited for effectiveness in all cases or state what actions had been taken to address any deficiencies. 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. To take this process forward, the monitoring team recommends that the IMC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report.
	Summary of Monitor's Assessment According to information provided to the monitoring team, DFPS confirmed two allegations of physical abuse and 25 allegations of neglect from 8/3/11 through 12/26/11 (less than five months). DFPS investigated a total of 193 allegations of abuse, neglect, or exploitation. This included 68 allegations of physical abuse, 26 allegations of emotional/verbal abuse, and 99 allegations of neglect. This was an increase in reported allegations from the previous monitoring visit, however, the number of confirmed allegations was the same. A list of all serious incidents investigated by the facility during the previous six months was also requested by the monitoring team. The facility provided a summary of incidents from the six months prior to the monitoring visit. There were an additional 38 serious incidents, listed below, at the facility that did not involve allegations of abuse or neglect investigated by the facility.

Incident Type	Total
Serious Injury- Determined Cause	21
Peer to Peer Aggression w/ Serious Injury	2
Serious Injury – Undetermined Cause	3
Choking	0
Unauthorized Departure	4
Death	4
Encounter with Law Enforcement	2
Other	2

According to the facility's QA report dated December 2011, there were a total of 990 injuries reported between 8/1/11 and 12/31/11. Through the week of the onsite review, there had been a total of 782 injuries for the fiscal year 2012 (since 9/1/11). This was an increase from the same period for FY 2011. Of the 782 injuries in FYI 2012, 25 of those were serious injuries involving fractures or sutures compared to 11 for the same period in FYI 2011.

The facility had taken steps to address concerns related to incident management at the facility. Some positive steps taken to address the provisions of section D included:

- SASSLC had created an AOD position to provide administrative presence and oversight during off-hours, weekends, and holidays.
- The Abuse and Neglect Coordinator and the QA Program Auditor had inserviced the AODs on incident management policies and reporting guidelines.
- The facility began using the new state office Avatar system for documenting investigations.
- The DADS Section D Monitoring Tool was implemented.

As noted in the findings for section D, it was not apparent that some of these steps had adequately addressed concerns noted in previous monitoring reports. Improvements were made in the documentation of activities taken during the investigation process. The facility needs to focus next on:

- Creating a database that accurately identifies all unusual incidents.
- Ensuring all staff know reporting procedures for unusual incidents.
- Ensuring investigation files include documentation of all notifications.
- Ensuring that the facility audit system accurately identifies areas of needed improvement.

There continues to be a high number of incidents and injuries 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 and take action to reduce the number of incidents and injuries.

#	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. The facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the facility director or designee. 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. As noted in the previous monitoring report, posters 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 statewide 800 number. • Competency-based training on abuse and neglect (ABU0100) was required annually for all employees. Training transcripts for 24 current employees at the facility were reviewed for current ABU0100 training. Of these, 24 (100%) had completed the course ABU0100 in the past 12 months. However, only 45% had completed the training annually as required by state policy. According to facility policy, employees at SASSLC were required to sign a form titled Acknowledgement of Responsibility for Reporting Abuse/Neglect Incident(s) form during pre-service training and every 12 months thereafter. Completed forms were requested by the monitoring team for a random sample of 24 employees. • All (100%) had signed a form acknowledging responsibility to report abuse and neglect within the past 12 months. • The monitoring found that employees in three refresher classes held on 2/21/11, 2/23/11, and 4/13/11 had not signed the acknowledgement form. Of the 24 employees in the sample, three had attended one of these sessions. During the review week, they were asked to sign the acknowledgement form. Other attendees at these three sessions were not asked to sign these forms.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Signed forms were provided for all employees hired within the past two months. One employee had signed the form, but not dated it. • The facility provided a copy of the signed acknowledgement for 48 new employees. Documentation of disciplinary action was reviewed for four cases in Sample #D1 in which DFPS substantiated an allegation of abuse or neglect and the AP was known. In all cases, disciplinary action was taken by the facility. Disciplinary action ranged from a written warning regarding the allegation of neglect in DFPS case #40828551 to termination in case #4032477 for an allegation of physical abuse. The facility reported that no evidence had been found that an employee had failed to report suspected abuse or neglect since the last monitoring visit. The facility was not in substantial compliance with this provision. The facility needs to ensure that all employees attend training on identifying and reporting abuse, neglect, and exploitation annually. The facility should also ensure that all employees sign an acknowledgement to report abuse and neglect at least annually.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious	According to DADS Incident Management Policy 002.3, staff were required to report abuse, neglect, and exploitation within one hour by calling DFPS. With regard to other serious incidents, the state policy addressing Incident Management required that all unusual incidents be reported to the facility director or designee within one hour of witnessing or learning of the incident. This included, but was not limited to: • Allegations of abuse, neglect, or exploitation, • Choking incidents • Death or life-threatening illness/injury • Encounter with law enforcement • Serious injury • Sexual incidents • Suicide threats	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Theft by staff, and • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a list of abuse, neglect, and exploitation investigations provided to the monitoring team, investigation of 81 cases involving 193 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility since the last monitoring visit. From these 193 allegations, there were: • 68 allegations of physical abuse, o 2 were substantiated, o 56 were unsubstantiated, o 1 was unfounded o 7 were inconclusive, and o 2 outcomes were pending. • 26 allegation of emotional/verbal abuse, o 23 were unsubstantiated, and o 3 outcomes were pending. • 99 allegations of neglect, o 25 were substantiated, o 39 were unsubstantiated, o 6 were inconclusive, o 4 were pending, and o 25 were referred back to the facility for investigation (four of which were for clinical reasons). According to a list provided to the monitoring team, the facility investigators conducted investigations for 38 additional serious incidents since the previous monitoring visit. From investigations since 8/1/11 reported by the facility, 23 investigations were selected for review. The 23 comprised three samples of investigations: • Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation. See the list of documents reviewed for investigations included in this sample. • Sample #D.2 included a sample of facility investigations that had been referred back to the facility by DFPS for further investigation. • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS.	

#	Provision	Assessment of Status	Compliance
		Based on a review of the 12 investigative reports included in Sample #D.1: • 10 of 12 (80 %) reports in the sample indicated that DFPS was notified within one hour of the incident or discovery of the incident. Two instances of late reporting were identified: o In DFPS Case #40278865, staff documented a bruise to the victims groin area at 11:30 am. He reported that someone had hit him. The allegation was reported to DFPS at 12:55 pm. o In DFPS case #40382477, a witness to the incident did not report physical abuse within one hour to DFPS. • Seven (58%) indicated that the facility director or designee was notified within one hour. Exceptions were DFPS Cases #40275896, #4032477, #40572156, #40716744, and #40954456. • Eleven of 11 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • One of 12 (8%) indicated that the state office was notified as required. The cases that included documentation of state office notification was DFPS #40278865. In reviewing Sample D.3 (serious incidents), documentation indicated: • In five of eight (63%) were reported immediately (within one hour) to the facility director/designee. Exceptions included: o UIR #12-009 encounter with law enforcement o UIR #12-029 encounter with law enforcement o UIR #12-033 serious injury • Documentation of state office notification was found in four of eight (50%) UIRs. Exceptions included: o UIR #12-030 encounter with law enforcement o UIR #12-033 serious injury o UIR #12-034 serious injury o UIR #12-036 serious injury The facility used the Unusual Incident Report Form (UIR) designated by DADS for reporting unusual incidents in the sample. This form was adequate for recording information on the incident, follow-up, and review. A standardized UIR which contained information about notifications was included in: o 12 out of 12 (100%) investigation files in Sample #D.1. o 12 of 12 (100%) investigation files in Sample #D.2 and Sample #D.3. Twenty-four serious injuries occurring since 8/11/11 were reviewed to determine if serious injuries were reported for investigation.	

#	Provision	Assessment of Status	Compliance
		• According to a list of all investigations completed by the facility, all serious injuries had been investigated. • Of the three serious injuries reviewed in Sample #D.3, one (33%) was reported to the facility director within one hour of determination of a serious injury. The other two were reported late to the facility director. 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 48 new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees (100%) in the sample had signed this form. A noted in D1, not all employees had signed the form annually as required by facility policy. 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. The facility was not in substantial compliance with the reporting requirements of this provision. The facility needs to ensure that all entities are notified when required by the nature of the incident within the appropriate timeline.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The facility did have a system in place for assuring that alleged perpetrators were removed from regular duty until notification was made by the facility Incident Management Coordinator. The facility maintained a log of all alleged perpetrators reassigned with information about the status of employment. Based on a review of 10 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. The monitoring team was provided with a log of employees who had been reassigned since 8/4/11. The log included the applicable investigation case number, the date of the incident, and the date the employee was returned to work or in some cases was discharged. In 12 out of 12 cases (100%) where the AP was known, there was no evidence that the employee was returned to client contact prior to the completion of the investigation or when the employee posed no risk to individuals. The DADS UIR included a section for documenting immediate corrective action taken by the facility. Based on a review of the 12 investigation files in Sample D.1, 12 (100%) UIRs documented additional protections implemented following the incident. For example,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• In DFPS case #40269362, the UIR indicated that a physical assessment was completed by a nurse, the AP was placed in non-client contact positions, and the IDT met to determine if a change was needed in LOS. • For UIR #12-002, in regards to an unauthorized departure, the police department and the Critical Incident Team were notified to organize a search. When the individual was found, he was transported to the hospital. The standardized UIR form had recently been revised by the state office. All investigations were completed using the new UIR format. Description of corrective actions taken was much more detailed on these reports. The facility was in substantial compliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The 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. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 10 (45%) of 22 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 8 (36%) of the 22 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 direct support staff in various homes and day programs: • 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 last monitoring visit.	Noncompliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to	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 review of training curriculum provided to all employees at orientation and annually	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The statement was requested for new employees hired in the past two months and for a random sample of 24 other employees at the facility. All employees in the sample had signed this form within the past 12 months. • As noted above in D1, however, the monitoring team found that three (13%) of the 24 employees in the random sample signed this statement during the week of the onsite review (2/15/12) because they were included in the sample and the statement was missing from their files. They had taken the refresher course in February 2011 or April 2011. It was likely that there were no signed statements for the other attendees at these refresher sessions. The facility was not in substantial compliance with this item. The facility needs to ensure that all staff persons who are mandatory reporters of abuse or neglect sign a statement evidencing their recognition of their reporting obligations at least yearly.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review was conducted of the materials to be used to educate individuals, legally authorized representatives (LARs), or others significantly involved in the individual's life. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. 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. The facility indicated that an abuse and neglect pamphlet was included in the IDT invitation letter that was sent out to families to educate and support individuals and their primary correspondents. It further noted that this information was shared with individuals and their families at IDT meetings. A sample of 12 ISPs developed after 9/7/11 was reviewed for compliance with this provision. The sample included ISPs for Individual #83, Individual #160, Individual #55, Individual #72, Individual #96, Individual #106, Individual #150, Individual #194, Individual #232, Individual #127, Individual #32, and Individual #86. • Five (42%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if somebody abused them or they had a problem with staff. None of the individuals were able to point out the poster with the #800 on it at the home. As noted below, postings were evident at the facility.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Additionally training of individuals regarding this information is suggested. The facility was not in substantial compliance with this item. QDDPs continue to need to be reminded to include documentation in ISPs regarding the sharing of information on recognizing and reporting abuse, neglect, and exploitation.	
	(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 a human rights officer at the facility. Information was posted around campus identifying the rights officer with her name, picture, and contact information. The rights officer was known by individuals at the facility and was actively involved in meetings regarding abuse, neglect, and rights issues. The Human Right Officer was assigned to monitor postings in each living unit and day program and replace missing posters as necessary. 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 12 allegation investigations completed by DFPS (Sample #D.1), DFPS had notified law enforcement and OIG of the allegation in 11 (100%) when appropriate. The facility was in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of	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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	would not be tolerated by the facility and disciplinary action would be taken if this it occurred. The facility was asked for a list of staff who alleged that they have been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported zero cases where fear of retaliation was reported. Based on a review of investigation records (Sample #D.1), there was no concern noted related to potential retaliation for reporting. The facility rated itself in substantial compliance with this item. The monitoring team agreed with that assessment.	
	(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. All three (100%) of the investigations were completed using a standardized UIR. Appropriate recommendations were made for follow-up action in each case. The monitoring team observed daily IMRT meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Serious injuries, suspicious injuries, and trends of injuries were investigated further and recommendations were made by the team for follow-up. The facility had initiated a review process for non-serious discovered injuries. This appeared to be an effective process for ensuring injuries were adequately reported for investigation and investigated. As noted in D2a, an additional sample of serious client injury reports were reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. According to a list of all investigations completed by the facility, all serious injuries in the sample had been investigated. Based on observations and the sample of documentation reviewed, the facility's audit process was adequate for ensuring that injuries or trends of injuries were reported for investigation.	Substantial Compliance

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D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting investigations and working with people with developmental disabilities. 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 seven employees designated to complete investigations. The training records for those designated to complete investigations were reviewed with the following results: • Seven (100%) facility investigators had completed CIT0100 Comprehensive Investigator Training or CSI 0100 Conducting Serious Incident Investigations. • Seven (100%) had completed UNU0100 Unusual Incidents within the past 12 months. • Seven (100%) had completed ABU 0100 Abuse and Neglect Training within the past 12 months. • Six (86%) had completed Root Cause Analysis according to training transcripts reviewed. • Seven (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Additionally, facility investigators did not have supervisory duties. Therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility was in substantial compliance with this provision.	Substantial Compliance

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	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that facility staff had failed to cooperate with investigators in any of the cases.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The 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 12 investigations completed by DFPS (Sample #D.1), 11 had been referred to law enforcement agencies. OIG completed investigations in seven cases. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility stated that audit results indicated substantial compliance with this requirement. 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.3): • There was no indication that evidence was not safeguarded during any of the investigations. The facility remained in substantial compliance with this item.	Substantial compliance

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	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DFPS had implemented a new commencement policy effective 8/1/11. Mandates in the new policy were described in the MH & MR Investigations Handbook published on 10/1/11. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations from Sample #D1 and #D2: • Investigations noted the date and time of initial contact with the alleged victim. o This contact did not occur within 24 hours in 10 of 15 (67%) investigations. All 15 (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. For the eight where initial contact was not made with the alleged victim, this included gathering other documentary evidence and making initial contact with the facility. o Although this met DFPS guidelines for investigation commencement, an immediate interview with the alleged victim is the best way to ensure that the individual is able to relay accurate information to aid in the investigation. One example is relevant to this point: ▪ DFPS Case #40382477 involved a confirmed allegation of physical abuse with injuries. The alleged victim was not interviewed within the first 24 hours of the initial report. Although the investigator was able to confirm the allegation based on evidence gathered in the case, evidence may have been lost due to the delay in interviewing principals in the case. • Fourteen of 15 (93%) were completed within 10 calendar days of the incident. This was a vast improvement over the sample reviewed during the last monitoring visit. o Two extensions were filed in DFPS Case #40278865. The first extension indicated that a second interview was required with one of the witnesses in the case. The investigator had not attempted initial contact with the witness until the 10th day of the investigation. The second extension indicated that an interview was required with a facility psychologist who was out of town. An initial attempt at contact with the psychologist did not occur until the 18th day of the investigation. • All 15 (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 10 of the 15 DFPS investigations reviewed (67%), concerns or recommendations for corrective action were included. Three of those cases resulted in administrative referrals. Concerns were appropriate based on	Substantial Compliance

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		evidence gathered during the investigation of those cases. Facility Investigations The following summarizes the results of the review of investigations completed by the facility from sample #D.3 : • Eight of eight (100%) of the UIRs reviewed indicated when the investigation commenced. All investigations in the sample commenced within 24 hours of the incident. • Six of eight (75%) indicated that the investigator completed a report within 10 days of notification of the incident. UIR #12-009 and UIR #12-012 indicated that the investigations were completed almost three months after the incidents occurred. • Seven of eight (88%) investigations included recommendations for corrective action. Overall, recommendations appropriately addressed findings in the investigation. The exception was UIR #12-030. The recommendation section contained a statement regarding action that had already been completed. The facility was found to be in substantial compliance with investigation commencement and conclusion timelines. DFPS needs to ensure that initial contact with the alleged victim is conducted as soon as possible to prevent the loss in critical evidence in the case.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of	DADS Incident Management Policy required a UIR to be completed for each serious incident. The facility had begun using the new statewide AVATAR system to enter all incidents. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #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. DFPS Investigations The following summarizes the results of the review of DFPS investigations: • For the investigations in Sample #D.1, the report utilized a standardized format that set forth explicitly and separately, the following: o In 12 (100%), each serious incident or allegations of wrongdoing; o In 12 (100%), the name(s) of all witnesses; o In 12 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 12 (100%), the names of all persons interviewed during the investigation; o In 12 (100%), for each person interviewed, a summary of topics	Substantial Compliance

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	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.	discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 12 (100%), all documents reviewed during the investigation; o In none (0%), were all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. This had been addressed and DFPS investigations now included a statement indicating that previous investigations were either found relevant or not relevant to the case. In this sample, however, the statement did not indicate which prior cases, if any were reviewed. In all cases, DFPS investigations stated that previous case history for the principals in the case was not relevant. Some examples where previous case history should have been noted included: ▪ DFPS Case #40296823 indicated that previous investigations were not deemed relevant though the investigator noted in an email to the facility that the individual had a history of reporting unfounded allegations. ▪ DFPS Case #4032477 indicated that previous investigations were not deemed relevant though the AP was named in another physical abuse allegation two months prior to the confirmed abuse allegation. o In 12 (100%), the investigator's findings; and o In 12 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of seven facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In eight (100%), each serious incident or allegations of wrongdoing; o In eight (100%), the name(s) of all witnesses; o In eight (100%), the name(s) of the individual involved in the incident; o In eight (100%), the names of all persons interviewed during the investigation; o In eight (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 eight (100%), all documents reviewed during the investigation; o In eight (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.	

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		o In eight (100%), the investigator's findings; and o In eight (100%), the investigator's reasons for his/her conclusions. There had been significant improvement in the facility's documentation of investigations since the last review. DFPS investigations should include documentation of previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. The facility was in substantial compliance with this item. Even so, the facility should take a closer look at the way in which it handles allegations that are referred back to the facility due to clinical reasons. For example, see the detailed case presented in section M4 below regarding the conduct of an investigation of an allegation referred back to the facility for clinical nursing practice investigation.	
	(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.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of a sample of 12 DFPS investigations included in Sample #D.1: • In 12 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. o UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and facility director. For UIRs completed for Samples #D.1, 12 (100%) DFPS investigations were reviewed by both the facility director, and IMC following completion. • Seven (58%) UIRs from Sample #D.1 were signed off on by the facility director and IMC within five days of receipt of the completed investigation from DFPS. Exceptions were DFPS Cases #40269362, #40572156, #40716744, and #40954456. o For Sample #D.2, three of three (100%) documented prompt review and approval of the investigation following the facility completion date. Two IMRT meetings were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily meeting. Recommendations for follow-up were made by the team.	Noncompliance

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		Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In seven of eight (88%) UIRs from sample #D.2 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon completion. UIR #12-034 appeared to have the signature sheet from a different investigation attached, as it was dated prior to the investigation commencement. • Seven of seven (100%) of the reviews by the IMC were completed within five days of the completion date. Investigation documentation should indicate that all DFPS investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent. The facility was not in substantial compliance with this provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A uniform UIR was completed for 23 out of 23 (100%) unusual incidents in the sample. A brief statement regarding review, recommendations, and follow-up was included on the review form.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in a sample of 10 investigations. Five investigations in Sample D.1 included confirmed allegations of abuse or neglect. One was confirmed on an unknown perpetrator. Of the four cases where the perpetrator(s) were identified, all included documentation of disciplinary action taken. In 10 of 15 DFPS cases reviewed from Sample #D1 and #D2, DFPS documented additional concerns or recommendations. In one of those 10 cases (10%), the facility investigation file did not include documentation that concerns or recommendations were addressed. • In DFPS case #40475431, was referred back to the facility as an administrative issue. The investigation file did not include documentation of follow-up on the concerns noted by DFPS. Recommendations for programmatic actions were made in seven of eight cases reviewed for facility investigations in Sample #D3. Completion of recommended action for facility investigations was maintained in log format by the IMC. The log indicated that follow-up action had been completed for each of the seven cases.	Substantial Compliance

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		The facility was in substantial compliance with this item.	
	(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
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 collect data on unusual incidents and investigations. Data were compiled in 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. Data provided to the monitoring team were not consistent in the numbers of incidents reported in all data reports. For example, facility provided a document of all abuse and neglect allegations reported to DFPS from August 2011 through December 2011. This document indicated there had been 39 allegations of physical abuse, 14 allegations of emotional/verbal abuse, and 32 allegations of neglect. A log of all allegations between August 2011 and December 2011 indicated that there had been 68 allegations of physical abuse, 26 allegations of verbal/emotional abuse, and 99 allegations of neglect. The monthly QA report included data and trends on DFPS investigations, injuries, and other serious incidents. Specific information on types of allegations and outcomes of those allegations was not included in the QA report. The facility had established a QAQI Council subgroup on 1/24/12 to look at data that were presented in the QA report in regards to ANE and develop an action plan for addressing any areas of concern. Action plans were still in the initial stages of development. 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 gather accurate data and frequently evaluate how data can best be used to evaluate that progress and take action to reduce the number of incidents and injuries.	Noncompliance

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		The facility was not in substantial compliance with this provision item. The facility needs to review various data collected in regards to incidents and investigations at the facility and ensure trend reports include accurate data.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. The information obtained about volunteers was also reviewed. 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. According to information provided to the monitoring team, for FYI 12, criminal background checks were submitted for 612 applicants. There were a total of 24 applicants who failed the background check in the hiring process and therefore were not hired. No employees had been dismissed due to results of background checks since the last review. 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	Substantial Compliance

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		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. • Signed acknowledgement forms were submitted for 24 of 24 employees (100%). The facility remained in substantial compliance with this provision.	

Recommendations:

1. The facility needs to ensure that all employees attend training on identifying and reporting abuse, neglect, and exploitation annually. The facility should also ensure that all employees sign an acknowledgement to report abuse and neglect at least annually (D1).

2. The facility needs to document all required notifications in the investigation file and ensure all incidents involving suspected abuse and neglect are reported to DFPS immediately (D2a).

3. 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).

4. The facility needs to ensure that all staff persons who are mandatory reporters of abuse or neglect sign a statement Facility evidencing their recognition of their reporting obligations at least yearly (D2d).

5. QDDPs continue to need to be reminded to include documentation in ISPs regarding the sharing of information on recognizing and reporting abuse, neglect, and exploitation (D2e).

6. Investigation documentation should indicate that all investigations are reviewed promptly by the facility to ensure that the investigation is thorough and complete and that the report was accurate, complete and coherent (D3g).

7. 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 if data are accurate and how data can best be used to evaluate that progress (D4).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o List of SASSLC facility-specific policies related to Quality Assurance (four policies) o DADS central office QA department document titled Inter Rater Reliability Process, January 2012 o DADS SSLC QE and Departmental QA/QI Planning FY 12 Workshop handouts, December 2011 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Organizational chart, undated o SASSLC policy lists, undated o List of typical meetings that occurred at SASSLC, undated o SASSLC Self-Assessment, 2/1/12 o SASSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/13/12 o SASSLC DADS regulatory review reports, through 11/10/11 o SASSLC QA draft self-monitoring tool for section E, undated, but most likely February 2012 o QA department meeting notes, December 2011 through February 2012 (4 meetings) o SASSLC Quality Assurance Plan/matrix, undated, but most likely January 2012 o Draft/initial list of data collected at SASSLC, undated, but most likely February 2012 o Many emails and attachments regarding the QA director's efforts to obtain data listings from department heads, November 2011 through February 2012 o Set of blank tools used by QA department staff (7) o SASSLC QA Reports, monthly, September 2011 through January 2012 o Detailed report of 12 nursing self-monitoring tools, prepared by Robert Zertuche and Mandy Pena o QAQI Council agenda and meeting minutes since last onsite review through 2/14/12 (8 meetings) o QAQI Council agenda and handouts for 2/14/12 meeting o Corrective Action Plan Tracking Sheet (1 page) o DADS SASSLC family satisfaction survey, cumulative since last onsite review, 18 participants o Self-advocacy meeting minutes, September 2011 through November 2011 (4 meetings) o Notes from any home meetings (none) o Recent facility newsletter, The Bridge, Fall 2011 <u>Interviews and Meetings Held</u>: o Laurence Algueseva, Director of Quality Assurance o Mandy Pena, QA department nurse, and Robert Zertuche, QA nurse from the nursing department o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors o Gevona Hicks, Human Rights Officer o Nancy Mifflin, Director of Community Relations o Sam Brown, Campus Coordinator Supervisor

	Observations Conducted: o QAQI Council meeting, 2/14/12 o QA department staff meeting, 2/15/12 o Self-advocacy meeting, 2/15/12
	Facility Self-Assessment: SASSLC submitted its self-assessment. This document included a list of the activities the QA department had engaged in related to each of the five provision items of this section. Although it was helpful to read this list, a self-assessment should instead describe what it is that the department did to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. In other words, the self-assessment should not describe what the department did to conduct quality assurance-related activities, rather it should be activities the department engaged in to assess whether the QA department was in substantial compliance with the requirements of each provision item. Determining how to assess the quality assurance provision items is a challenging task. Consider that much of what the QA department does is to help the departments self-assess their own performance (and to make changes, corrective actions, etc.). This task requires a subtle distinction be made. That is, the task is for the QA director is to determine how to self-assess his department's activities in supporting self-assessment activities of departments, collecting data, analyzing data, etc. The monitoring team recommends that the QA director review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. The understanding of the monitoring team was that SASSLC will implement the new style self-assessment that is being used at other SSLCs by the time of the next onsite review. The facility self-rated itself as being in noncompliance with all five of the provision items of section E. The monitoring team agreed.
	Summary of Monitor's Assessment: SASSLC had a new director of quality assurance. He was promoted to this position only five weeks before this onsite review. As a result, it was not surprising that there was little progress made. The new director was knowledgeable of the facility, and was very motivated to create a well running, competent, comprehensive QA program. This made it likely that the QA department and the facility's QA program would move forward over the next six months. Support and collaboration from the facility director, state office quality assurance coordinator, and the new SAC at SASSLC should be provided to the new director.

	Revisions to the state's QA policy were completed and included more detail and direction than did the previous policy. Training and orientation to this new policy and its requirements were needed. Some progress had been made in creating a listing/inventory of all data collected at SASSLC. An adequate QA plan, that contained a succinct narrative and a detailed QA matrix needed to be developed. The QA matrix was, for the most part, the same as during the last review (i.e., inadequate). The statewide self-monitoring tools continued to be used throughout the facility. A number of considerations for continued use are presented in section E1 below. Family satisfaction measures were obtained and shared with QAQI Council. Data were not yet being appropriately reviewed and summarized (e.g., graphed) for all of the sets of data that were on the current QA matrix. Some data, however, were being graphed, including the statewide self-monitoring tools for the current month, the measures being collected by QA staff, and some of the other data determined important by the facility (e.g., pneumonias). The work of the QA nurses, however, was exceptional and can provide a model for other departments at SASSLC. These nurses created an organized system to implement, assess, and follow-up on the findings from all 12 of the nursing statewide self-monitoring tools. A QA report was completed each month. The January 2012 report, created by the new QA director, was the best of those reviewed by the monitoring team. The report, however, still needed a lot of work and improvement, as detailed in section E2 below. QAQI Council had met intermittently over the past six months. The facility director should take a stronger lead role in the meeting. During the onsite review week, the QAQI Council changed its operation to meet three times per month from now on, and to discuss a portion of the 20 Settlement Agreement provisions during each of the meetings. The QAQI Council should also be more involved in the coordination of performance improvement teams (PIT). A systematic, organized way of managing corrective actions, and corrective action plans, was not yet in place at SASSLC.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care;	SASSLC had a new director of quality assurance, Larry Algueseva. This was the third director of quality assurance at SASSLC since the initiation of the Settlement Agreement. Mr. Algueseva was promoted to this position only five weeks before this onsite review. As a result, it was not surprising that there was little progress made towards substantial compliance with this provision since the last monitoring review. Mr. Algueseva, however, had worked for many years in the facility's QA department, was knowledgeable	Noncompliance

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	individual staff; and/or individuals receiving services and supports.	of the many workings of the facility, and was very motivated to create a well running, competent, comprehensive QA program at SASSLC. This made it likely that the QA department and the facility's QA program would move forward over the next six months. <u>Policies</u> After many months in development, revisions to the state's QA policy were finalized and disseminated. The new policy was titled #003.1: Quality Assurance, dated 1/26/12. The new policy provided detail and direction to QA directors and facility staff, much more so than did the previous policy. Therefore, training and orientation to this new policy and its requirements needs to occur and should: • Be provided to the QA director and QA staff, • Be required for senior management, including but not limited to QAQI Council, • Involve more than just the reading of the new policy, and • Include state and facility-specific QA-related policies. The new state policy also called for a statewide QAQI Council, and for statewide discipline QAQI committees. The statewide QAQI Council requirement was being met by the recent (3/5/12) formation of the statewide leadership council. Statewide discipline QAQI committees were not yet in place. Also, given that the statewide policy was in development for more than a year, edits may already be needed. State office should consider this. The monitoring team also reviewed a document titled Inter Rater Reliability Process Instructions. This was from central office with the goal of guiding the facility in the way it developed self-monitoring tools, implemented the tools, trained monitors/observers, and obtained inter rater agreement. These were all very appropriate and good topics, however, the document was not written in a clear manner, the flow chart was confusing, the examples referred only to monitoring of engagement activities and did not contain good operational definitions, and there was no instruction as to how to calculate agreement/disagreement (e.g., gross reliability calculation, point by point reliability calculation). Further, it was not clear if this was for the statewide self-monitoring tools, facility-specific monitoring tools, or both. The monitoring team recommends that this document be revised so that it provides specific direction regarding how to conduct inter rater agreement activities. The QA director also shared a draft version of a self-monitoring tool for this entire provision (i.e., section E). The monitoring team recommended that the QA director not use this tool because it would not allow him to adequately assess his own department's activities.	

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		SASSLC had four facility-specific policies that were related to quality assurance (Quality Enhancement, Quality Enhancement Plan, Data Collection Systems, and QAQI Council). Now that state policy had been disseminated, the QA director should revise these policies as appropriate. It is possible that some of these policies will no longer be needed, and/or that other new policies need to be created. <u>General QA Planning</u> Listed below are 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. These component steps were listed in the previous monitoring report, however, the detail is <u>not</u> repeated here. Instead, the reader should refer to previous monitoring reports. 1. Create a listing/inventory of all data collected at the facility that includes the variety of categories of data detailed in previous monitoring reports. 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 matrix). 3. Determine which of these data are to be included in the QA report. 4. Determine which of these data are to be presented regularly to the QAQI Council. 5. Create and manage corrective actions based upon the data collected, and direction from the QAQI Council. <u>QA Department</u> Mr. Algueseva was new in his leadership role. The facility will be looking to him for direction regarding quality assurance. The monitoring team has confidence in Mr. Algueseva. His style was collaborative, and he was highly motivated. To increase the likelihood of success, the QA director will need direction and assistance from both the facility director and the state office Quality Assurance coordinator. Furthermore, he may benefit from a mentoring relationship with another facility's QA director. Also important will be his working collaboratively with the Settlement Agreement Coordinator (who was also brand new to the facility). During the week of this onsite review, the SAC from San Angelo SSLC was present at SASSLC. The SAC and QA director at San Angelo SSLC worked very well together. This might provide a model for the SASSLC QA director and SAC to emulate. QA staff meetings were initiated at the time of the previous review, however, appeared to have halted until mid-December 2011. The monitoring team reviewed all of the minutes and attended one meeting. As discussed with the QA director and as recommended in the previous report, these meetings should include topics about quality assurance rather than only being used to make announcements. In other words, the meetings should be	

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		used as a staff training-type of opportunity, so that staff can learn about the profession of quality assurance, participate in creating processes for the department and facility, and so forth. <u>Quality Assurance Data List/Inventory</u> The creation of a list of all of the data collected at the facility is an important first step in the development of a comprehensive quality assurance program. This was discussed numerous times during previous onsite reviews and in previous monitoring reports; the detail from the previous reports will not be repeated here. The QA director had made some progress towards this. He presented a four-page listing of data (he also talked about a longer, more up to date, nine page list, but the monitoring team never received this). This was an OK start, however, improvement was needed, as was discussed with the QA director and as is recommended below: • The list/inventory should be a simple list. It does not need to include all of the additional columns that were in this list (e.g., how often, who collects, sample size). Remember, the goal is to have a simple listing that can be easily read by QAQI Council members as well as any other interested parties. Further, clinical and operational staff are more likely to contribute to the list if it is easy to do so. • The list should be separated by department (as it was), but each type of data should be on a separate line. • Each department's list could be further subdivided to indicate which data were statewide self-monitoring, which were department self-monitoring, and which were regular data kept and used by the department. The monitoring team acknowledges the efforts of the QA director to obtain information from the many departments at SASSLC. This was reflected, in part, in more than 100 pages of emails, from 11/15/11 through 1/25/12, showing requests from the QA director to department heads. In some cases, there were detailed responses and in other cases there was back and forth correspondence. All of the information in the responses of the department heads was relevant to the creation of this type of list/inventory. The lists provided by many of the departments were done very well. <u>Quality Assurance Plan</u> The QA Plan remained almost identical to that at the time of the last onsite review. Please see the comments in the previous monitoring report. The QA Plan should contain a combination of a narrative description of the overall QA program at the facility and the QA matrix. It might include a one or two page overall description of how QA is conducted at SASSLC; a description of the comprehensive	

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		inventory listing of all data that are collected across the facility; a description of the QA matrix and how those data are managed, reviewed, trended, and analyzed by the QA department; the role of any QA databases; and the overall expectation and process for data analysis and corrective action management. The QA matrix would be attached to this description, thereby, creating the QA plan. The columns of the QA matrix should contain the detail (i.e., columns) that the matrix currently contained. Each of the lines should be a single data measure. Remember, the QA matrix should list those data that are important for the QAQI Council and/or QA department to review. Therefore, typically, a QA matrix will include: • A list of tools to monitor each of the provisions of the Settlement Agreement. Usually, this is the statewide self-monitoring tools plus any other self-monitoring tools used by the department. • A list of data that the QAQI Council wants to see. In some facilities, these are called key indicators. • A list of data that the QA staff collect themselves. • Any other data that the QA department wishes to receive from the facility's many departments. <u>QA Activities and Indicators</u> QA staff went out and collected data for areas that QA was responsible for monitoring (seven areas), completed statewide self-assessment tools primarily to assess interobserver agreement, and participated on various committees and in meetings. Across the facility, a great deal of time was devoted to the implementation of the statewide Settlement Agreement provision self-monitoring tools. There are some important next steps in the use of the statewide tools. • First, update the content of the statewide tools so that they are relevant and valid. Facility managers and clinicians would likely welcome the opportunity to participate in making suggestions for additions, deletions, and re-wording of items in each tool. o For example, at SASSLC, the QA nurses reported that two of the 12 tools most definitely needed updating because the content was not right (seizure management and chronic respiratory distress). This should be fixed and updated. • Second, consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. • Third, some items in each tool may be more important than others. These should be indicated. • Fourth, the overall process of self-assessment was soon to be updated at SASSLC.	

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		These tools should be one of many components of the self-assessment procedures used by each of the departments. As discussed in previous reviews, a variety of satisfaction measures are important indicators to include in a comprehensive QA program. Family and LAR satisfaction information was collected since the last onsite review. It was managed by the director of community relations. In the past six months, there were 18 responses, for a total of 69 reported responses over the past year, though this number did not line up with the monitoring team's number. Nevertheless, the director of community relations summarized these data in graphic format and presented them from time to time at QAQI Council. The facility attempted to follow-up on any identified dissatisfaction. This was good to see. Further improvements discussed with the director of community relations included changing the graphic presentation of each item to show the number of responses rather than a single bar showing the average, and other ways of obtaining family satisfaction, such as phone calls to a small number of families. In addition, as noted in previous monitoring reports, satisfaction measures should also be obtained for (a) individuals living at the facility, (b) staff, and (c) others in the community with whom the facility interacted, such as restaurants, stores, community providers, medical centers, and so forth. The human rights officer had made some good progress in the development of the self-advocacy committee. Home meetings, however, were not occurring. These can be another way for individuals to learn to make decisions and to express themselves, as well as for the facility to assess their satisfaction. The QA director should figure out a simple way to include the family data and data from self-advocacy group into the QA plan and matrix, and QA report/QAQI Council. Staff and community satisfaction should be assessed, too.	
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.	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. The activities that are relevant to this provision item are the facility's management and analysis of data, the QA report, the QAQI Council, the use of performance improvement teams, and the management of corrective actions and corrective action plans. Some progress was seen at SASSLC. <u>QA Data Management and Analysis</u> To repeat from E1 above, the QA director will need to assemble a listing of all data collected at the facility, and he will also need to create a QA matrix that indicates which of these data will come in to the QA department. These data that come into the QA department (i.e., the items on the QA matrix) need to be reviewed by the QA department (probably primarily by the QA director) <u>and</u> they need	Noncompliance

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		to be summarized. This was not yet occurring. Summarizing of data is typically done in the form of a graph or a table. Most typical, and most useful, will be a graph. To repeat from the previous report, 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. A proper graph takes time to initially create, but after that, only requires an additional data point to be added each month, quarter, etc. Note that not all of these graphs need to be created by the QA department. It is possible for the facility to set an expectation for the service departments to submit data and graphic summaries each month (as the QA nurses were already doing). Many of these graphs can be inserted into the QA report and be presented to QAQI Council. The work of the QA department's QA nurse (Mandy Pena) and the nursing department's QA nurse (Robert Zertuche) again deserves special mention. To somewhat repeat from the previous report, they continued their outstanding system of managing the 12 statewide self-monitoring tools for nursing. This included a systematic way of implementing these tools across the facility's nurses. They also analyzed, tracked, and trended data by tool, by nurse, by home, and so forth. They followed up on <u>every</u> item that was scored "no" on any of the tools (i.e., not only on tools that scored below 70%). In addition, they were responsive to all of the recommendations and discussion from the previous onsite review and report (e.g., making a single page that contained the month-by-month data for all 12 tools). Similarly, during this onsite review, the monitoring team noted that the two highest scoring of the 12 tools were each scored only by one staff member, the one responsible for that area (infection control, medication administration). Due to possible unintentional bias in scoring, the monitoring team recommended that implementation of these two tools be rotated to other staff, too. By the end of the onsite week, the two QA nurses had already made this change to their system. The monitoring team again recommends that the state office look at Mr. Zertuche and Ms. Pena's system as a possible best practice. In addition, the facility should consider whether this system can be used with other departments and other provisions. Although most other departments did not have a staff person solely dedicated to QA activities, most departments only had a single statewide self-monitoring tool. The monitoring team learned that there had been some interest by those who managed medical services, polypharmacy, at-risk processes, and the work of the QDDPs, however, no actions had occurred beyond initial inquiries.	

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		QA Report A monthly QA report was being completed by the QA director. This was another area of progress. The new QA director completed the most recent report (January 2012). This report was the best of the five submitted to the monitoring team, though much work still needed to be done. The monitoring team's comments below are based on this most recent report. The organization of the report needed improvement. It should be organized by sections, such as: • Each of the Settlement Agreement provisions. Within each of the provisions would be (a) the statewide self-monitoring tools with one graph showing detail for the current month, and a second graph showing a single data point for consecutive months, and (b) any other data deemed relevant by the department head, QAQI Council, and/or the QA director. o Data from the four portions of the statewide trend analysis can be included within the corresponding Settlement Agreement provision, that is, provisions C (restraint) and D (allegations, injuries, incidents). • Any key indicators chosen by the QAQI Council or QA director. o Data from the seven tools collected by the QA department can be included within this section. o Staffing data (e.g., turnover) can be included in this section. • Data from performance improvement teams (see below). Other comments regarding the QA report: • The QA report was used as a handout for QAQI Council to use during QAQI Council meeting. This was good, but in addition, the QA report should be presentable as a stand alone document/report for the many people who may be interested in the content, but do not attend the meeting. • The QA director should work with state office to ensure the QA report is progressing in a way consistent with the standards set and expected by state office and the new state policy on quality assurance. • There is no need to include the tabled data underneath the graphs. The data are evident in the graphic presentation and the tabled data only clutters the presentation and unnecessarily adds more pages to the length of the report. • The data should show trends over time (e.g., month to month), not only the current month's performance. • A lot of detail from the statewide trend analysis was included. This should be shortened and only the most relevant information included in the QA report. The QA report might include a sentence stating that a more detailed standardized statewide report was available for review.	

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		• The 12 nursing graphs should be somehow summarized or reduced so that they do not take up an inordinate amount of space in the report. The QA nurses may be able to help with this. • Having space to provide a brief narrative explaining the data was good to see included in the report. • The QA director will need to determine whether and how action plans, corrective actions, and/or CAPs should be incorporated (or separated) from the QA report. <u>QAQI Council</u> The monitoring team reviewed the QAQI Council minutes and attended a QAQI Council meeting. Overall, the meeting and process of QAQI Council appeared to continue to be in the early stages of development. This was somewhat surprising given that this process was now in place for more than a year. The meeting would benefit from the facility director taking the lead of the meeting rather than it being run primarily by the QA director. The committee met eight times over the past six months (including the meeting observed during this review). The meetings did not appear to be regularly scheduled (i.e., none held from mid-August 2011 to mid-September 2011, two meetings in November 2011, one meeting each in December 2011 and January 2012, and two in February 2012). During the week of this review, the facility made the decision to hold QAQI Council three times each month. During each of these meetings, the committee planned to look at a portion of the Settlement Agreement provisions. Up to this point, this was not happening in any organized manner. Holding more frequent meetings and having a somewhat pre-planned agenda of topics seemed like a good way to proceed. <u>Performance Improvement Teams</u> SASSLC and the QAQI Council were not using performance improvement teams (PIT) regularly, thoroughly, or in any organized manner. The QAQI Council and the facility director need to take a more active role in the various aspects of PITs. This includes establishing each PIT based upon data and/or discussion, contributing to a discussion of what the PIT's goals should be, suggesting some initial activities for the PIT to engage in, receiving and reviewing regular updates and reports from the PIT, providing additional direction to the PIT as needed, and disbanding the PIT when its work is completed. At SASSLC, there were some PITs and some PIT-type activities occurring, however, these activities should be brought more formally into the QAQI Council process. For example, the QA nurses had created an acute care planning group based on the results of their own monitoring activities. It should be designated as a PIT and be part of the QA program.	

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		The monitoring team heard discussion of an abuse/neglect PIT that been operating for a month or two, and the possible formation of other PITs for incident management, psychology, peer to peer aggression, and section S of the Settlement Agreement. Moreover, the interesting discussion at the QAQI Council meeting regarding high rates of turnover being due primarily to working relationship problems with co-workers begged the question of why not create a PIT to address that. The benefits of having an organized PIT process were also noted in the previous monitoring report. <u>Corrective Actions</u> SASSLC continued to struggle with addressing the corrective action requirements of section E. At the time of the previous review, the facility was approaching this in an incorrect manner. At this time, the QA director had begun a corrective action plan tracking form. It was one page with three items from nursing. These, however, were items regarding single individuals that were obtained from the QA nurses' comprehensive system (described above). There was discussion at QAQI Council (and in other meetings during the onsite review) about there needing to be corrective actions for any statewide self-monitoring tool that scored below 70%. This somewhat arbitrary criterion, however, can lead to some problems. First, a 70% criterion means that there can be much variability. Consider that the 70% is often arrived at by averaging a number of tools for the month. Therefore, some tools could score 95% and others 45%, together resulting in a 70% average. If so, there would be no actions required, even though there would likely have been serious problems in some of the observations. Second, a high score could be obtained even if some essential key components of the tool were not done correctly (also see E1 above). The QA nurses addressed this by following up on <u>every</u> item not done correctly on <u>every</u> implementation of <u>every</u> tool. Third, CAPs can be drawn from any data from any area of operation or service provision at the facility, not only from the results of the statewide self-monitoring tools. Fourth, not all activities that require corrective action require a formal corrective action plan. To move forward towards substantial compliance regarding CAPs for this provision item, as well as provision items E3, E4, and E5, the facility needs to do the following: • Work with state office on the criterion for determining what does, and what does not, require a corrective action plan. The intention of this provision item is not for there to be a corrective action plan for every activity that every department engages in to correct some aspect of its regular, typical operation or service provision.	

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		• The monitoring team recommends that state office (with perhaps with the participation of all of the facilities so that this can be consistent across all of the SSLCs) develop and provide detailed, specific direction to the SSLCs for: o A criterion, or set of criteria, for determining if a corrective action requires a corrective action plan. o Guidance on the types of activities that should have a corrective action plan. o A way for state office to provide some feedback to the facilities regarding their set of corrective action plans. This might be for a limited time period, such as six months or a year. Once this is determined, the facility can then appropriately track each CAP as required by this provision item and provision items E3, E4, and E5.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SASSLC was not in compliance with this provision item. See comments above in section E2.	Noncompliance

Recommendations:

1. Provide training to the QA director, QA staff, and senior management and clinical staff on the new state policy and any QA-related facility-specific policies. Training should involve more than the reading of the policies (E1).

2. Implement the statewide discipline QAQI committees, as per the new state policy (E1).

3. Revise, create, and/or eliminate facility-specific policies now that the state policy is approved and disseminated (E1).

4. Revise the inter rater reliability process document (E1).

5. Ensure that the new QA director gets support from the facility director and central office quality assurance coordinator; mentoring from

another experienced QA director (if deemed appropriate to do so by the central office quality assurance coordinator and the SASSLC facility director; and collaboration from the new SAC (E1).

6. Include professional development activities for QA staff during the QA staff meetings (E1).
7. Create a listing/inventory of all data collected at SASSLC. Divide and subdivide the list into categories so that it is easy to read (E1).
8. Make an appropriate QA plan, with a narrative and comprehensive, organized QA matrix (E1).
9. Along with state office guidance, determine how to best use the statewide self-monitoring tools and whether/how to update their content (E1).
10. Revise, fix the two nursing tools as identified by the QA nurses (E1).
11. Make changes to the graphs in the family satisfaction survey data; consider other ways of assessing family satisfaction, such as via a sample of phone calls (E1).
12. Include a range of satisfaction measures in the QA program (e.g., individuals, staff, and related community businesses). Consider holding home meetings where appropriate to do so (E1).
13. Review and summarize (e.g., graph) all data in the QA matrix (E2).
14. Consider using the QA nurses' system for other provisions of the Settlement Agreement (E2).
15. Organize the QA report; see the list of comments and suggestions in E2 (E2).
16. Facility director should lead the QAQI Council meeting (E2).
17. QAQI Council should be more involved in the coordination of PITs, as detailed in E2 (E2).
18. Determine what actions do and what actions do not require a corrective action plan (E2).
19. 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 DADS Procedure: Personal Focus Assessment dated 9/7/11 o SASSLC Facility Most Integrated Setting Practices dated 12/1/11 o SASSLC Self-Assessment o SASSLC Section F Presentation Book o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Quarterly Reviews for the following Individuals: • Individual #130, Individual #96, Individual #72, Individual #106, Individual #55, Individual #194, Individual #150, Individual #83, Individual #160, Individual #127, Individual #32, Individual #86, Individual #232, Individual #116, and Individual #254 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Michelle Enderle-Rodriguez, Incident Management Coordinator o Daisy Ellison, Psychology Coordinator o Audrey Wilson, QDDP Coordinator o Gevona Hicks, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 2/14/12 o Incident Management Review Team Meeting 2/14/12 and 2/15/12 o Human Rights Committee Meeting 2/16/12 o Annual IDT meeting for Individual #311 on 2/10/12 o Quarterly IDT meeting for Individual #111 on 2/15/12 o QDDP meeting on 2/15/12
	Facility Self-Assessment: SASSLC submitted its self-assessment. It was updated on 2/1/12. During the onsite review, the QDDP Coordinator reviewed the presentation book for this provision. The facility reported that it was focusing on the new ISP process and risk identification process, 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.

	According to the facility, its self-rating was, in part, determined through monitoring of the ISP and ISP process by the QDDP Coordinator. The self-assessment, 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. The facility indicated that a number of new processes had recently been implemented in regards to ISP development and implementation. It was too soon to evaluate the adequacy of most of these changes. The facility self-assigned a noncompliance rating to all the provisions items in section F. The monitoring team agreed and did not find substantial compliance with any of the provisions in section F. As noted throughout section F, while the monitoring team did see continued progress in this area with the new style ISPs, assessments were still not completed or updated as needed, key members of the team were not present at annual meetings, plans still did not integrate all services and supports, and plans were not consistently implemented and revised when needed.
	Summary of Monitor's Assessment: DADS had recently initiated a thorough review of the ISP process and hired a set of consultants to help the SSLCs move forward in ISP development and the meeting of this provision's requirements. Comments are more generalized for section F in this report in light of the fact that SASSLC had received technical assistance from consultants in January 2012 before fully implementing the person centered planning process. The facility had begun implementation of the new ISP process as of 2/1/12. Only two ISPs had been developed since training had occurred. These two ISPs showed improvement in including supports and services in a manner that would guide staff implementing plans. Three annual IDT meetings scheduled during the review week were observed by the monitoring team. In meetings observed, the QDDPs were attempting to ensure that all necessary information was covered during the IDT meeting. Meetings attended were lengthy (three hours) and somewhat fragmented in discussing risks and supports. Teams engaged in better-integrated discussion in the meetings observed than during previous onsite reviews. There was, however, minimal progress being made on developing plans that would lead to a more meaningful day for individuals. IDTs were still building plans around programming that was available at the facility rather than looking at what each individual may need or want. 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. Quality assurance activities with regards to ISPs were in the initial stages of development. The facility had begun to use state developed audit tools to review both meeting facilitation and the ISP development process, but had not yet evaluated the outcome of those audits. 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 IDT. The ISPs that were reviewed were chosen from among the most recently developed ISPs. The sample included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QDDPs and IDTs had been responsible for the development of the plans.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	QDDPs were responsible for facilitating IDT meetings at the facility. The QDDPs were also responsible for ensuring that team members were developing, monitoring, and revising treatments, services, and supports. DADS Policy #004 at II.C.1.b indicated that QDDPs would plan and facilitate the ISP meetings. QDDPs had attended facilitation skills training. QDDPs were at varying stages in learning to competently facilitate meetings that encouraged integrated discussion adequate for developing appropriate supports. DADS had hired a team of consultants who were providing classroom training, coaching, and mentoring to the QDDPs on facilitation skills and ISP development. The consultants had recently provided technical assistance to SASSLC. The QDDP Coordinator was attending a sample of IDT meetings and evaluating the QDDP's facilitation skills using the Q Construction QMRP Facilitation Skills Performance Tool. She indicated that she was providing additional mentoring and coaching to QDDPs during observation of meetings. While onsite, the monitoring team observed three annual ISP meetings. Meetings observed during the monitoring visit confirmed that QDDPs were facilitating ISP	Noncompliance

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		meetings. Meetings observed were very lengthy (three hours). As QDDPs gain experience with the new format, their ability to keep meetings moving and ensure discussion of all necessary topics should improve. A sample of 10 IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. At all annual meetings, there was a QDDP present. The facility's self-assessment indicated noncompliance with this requirement. While progress had been made in towards meeting substantial compliance, the monitoring team agreed with that assessment. It will be important for the QDDPs to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify. Furthermore, DADS reported that it was continuing to work on describing and defining the aspects of facilitation that should be demonstrated by the QDDPs.	
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 IDT meetings. The sample included ISPs for the following individuals: Individual #106, Individual #72, Individual #96, Individual #55, Individual #150, Individual #194, Individual #83, and Individual #160. • Five of eight (63%) indicated that the individual attended the meeting; o The exceptions were Individual #106, Individual #72, and Individual #194. o Only one of the individuals in the sample had a guardian. The guardian was in attendance at the annual IDT meeting. The monitoring team does not expect that all individuals or their LARs will want to attend their IDT meetings. When individuals are not present for meetings, the QDDP 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 contributed to the refusal to attend and brainstorm ways to encourage participation. A review of eight signature sheets for participation of relevant team members at the annual IDT meeting indicated that one (13%) of the meetings was held with <u>all</u> relevant staff in attendance. For the other meetings, there was no documentation included in any of the ISPs that would indicate input was given prior to the meeting by staff that were unable to attend the meeting. Some examples where team participation was not found to be adequate include: • A review of the attendance sheet for Individual #96 indicated that several key	Noncompliance

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		IDT members did not attend his annual team meeting. Absent staff included his dietician, communication therapist, physical therapist, and physician. Professional staff should have been in attendance to contribute their expertise in developing appropriate supports to address his identified risks and noted regression. • Individual #55 was on a modified textured high calorie diet. His ISP recommended a dietary consult. He was overweight and continued to get double portions and high calorie supplements. The dietician did not attend his annual meeting. His psychiatrist did not attend his annual IDT meeting though his ISP noted that meeting his needs in the community would require "extensive coordination and support of a psychologist and psychiatrist." Residential staff did not attend his meeting. Attendance by DSPs is crucial in helping the team develop an ISP based on preferences and needs. • The dietician did not attend the annual IDT meeting for Individual #72. The team determined that she was at medium risk for weight issues. Her weight had not remained stable for three months. Her weight had ranged from a high of 127 in December 2010 to a low of 85 pounds in August 2011. She did not have a nutritional assessment prior to her IDT meeting. Her vocational assessment indicated that work was important to her. Vocational staff did not attend her meeting. • Home staff did not attend the annual IDT meeting for Individual #106. • Psychiatry and home staff were not in attendance at the annual IDT meeting for Individual #194. Her ISP indicated that she was taking a number of psychotropic medications and was at risk for polypharmacy. She also had a number of medical and behavioral issues. The expertise of both of these team members would have contributed to overall planning in regards to his supports and programming. • The dietician did not attend the annual IDT meeting for Individual #83. Her ISP indicated that she was morbidly obese at 136 pounds over the top of her ideal weight range. All relevant disciplines were in attendance at the IDT meeting observed the week of the review for Individual #311. As a result, all disciplines were able to contribute to discussion regarding his complex healthcare supports and services. The absence of key members was a significant barrier to integration in the development of ISPs. It is 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 facility had recently implemented the use of a database to track attendance at IDT	

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		meetings for relevant team members. This process was new, but should have a positive impact on meeting participation.	
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 facility had taken steps to improve the assessment process used for planning included: • An assessment tracking worksheet was created to track assessment submission. • The facility had begun using the new statewide Functional Skills Assessment (FSA) to identify strengths, preferences, and needs of individuals. o IDTs were not completing the FSA to identify each individual's strengths and areas of needed support. • The QA nurse and QDDP coordinator inserviced nurse case managers and QDDPs on the Integrated Risk Rating Discussion Form. The monitoring team found the quality and timeliness 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 ISP, 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). 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 ISPs reviewed, the PFA was used to develop a list of priorities and preferences for inclusion in the annual ISP. The PFA format had been revised in September 2011. If completed prior to the annual ISP meeting, the PFAs could have been an effective tool for planning based on the individual's preferences. A review of PFAs for individuals in the sample did not support that IDTs were completing PFAs in advance of the annual ISP meeting. For example, the PFA for: • Individual #106 was completed on the day of his annual ISP meeting. • Individual #55 was completed four days after his annual IDT meeting. • Individual #96 was completed six days after his annual IDT meeting. • Individual #150 was completed the month following his annual IDT meeting. • Individual #127 was completed two months after his annual IDT meeting. • Individual #86 was blank. The list of preferences developed from the PFA process was reviewed for eight	Noncompliance

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		individuals. Teams were at varying stages in developing a list of priorities and preferences that could be used for planning. Overall, there had been improvements in identifying individual's preferences, however, as noted above, this was not occurring prior to the development of the ISP. An example where the PFA process was not adequate for identifying preferences and priorities was: • The PFA for Individual #106 indicated no preference or no response in a number of sections. This individual had lived at SASSLC for a number of years. Staff familiar with him should have completed the PFA with information gained from years of observation since he was unable to communicate his preferences in a number of areas. The team did not develop outcomes to provide greater exposure to activities and opportunities to express his preferences considering his limited exposure to a range of activities. The two "new style" ISPs in the sample, however, included a much more individualized list of preferences and priorities. Information gathered from the PFA was discussed in the IDT meetings observed. Each QDDP reviewed the individual's list of preferences and members of the team engaged in discussion on how this might be supported. Teams should use this list of preferences to brainstorm ways individuals might gain greater exposure to new activities that might be of interest. Consideration of outcomes was limited based on activities available at the facility. Outcomes should be considered that might lead to greater exposure to the community. Some examples where adequate assessments were not completed for the individual prior to the annual IDT meeting, or updated in response to significant changes included: • Not all PFAs were completed in advance of the annual IDT meeting to allow all disciplines to review the assessment prior to the team meeting. • Individual #55's Habilitation Therapy Assessment was completed the day before his annual IDT meeting. • Individual #72 did not have a nutritional assessment, though the team noted that she was at risk in the weight category due to fluctuations in her weight. • A communication assessment was not completed for Individual #96 prior to his annual ISP meeting, though he was nonverbal and did not have a system in place to facilitate communication. Further, it was observed during the review that a wrist tie was being used to immobilize his hand. Staff reported that the wrist tie had been in place for awhile and was used 24/7 with brief periods of release every hour. His psychological assessment and therapy assessment did not	

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		include use of the wrist ties. His PFA, however, noted that the wrist tie was used at night in bed. There was no direction found for the use of the wrist tie, monitoring, or release. All team members will need to ensure assessments are completed, updated when necessary, and accessible to all team members prior to the IDT meeting to facilitate adequate planning. Assessments should result in recommendations for support needs when applicable. The facility was not in compliance with this item.	
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.	ISPs included a summary of assessment information and recommendations, but as noted in F1c, it was not evident that assessments were completed prior to the annual IDT meeting, were adequate to address needs, or were revised as individual's needs changed. In order to gain substantial compliance with F1d, an adequate assessment process will have to be in place. QDDPs were still at varying stages in integrating information from assessments into a meaningful plan that identified supports in relation to the individual's preferences and needs. None of the plans in the sample offered clear guidance to direct support staff on all supports needed by the individual throughout the day. There were still some plans in the sample where QDDPs were copying information from assessments into the narrative section of the plan without any additional discussion of how direct care staff should support the individual throughout the day. ISP narratives referenced other plans that addressed specific recommendations including PNM plans, healthcare plans, and behavior support plans. These plans were not submitted with the ISP so it was unclear what supports were being provided and who was responsible for evaluating the efficacy of these plans. The new ISP process included a better format for including assessment information. The two ISPs developed in the new format offered much clearer directions for providing supports and services based on assessment recommendations. It was not evident in the sample reviewed that assessments were always used to develop or revise protections and supports, as necessary. For example: • Individual #96's communication assessment noted significant regression in his communication skills, at least in part, due to fewer opportunities for maintenance of language skills via activities. The team did not develop outcomes to address his communication skills or to address his decreased participation in activities. His PFA noted very few preferences other than music or being outside. His ISP did not ensure that these preferences were adequately incorporated into his day. He had an outcome to participate in an on-campus activity twice a year. His ISP did not describe how he spent the majority of his	Noncompliance

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		day. • Individual #72's ISP stated that she was not high risk in any area, but was at medium risk for weight, medical concerns, and polypharmacy. Her risk assessment indicated that she was at high risk for dental concerns and medium risk for skin integrity, falls, choking, weight, constipation, and gastrointestinal problems. She was considered high for dental concerns due to poor oral hygiene and the need for dental pre-sedation and mechanical restraints during dental visits. Outcomes were not developed to reduce the need for dental restraints. Communication strategies were not incorporated into her skill acquisition plans. • Individual #106 had 10 falls over the past year. One resulted in a serious head injury requiring staples to his scalp. His ISP did not indicate that the team had an aggressive plan in place to safeguard him from further injury. He had an outcome stating "will be free from serious injuries due to falls over the next twelve months." There were no action steps associated with this outcome. It was not evident that adequate protections were in place. The facility was not yet in compliance with this item. QDDPs will need to ensure that all relevant assessments are completed prior to the annual ISP meeting and information from assessments is used to develop plans that integrate all supports and services needed by the individual. Plans should be clear and easy to follow for all nonclinical staff responsible for providing daily supports.	
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).	DADS Policy #004: Personal Supported Plan Process dated 7/30/10 mandated that Living Options discussions would take place during each individual's initial and annual ISP meeting at minimum. A sample of 10 ISPs was reviewed for indication that individuals and/or their LARs were offered information regarding community placement as required. In 10 (100%), this discussion took place at the annual IDT meeting. In all cases, SASSLC was determined to be the most appropriate living option. As evidenced by the examples below, this discussion, however, was not always adequate (also see section T of this report). • For Individual #72, the team agreed that there were no barriers or obstacles to living in a less restrictive environment with appropriate supports. The team concluded that she was not familiar with other living options, however, when asked she indicated that she did not wish to move. Without understanding living options, this would not constitute an informed decision. • The ISP for Individual #106 indicated that he and his family were not familiar with alternative living options. The team noted that he appeared to be content	Noncompliance

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		living at SASSLC and had expressed no dissatisfaction. There were no barriers noted to his living in a less restrictive environment. The team concluded that he should continue to live at SASSLC and information on living alternatives would continue to be provided at least annually or as requested. • Individual #130 indicated that she would like to live in the community closer to her family. Her ISP stated that the only obstacle to living in the community was that her mother lived in Corsicana, TX. The team did not discuss exploring living options in that area. The MRA stated that she would benefit from tours and exposure to community living options. No outcomes were developed to ensure that she had additional opportunities to explore living options. On 2/15/12, the IDT met and determined that her home was no longer the most appropriate placement for her following a change in health and behavioral status. The team did not feel that other homes at SASSLC were appropriate. Alternative community living options that might provide adequate behavioral supports were not considered. Placement in a nursing home was discussed and was determined to be inappropriate. The team agreed to refer her to SASH for now. • Information in Individual #127's ISP regarding optimal placement was conflicting. One paragraph noted that he would benefit from living in a smaller group home of three, four, or fewer people. The community living options summary stated "based on the information shared at this meeting, he would not benefit from community placement at this time." It was noted in discussion at IDT meetings observed, that IDTs were beginning to talk about community living options. Teams, however, remained not well informed regarding living options. At the IDT meeting for Individual #311, the nurse stated that she did not think 24 hour nursing supports were available in the community. The QDDP agreed that this was probably the case. There was no discussion regarding exploring other options to see if supports were available in the community. Teams still were not developing appropriate actions to move individuals forward with living in a more integrated setting. There were some common themes among the discussion and determination of optimal living placement in the ISPs 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. • Teams were not aware of all community options and supports available to individuals in the community. • Community integration and employment were not adequately addressed in any of the ISPs reviewed or at any of the IDT meetings observed. • Measurable action plans with reasonable timelines for completion were not	

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		developed when IDTs agreed that placement in a least restrictive environment would be an appropriate consideration. • Outcomes addressing community awareness were not based on priorities identified by the team and were not functional in the community. IDTs need to give consideration to the following: • The primary focus of all IDTs should be to provide training and supports that would allow each individual to live in the most integrated setting possible. • 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. • Team members need to be provided with updated training on services and supports that are now available in the community. Plans included limited opportunities for community based training. None of the plans in the sample included opportunities to develop relationships and gain membership in the community. Although the facility reported that some training was occurring in the community, it was not evident in ISP outcome documentation. Plans will need to include community based teaching strategies to ensure that training is consistent and measurable. There was no progress towards ensuring opportunities for community integration in the two newest ISPs in the sample. The ISP for Individual #254 included an outcome for community awareness that was written to take place in the classroom setting rather than the community. He had an SAP to state how many one-dollar bills equaled five dollars. He did not have a money management outcome that could be functionally implemented in the community. His team acknowledged that work was important to him, but determined that he had no desire to work in the community. There was no evidence that he had ever been exposed to community employment or offered that option. Individual #229 had an outcome to continue to participate in community and campus activities. There was no indication that functional training would be implemented in the community or that the activity would necessarily have to occur in the community. 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.	

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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 self-assessment indicated that while the facility was not yet in substantial compliance with this provision, steps had been taken to address this provision, including: • The QDDP Coordinator was attending IDT meetings and providing immediate feedback to teams. • QDDPs had attended ISP training with the DAD consultants. The ISPs in the sample 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. In order to meet compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those preferences are integrated into each individual's day. Observation did not support that individuals were spending a majority of their day engaged in activities based on their preferences. ISPs reviewed were reflective of the lack of options and programming available at SASSLC. While some plans included opportunities to take trips to the community, and minimal training opportunities in the community, none presented opportunities for participation in a manner that would support continuous community connections, such as friendships and work opportunities. Supports and services were not in place to encourage individuals to try new things in the community. Examples are noted in F1e above. The facility was not in compliance with this item.	Noncompliance
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. ISPs in the sample reviewed did not consistently specify individualized, observable, and/or measurable goals and objectives, the treatments or strategies to be employed,	Noncompliance

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	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;	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. Teams continued to struggle with developing measurable outcomes for individuals. Often the outcome was expressed as a broad process (e.g., individual will participate in one community outing per month), rather than specifying a measureable training objective designed to teach a new skill in a specific setting. Specific behavioral indicators should be identified to determine successful implementation. For example: • Individual #96 had an SAP that stated, "will be exposed to money management skills at least once per month." Strategies had not been developed to ensure consistent implementation and documentation of successful attempts. • Individual #229 had an outcome to continue to participate in community and campus activities. No guidance was offered to staff in what activities should be offered or how staff would ensure that participation was meaningful to her. • Individual #254's ISP included numerous outcomes to address healthcare areas that were identified as risk areas. The outcomes did not provide guidance on offering supports. For instance, he had outcomes that stated, "will continue to be seizure free" and "will be free of complications secondary to osteoporosis." 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 T1b1 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. PNM, healthcare management plans, and dining plans were not submitted as part of any of the ISPs submitted to the monitoring team. These plans should be attached to the ISP and considered an integral part of the plan. The facility self-assessment found that ISP assessments were not always submitted 10 days prior to the annual IDT meeting, thus, integration of all plans was not possible. When developing the ISP for an individual, the team should consider all recommendations from each discipline along with the individual's preferences and incorporate that information into one comprehensive plan that directs staff responsible for providing support to that individual. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings.	Noncompliance
	4. Identifies the methods for implementation, time frames	For the goals and objectives identified, ISPs described the timeframes for completion and the staff responsible. Methods for implementation were not always adequate, as is	Noncompliance

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	for completion, and the staff responsible;	discussed in further detail in section S this report. Professional or supervisory staff were often designated as the responsible person in action plans. Direct support staff's role was not specified when they typically played a key role in monitoring healthcare needs and providing daily support. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs. For example, Individual #254's ISP included supports to reduce his risk of constipation, GERD, osteoporosis, weight gain, and serious injuries due to falls. Responsibility was assigned to the nurse case manager. The ISP did not offer direct support staff clear instructions on monitoring his risk and providing adequate supports. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the plans and measure progress. The role of direct support staff in implementing plans should be clearly documented in the ISP.	
	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, plans did not always adequately address supports needed by the individual to achieve the outcomes. Minimal functional learning opportunities were included in the ISPs in the sample. As noted throughout other sections of this report, there was 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. Few training opportunities were offered in a natural setting, such as the home or community. Vocational training was not geared towards moving the individual closer to community employment. There were certain constraints that limited functional training opportunities due to the fact that individuals were living at the facility rather than in the community. 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. Individuals were sitting at tables in the classroom identifying things in the community in pictures rather than going out in the community. This type of training was observed in the day program during the review week. Not surprisingly, this appeared to have little meaning or interest to the individuals.	Noncompliance

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		Interventions, strategies, and supports did not adequately address individual's needs and many were not practical and functional at the facility and/or in community settings.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	ISPs identified the person responsible for implementing service and training objectives and the frequency of implementation. ISPs also included a column to note where information should be recorded. 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. Training program/data collection sheets were generated for training objectives, but not healthcare and behavioral objectives. This form included what data would be collected, the frequency of data collection, who would collect data and who would monitor data. Since healthcare plans, PNM plans, and behavioral plans were not attached to the ISP(as part of the overall plan), it was not clear what data would be collected to evaluate progress or regression on those outcomes. It was not evident that team members were using data collected to drive planning in regards to necessary supports. This was particularly true in regards to risk discussions. Data that should have been reviewed by the team included test/laboratory results, skill acquisition goal data, injury and incident data, data related to nursing care plans (e.g., weight, number of seizures, hospitalizations), behavioral data, and response to medications. Quarterly reviews did not include data collected over the quarter. See section I for additional comments regarding adequately identifying risks. 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 management indicators.	Noncompliance
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will require 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. As noted in F1b and F1c, representation from all relevant disciplines was not evident during planning meetings and adequate assessments were not completed prior to the annual meetings. The monitoring team found a lack of coordinated supports and services throughout the facility. IDTs will need to work together to develop ISPs that coordinate all services and supports.	Noncompliance

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		The facility did not have a process to ensure coordination of all components of the ISP.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The facility indicated that that no new initiatives had been taken to address this provision item. Interviews by the monitoring team throughout the residential and day programs found that staff interviewed were familiar with the primary risks and supports needed for the individuals assigned to them. Some "pulled" (i.e., substitute) staff" were not as familiar with plans for individuals in the homes. A sample of individual records was reviewed in various homes at the facility. Current ISPs were not available in 5 of 23 (22%) of the records, indicating that support staff did not have information necessary to fully implement ISPs. This was noted to be a problem during the last monitoring visit. Although, this was an improvement from the last monitoring visit, there were still a significant number of plans not available to staff providing supports. As noted above, many health and therapy related outcomes did not assign responsibility to direct support staff that would need to carry out the plan, so staff did not have information available to offer guidance in providing supports. A lack of integration of plans contributed to confusion over what supports were needed. Many separate plans existed that were not integrated into the one comprehensive plan. As the state continues to provide technical assistance in plan development, a strong focus needs to be placed on ensuring that plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation. The facility remained out of compliance.	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	A review of records indicated that the IDT routinely met to discuss significant changes in an individual's status, particularly regarding healthcare and behavioral issues. As noted throughout this report, it was not evident that teams were aggressively addressing regression, lack of progress, and risk factors by implementing appropriate protections and supports, and revising plans as necessary. An example of this noted during the review week occurred when Individual #130 sustained a serious injury to the head with significant bruising. Lab work prior to the injury indicated a low platelet count that may have contributed to the significant bruising. The IDT had not discussed her lab work prior to the injury. She had been refusing to attend medical appointments, but the team had failed to adequately address this. Following the injury, she refused adequate medical treatment. The team should have addressed these issues prior to a critical incident	Noncompliance

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	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.	occurring. QDDPs completed quarterly reviews. The quarterly review form included a section to note progress or regression on all service and training objectives monthly and a place for QDDPs to comment quarterly on the progress or lack of progress. It was not evident that this process was thorough enough to adequately assess the progress and efficacy of the related interventions. Examples of findings: • The quarterly review for Individual #106 dated 7/29/11 offered no information on his progress or response to the implementation of outcomes based on data collected. The QDDP comment section on five of his outcomes stated, "Progress notes were not available for review." Data were only included for one of 26 outcomes. For 25 outcomes, data were reported as "maintained," with no further information on progress or regression. All outcomes were recommended to be continued. Review of assessments, such as the nursing plan, stated, "See most updated report." There was no information on assessments or supports provided during the previous quarter. • The quarterly review for Individual #32 dated 8/31/11 did not include data collected throughout the three months reviewed for 14 of his outcomes. Notes regarding data collected for other outcomes were not sufficient for determining if action plans in place were effective. For example, in regards to his outcome "will experience 3 seizures or less per quarter," the QDDP noted "regressed, 3 this quarter, continue without change." He had an outcome to keep his mouth open during the completion of the oral hygiene process. Data for each of the three months in the reporting period was noted as 0/8 trials. The QDDP commented, "Continue w/o change." No additional information was recorded on progress or lack of progress. • The quarterly review for Individual #150 dated 9/30/11 included data, though it was not evident that the data collected resulted in any changes in action plans when progress was not evident. For example, one of his outcomes stated, "will have 4 or less episodes of refusals per week." Data indicated that he had eight refusals during June and 23 refusals for both July 2011 and August 2011. The comment section stated "continue objective." There was no indication that the team discussed the efficacy of his program. The quarterly review of his outcome to participate in at least one off campus and one on campus activity per month, just noted multiple outings. Information did not include where he had been on outings or his response to those outings. The facility did not have an adequate review system in place. Monthly and quarterly reviews should address the lack of implementation, lack of progress, or need for revised supports based on data collected. Follow-up on issues occurring during the quarter	

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		should be documented. As the facility continues to progress toward developing person centered plans for all individuals at the facility, QDDPs need to keep in mind that ISPs 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. QDDPs 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 updated competency- based training when the plans are revised.	In order to meet the Settlement Agreement requirements with regard to competency based training, QDDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. • A review of training transcripts for 24 employees indicated that 24 (100%) had completed the new training on ISP 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 was aware of deficits in the implementation of the ISP and was providing additional training to direct support staff. The facility's self-assessment indicated noncompliance with this requirement. The monitoring team agreed with that assessment.	Noncompliance
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	Of ISPs in the sample reviewed, all (100%) had been developed within the past 365 days. As noted in F2c, a sample of 23 plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. It was found that 22% of the plans in the sample were not current. This is concerning for a number of reasons. The ISP should be the plan that ensures all support staff have information regarding services, risks, and	Noncompliance

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	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.	supports for individuals in the home. Without it, staff did not have the tools that they needed to safely and consistently support individuals. As noted in F2d and other areas of this report, plans were not always revised when supports were no longer effective or applicable. The facility was rated as being out of compliance with this provision item.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). SASSLC had not yet fully implemented the audit process utilizing the statewide audit tool for section F. Once the audit process has been implemented, the facility will need to analyze findings and develop corrective action plans. The QDDP Coordinator continued to attend ISP meetings and evaluate the ISP process. She was providing immediate feedback to QDDPs facilitating meetings observed. An effective quality assurance system for monitoring ISPs was not fully 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. It will be important for the QDDP's to gain some facilitation skills that will allow them to keep the teams on track while making sure that everything is addressed particularly supports to address all risk that teams identify (F1a).

3. When individuals are not present for meetings, the QDDP 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).

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

5. A description of each person's day along with needed supports identified by assessment should be included in ISPs. All supports and services should be integrated into one comprehensive plan (F1d).

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

7. Outcomes should be developed to address communication skills, decision making skills, and increased exposure to life outside of the facility (F1e).

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

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

10. Teams should develop meaningful, measurable strategies to overcome obstacles to individuals being supported in the most integrated setting appropriate to their needs. Specific behavioral indicators should be identified to determine successful attempts at outcomes (F2a2).

11. IDTs 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).

12. The team should develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. The ISP should be a guide to providing support services for direct support staff. Their responsibility should be clearly stated in ISPs (F2a4, F2c).

13. IDTs should develop outcomes that are practical and functional at the facility and in community settings (F2a5).

14. 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).

15. Ensure plans are accessible, integrated, comprehensible, and provide a meaningful guide to staff responsible for plan implementation (F2c).

16. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues (F2d).

17. Develop a process to revise ISPs when there is lack of progress towards ISP outcomes or when outcomes are completed or no longer appropriate outside of schedule quarterly review meetings. Review and revise plans when there has been regression or a change in status that would necessitate a change in supports. Ensure that staff are retrained on providing supports when plans are revised (F2d, F2e, F2f).

18. Develop an effective quality assurance system for monitoring ISPs (F2g).

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 SASSLC Standard Operating Procedure: 200-5C, Facility Integration of Clinical Services o SASSLC Self-Assessment, 2/1/12 o SASSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes, August 2011 – January 2012 Interviews and Meetings Held: o Carmen Mascarenhas, MD, Medical Director o JoAnn Smith, RN, Medical Compliance Nurse o Ralph Henry, Facility Director o Liesl Schott, MD, Primary Care Physician o Yenni Michel, DO, Primary Care Physician 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 Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: The facility's self-assessment was completed on 2/1/12. For each provision item, the medical director, who served as lead, provided a list of actions that occurred that would assist the facility in achieving substantial compliance. This was helpful information, but it did not assist the monitoring team in understanding how the facility arrived at its self-ratings. The self-assessment should help the facility gain some sense of where it stands relative to achieving substantial compliance. In moving forward, the medical director should read each provision item in this report noting (1) the activities the monitoring team described that were used in the assessment of the provision item, (2) the topics that the monitoring team commented on, and (3) suggestions and recommendations contained in the body of the report as well as the recommendations section. This

	approach should assist the medical director in developing a series of activities that can be completed in order for SASSLC to conduct a self-assessment. Completion of the self-assessment should provide a reasonable sense of where the provision stands relative to compliance. Thus, the medical director would report a self-rating of substantial compliance or noncompliance and provide a concrete reason for that determination. The facility found itself in substantial compliance with Provision G2 and in noncompliance with Provision G1. The monitoring team agreed with the self-rating of noncompliance with G1. Due to the facility's performance data for G2 (external medical reviews Question #27), the monitoring team found noncompliance with Provision G2.
	Summary of Monitor's Assessment: The facility continued to make progress in this area. Many steps occurred, locally and at the state level, in an effort to integrate clinical services. State office developed a draft procedure Minimum and Integrated Clinical Services to address the requirements of Provision G and Provision H. Similarly, in January 2012, the facility formally adopted a procedure related to the integration of clinical services. It was clear that as new initiatives rolled out, thought was given to how clinical services could and should be delivered in an integrated manner. For example, clinical protocols developed by state office were presented as a series of color coded flowcharts that described each disciplines responsibilities, thereby promoting the concept of integrated service delivery. New committees such as the Medication Variance Review Committee and Pneumonia Review Committee were multidisciplinary in approach and this was good to see. The monitoring team had the opportunity to meet with the facility director, medical director, and medical compliance nurse to discuss integration activities at the facility. It was clear that this important provision was taken seriously and a great deal of effort had been devoted to moving towards substantial compliance. Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted. Continued work in this area is needed. The monitoring team expects that as additional guidance is provided from state office in the form of a finalized policy, the facility will have greater clarity on how to proceed.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The medical director, who served as the lead for this provision, developed a procedure that outlined the many activities that occurred in an integrated manner. The procedure described 23 activities that promoted integration of clinical services. Many of the activities were committees that had existed for quite some time. Others were new committees implemented to address clinical issues through a multidisciplinary approach. Several of the items simply explained how the process was carried out to achieve integration. The description of the activities provided a "metric" that could be used to determine if integration occurred. The facility's procedure was consistent with the state office draft procedure on Minimum and Integrated Clinical Services. In addition to developing the clinical integration procedure, the medical director requested that other discipline heads develop policies and procedures that outlined how their departments integrated with other clinical services. Policies were submitted by habilitation services and psychology. Each document provided a series of activities describing how the disciplines worked with other clinical areas to achieve integration. This likely served as a good mechanism for departments to reflect on how to achieve integration. The monitoring team reviewed local and state procedures, conducted interviews, completed observations of activities, and reviewed records and data to determine compliance with this provision item. During the conduct of this review, many examples of integration of clinical services were observed. There were also several instances in which integration needed to occur, but did not. The following are examples of integration that were noted: • Daily Clinical Services Meeting - The monitoring team attended several meetings and found this to be an excellent effort at integration. Participants included 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. The dental director also attended on Tuesdays to discuss dental sedation. Notes were recorded for this meeting and posted on the shared drive. • Consultation requests for sedation for dental clinic were a collaborative effort between the dentist, primary care physician, clinical pharmacist, and psychiatrist. As noted in section J, one concern was that while information regarding dental pretreatment sedation plans was vetted through the necessary disciplines, it was not possible to determine the integration of that information into a cogent decision regarding the individual's treatment. A meeting to briefly review and collate that information into a plan of treatment for the individual was necessary.	Noncompliance

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		• The dental clinic recently implemented a daily summary that included important events of the day, such as missed appointments and each individual's response to sedation administered. • There was integration among nursing, psychiatry, psychology, and pharmacy with regard to the IDT process evident in psychiatry clinic. • The Pharmacy and Therapeutics Committee was a multidisciplinary committee that provided oversight for issues related to safe medication practices. Medication errors, adverse drug reactions, restraints, and psychotropic drug use were a few of the topics discussed. • Quarterly Drug Regimen Reviews were completed by the clinical pharmacists and recommendations made to prescribers. • Psychotropic medication justification was discussed in the daily clinical services meeting. The psychiatrists provided the rationale for initiation of new medications and meeting participants had the opportunity to discuss the relevant issues. • Some improvements in integration were observed between psychology and psychiatry (though see below), and between the rehabilitation staff and the active treatment coordinator in the development of SAPs. Several areas offered great opportunities for improvement: • Integration between psychiatry and psychology was lacking. A first step in providing integrated services was to have the lead psychiatrist and psychology coordinator meet on a weekly basis and this was an improvement. In recent months, there had been a hiatus of these meetings due to extended leave of the lead psychiatrist. • Consent for dental treatment was cited as a collaborative effort between the dentist, QDDPs, and human rights officer. Although this was not an integration of clinical services, a lack of true collaboration resulted in many individuals having treatment delays due to a lack of consent. • The development of strategies to overcome barriers to dental treatment was intended to be collaboration between psychology, dental, and medical. Interviews with various disciplines indicated that this process had not been effective. Development of a new dental restraint procedure should provide further structure and guidance for this process. • The primary care physicians did not participate in the Pharmacy and Therapeutics Committee meeting and, therefore, information on DUEs, ADRs, and FDA announcements did not get communicated in the meeting as described in local policy. Polypharmacy was discussed at the meeting attended by the monitoring team, but the psychiatrist did not attend. • While the daily clinical services meeting served as a forum for discussion, a	

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		review of meeting notes indicated that many issues that required collaboration did not have documentation of follow-up or closure. • The PNMP Committee focused on the integration of nursing, dietary, and habilitation services regarding physical and nutritional management plans, positioning, and medication administration. The monitoring team found that the PNMT did not receive many, if any, referrals from the IDTs for individuals who would benefit from this specialized team. The PNMT nurse attended many clinical reviews and, as a result, there were some PNMT-initiated referrals of individuals who had changes in status, such as hospitalizations and pneumonia. It appeared that there was a reliance on an expected physician's order for PNMT involvement when, in fact, any team member can make a referral (i.e., a physician's order is not necessary).	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility made progress with this provision item. The medical services policy provided clear direction on the requirements for this provision item and there was documentation in physician meeting notes that the medical director discussed this requirement with the medical staff. The medical director reported that the primary care physicians were documenting the summary of consults in the integrated record within the required timelines. In addition to this, a copy of all consults and the IPN were forwarded to the QDDP for discussion at the team meetings. This was particularly important in those instances where a procedure was being scheduled and additional supports would be required. For the record sample in section L, there was evidence that the primary care physicians documented in the IPN. This was not seen in every record for every consult, but during recent months, more frequent documentation was noted. Other reviews indicated that the IDT did not adequately review information from outside consultants. For example, on 9/4/11, Individual #99 was sent to the emergency room for treatment of nasal abscess and infection of the skin of his face, which required incision, drainage, and treatment with intravenous antibiotics. On 9/6/11, Individual #99's IDT met to "discuss, review, and approve the interventions listed on Individual #99's ACP regarding left facial cellulitis." Although Individual #99's IDT reviewed the medications/antibiotics administered and prescribed by the ER physicians, there was no evidence that they received and reviewed information, such as the nature and type of infection that he suffered and what, if any, specific recommendations were made by the tertiary care professionals to reduce the likelihood that he would suffer a reoccurrence of infection.	Noncompliance

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		The current state medical audit included two questions that focused on Provision G2. Question #27 addressed the documentation in the IPN within five days by the physician. Question #28 addressed the physician's documentation of a rationale in those cases that the recommendation was not accepted. External medical audit data, however, for round 2 showed compliance rates of 75% and 100% for question #27 and question #28, respectively. Data for round 3 showed compliance rates of 75% and 0% for question #27 and question #28, respectively. Thus, compliance for question #27 fell below the facility's requirement of 80%. There was some inconsistency in how NA (not applicable) ratings were dealt with in determining these calculations. Further, these two questions probably require modification if they are to directly assess the requirements of G2 and if they are to serve as valid and reliable measures for assessing G2.	

Recommendations:

1. The daily clinical services meeting should record minutes, which should be reviewed for accuracy and signed by the medical director. When follow-up is required, the minutes should document action steps, responsible persons, and timelines for follow-up. (G1).

2. The facility should ensure that committees are functioning as stated in policy with the required participants. It might also be helpful to review the function of committees to determine if there is duplication of efforts. (G1).

3. The facility needs to develop a system to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).

4. The facility needs a mechanism to track all consultations and appointments for diagnostics. Consideration should be given to using a format that will allow sorting by multiple fields including specialty, individual, appointment date, and PCP (G2).

5. State office will need to address the use of the current external audit criteria (questions 27 and 28) as an assessment for compliance with Provision G2 (G2).

6. DADS should develop and implement policy for Provisions G1 and G2 (G1, 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 SASSLC Standard Operating Procedure: 200-5C, Facility Integration of Clinical Services o SASSLC Self-Assessment, 2/1/12 o SASSLC Sections G and H Presentation Books o Presentation materials from opening remarks made to the monitoring team o Organizational Charts o Review of records listed in other sections of this report o Daily Clinical Services Meeting Notes, August 2011 – January 2012 Interviews and Meetings Held: o Carmen Mascarenhas, MD, Medical Director o JoAnn Smith, RN, Medical Compliance Nurse o Ralph Henry, Facility Director o Liesl Schott, MD, Primary Care Physician o Yenni Michel, DO, Primary Care Physician 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 Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: The facility self-assessment was completed on 2/1/12. For each provision item, the medical director, who served as lead, provided a list of actions that occurred that would assist the facility in achieving substantial compliance. This was helpful information, but it did not assist the monitoring team in understanding how the facility arrived at its self-ratings. The self-assessment should help the facility gain some sense of where it stands relative to achieving substantial compliance. In moving forward, the medical director should read each provision item in this report noting (1) the activities the monitoring team described that were used in the assessment of the provision item, (2) the topics that the monitoring team commented on, and (3) suggestions and recommendations contained in the body of the report as well as the recommendations section. This

	approach should assist the medical director in developing a series of "activities" that can be completed in order for SASSLC to conduct a self-assessment. Completion of the self-assessment should provide a reasonable sense of where the provision stands relative to compliance. Thus, the medical director would report a self-rating of substantial compliance or noncompliance and provide a concrete reason for that determination. The facility found itself in substantial compliance with Provision H2 and noncompliance with all other provision items. The monitoring team was in agreement.
	Summary of Monitor's Assessment: The facility was positioned at the time of the onsite review to move forward with this provision item. The medical director and medical compliance nurse were quite familiar with every provision item and understood that Provision H reflected a means of ensuring that all of the elements of clinical care were appropriately coordinated and monitored. To that end, they drafted the facility-specific procedure Minimum Common Elements of Clinical Care. This procedure was congruent with the state draft procedure for the Provision H. For each provision item, the procedure described how the clinical disciplines captured and monitored the delivery of care. This represented a good effort by the facility, but more importantly, indicated that this important provision was being taken seriously. Overall, the monitoring team found that routine assessments, such as medical assessments, were being completed in a timely manner, but in some areas, routine assessments were not being completed as required. Additionally, the content of the assessments in many areas will need improvement. Since many of the activities in this provision were related to the determination of quality, it will be important for the quality assurance department to work collaboratively with the areas of clinical services. Additional direction from state office and involvement of the facility director will be critical in helping to achieve substantial compliance.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals'	Incremental progress was noted for this provision item. The state office policy, which remained in draft, required each department to have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice. SASSLC drafted a procedure on the Minimum Common Element of Clinical Care. The medical director indicated that this policy draft was based on information obtained from state office and the local procedure followed the direction of the state draft. The	Noncompliance

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	needs.	document was actually a list of the activities and processes that the facility engaged in to meet compliance. The document described all of the various assessments that were completed, including the annual medical assessment, quarterly medical assessment, comprehensive annual and quarterly nursing assessments, drug regimen review, Reiss screen, comprehensive psychological assessment, comprehensive psychiatry assessment, comprehensive annual therapy assessment, audiology assessment, and dental assessments. While the document nicely outlined the frequency of assessments, the facility did not have a mechanism to track all of the required assessments in any kind of centralized way. In other words, the medical director as lead for this provision item, did not have data on the compliance for nursing assessments, psychological assessments, or the other assessments listed in the draft procedure. This will require that every department monitor its assessments on a regular basis. Recognizing the need for the facility to track all assessments, the medical director and medical compliance nurse developed a corrective action plan, which outlined the mechanisms that could be used by the various departments to ensure that assessments were occurring in a timely manner. This was a good start for the facility to comprehensively "assess its assessments" as far as timelines for completion were concerned. The monitoring team needs to emphasize that the facility must monitor all three elements that this provision item addresses: (1) the timelines for completion of scheduled assessments, (2) the appropriateness of interval assessments in response to changes in status, and (3) the quality of all assessments (compliance with accepted standards of practice). This report contains, in the various sections, information on the required assessments. This provision item essentially addresses the facility's overall management of all assessments. In order to determine compliance with this provision item, the monitoring team participated in interviews, completed record audits, and reviewed assessments and facility data. The results of those activities are summarized here: • The format for the Annual Medical Summaries was revised in September 2011 and the changes resulted in a document that was more readable and had better content. The external medical reviews noted compliance rates of approximately 93% for round 2 and 100% for round 3. • Quarterly Medical Summaries were completed and noted in the records. • Quarterly Drug Regimen Reviews were completed in a timely manner. • Annual Dental Assessments were noted in the records, but data indicated very low compliance for completion within required timeliness.	

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		• With regards to nursing, it was noted that there continued to be 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. • For habilitation services, a new assessment format had been implemented and was an improvement in format and content. There was very limited evidence of comprehensive or even brief discipline-specific assessments based on change in status, such as hospitalizations with the exception of suspected choking events. These were noted in both cases of choking reported in the last year. • Initial psychological assessments and annual assessments were improving, but neither was consistently completed. Moreover, functional assessments were not completed for all individuals with PSSPs. • Psychiatry clinic was providing quarterly medication reviews that were timely (i.e., of 191 individuals participating in psychiatry clinic, there were eight individuals who were overdue for quarterly clinical review). • SASSLC was behind with regard to Appendix B psychiatric evaluations.	
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.	The medical director reported that medical and psychiatric diagnoses were formulated in accordance with ICD/DSM nomenclature. A training module was provided to the medical and psychiatry staff in January 2012. It included information on ICD official coding guidelines, ICD/DSM interphase, and examples of ICD/DSM usage. It was documented that the monthly audits indicated that physicians "conform to ICD and DSM criteria." Data presented at the opening meeting indicated 100% compliance in both areas based on monthly audits of 5% of the records (APL and psychiatric quarterlies). The monitoring team assessed compliance with this provision item by reviewing many documents including medical, psychiatric, and nursing assessments. • Generally, the medical diagnoses were consistent with ICD nomenclature. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed documentation of specific criteria exhibited by an individual indicating a particular diagnosis. • None of the 21 sample individuals' nursing assessments resulted in complete or accurate lists of nursing diagnoses, in accordance with NANDA. The medial director will need to determine how to continue to audit for the appropriateness of the psychiatric diagnoses because this cannot be determined by the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		compliance nurse. The medical director will also need to ensure that the diagnosis in the assessments is consistent with disease presentation, symptomatology, and results of diagnostics.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The facility procedure commented on the responses that various departments made when there was a change in clinical status. This included nursing, medical, psychiatry, dental, and team interventions. Although the document clearly outlined actions that needed to occur, there was no process in place that could reliably prove that these actions and interventions actually took place. It appeared that the facility was in need of guidance from state office on how to proceed with this provision item, particularly regarding what needed to be monitored. State office, through the development of clinical protocols, had in fact provided the foundation for assessing compliance for some elements of care. The multidisciplinary protocols for seizure management, bowel management, aspiration, and urinary tract infections described a series of actions or interventions that the medical and nursing staff needed to take in managing certain conditions. The facility also implemented additional clinical guidelines related to anaphylaxis, seizure management, osteoporosis, diabetes, and urinary tract infection that described processes and outcomes. Notwithstanding concerns related to implementation, the facility had data that could be used to determine if interventions were appropriate for some clinical conditions. Quality audits of diabetes and aspiration management were completed. Based on the facility's own reviews, interventions were frequently not clinically appropriate as compliance with some process indicators was low. This is discussed in section L3. In order for the monitoring team to assess compliance with this provision item, the usual activities of interview and document reviews were completed. • Based on the review of records listed in section L, the medical staff generally responded to the needs of the individuals, provided treatments, and ordered diagnostics. Improvement was needed in timeliness and appropriateness of follow-up evaluations. There was also a need to focus on certain high risk conditions to improve clinical outcomes. • Facility data, reported in section L2, indicated that interventions for management of diabetes, aspiration, and seizure disorder required improvement. Again, the facility must include all clinical disciplines when addressing this provision item.	Noncompliance

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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 facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Medical quality audits were completed, but the criteria used will need to be reviewed. Clinical indicators assess particular health processes and outcomes. Monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization of health care delivery. The facility will need to give considerable thought to this process to ensure that a solid combination of clinical indicators is selected. This must be established for individuals and for facility aggregate data. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas. The current local draft policy addressed only medical indicators. Indicators are needed for psychiatry, psychology, nursing, and habilitation services.	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The facility did not have an overarching plan to address this provision item. Databases were established to track some elements of preventive care, diabetes, and seizure management. The local draft procedure defined the numerous ways which the various clinical areas monitored status. With the exception of the medical audits, for the data elements that were in place within the medical department, there was no evidence that this information was reviewed and analyzed on a routine basis. There was no systematic monitoring of health status of all individuals. Achieving such a system will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The first step in the process is to define what is important to the individuals and what is important that the facility monitor. Much of this work had already been completed. The facility needs to proceed with developing a comprehensive list of indicators based on these findings.	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.	As mentioned in H5, the facility needs to establish a comprehensive set of clinical indicators. Many of those will be based on clinical guidelines developed. There are many other indictors that could and should be included. Examples would include the rate of hospitalizations, readmission rates, the incidence of pressure ulcers, the days of healing for pressure ulcers, the number of acute interventions required for bowel management, the prevalence of dehydration, and the prevalence of undesired weight loss. Once the indicators are established and treatment expectations outlined, audits of records and other documents will indicate if treatments and interventions were appropriate.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	State office had developed a draft policy for Provisions G and H. The facility had not finalized the local policy on minimum common elements. It should be reviewed and revised as necessary. The revision should include those steps listed in the action plan that addressed how the various departments will monitor assessments and other activities.	Noncompliance

Recommendations:

1. The facility must ensure the following with regards to assessments:
    a. All assessments must occur within the required timelines. This will require tracking of scheduled assessments in all clinical disciplines.
    b. Interval assessments must occur in a timely manner and in response to a change in status.
    c. All assessments must meet an acceptable standard of practice (H1).

2. In addition to tracking assessments, the medical director will need to generate a report on a regular basis, perhaps quarterly, that shows compliance with timelines, appropriateness of assessments, the quality of assessments and other chosen indicators. If deficiencies are noted, a corrective action plan should be developed to address the problems. This should apply to all clinical disciplines (H1).

3. The medical director will need to ensure that the medical diagnoses are consistent with the signs and symptoms of the condition (H2).

4. The facility must develop a comprehensive list of clinical indicators across all clinical disciplines. The timeliness and clinical appropriateness of treatment interventions will be difficult to measure without establishing clinical indicators that assess (1) processes or what the provider did for the individual and how well it was done and (2) outcomes or the state of health that follow care (and may be affected by health care) (H3, H4).

5. The facility must have a system that regularly reviews clinical guidelines, protocols and selected indicators to ensure that current practices are implemented and the most relevant indicators are being measured (H3, H4).

6. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).

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 SASSLC self-assessment for Section I o SASSLC Section I Presentation Book o List of serious injuries for the past six months o List of individuals seen in the ER since 2/1/11 o List of individuals hospitalized since 2/1/11 o List of individuals with pneumonia incidents in the past 12 months 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 Incidents and Injuries for the past six months o List of individuals at risk for respiratory issues o List of individuals at risk for GERD o List of individuals with a history of seizures o List of individuals with metabolic syndrome 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 individual at risk for skin breakdown o List of individuals with dysphagia o List of individual at risk for choking o List of individuals with contractures o List of individuals with osteoporosis or osteopenia o List of individuals 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 ISPs, Risk Rating Forms, Risk Action Plans for: • Individual #130, Individual #96, Individual #72, Individual #106, Individual #55, Individual #194, Individual #150, Individual #83, Individual #160, Individual #127, Individual #32, Individual #86, Individual #232, Individual #116, and Individual #254. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Daisy Ellison, Psychology Coordinator o Audrey Wilson, QDDP Coordinator o Meeting with various staff involved in the at-risk process, 2/14/12 <u>Observations Conducted</u>: o Observations at residences and day programs o Daily Unit Meeting 2/14/12 o Incident Management Review Team Meeting 2/14/12 and 2/15/12 o Human Rights Committee Meeting 2/16/12 o Annual IDT meeting for Individual #311 on 2/10/12 o Quarterly IDT meeting for Individual #111 on 2/15/12 o QDDP meeting on 2/15/12
	Facility Self-Assessment: SASSLC submitted its self-assessment. It 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., RN case manager received At Risk Training) The self-assessment 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, however, how SASSLC came to these self-ratings.

	Summary of Monitor's Assessment: SASSLC had taken minimal steps towards compliance with this provision including: • A DADS consultant had provided training to the facility on the new ISP Process and Risk Identification Process. • The QDDP Coordinator and QA Nurse had provided training on the new risk identification process to nurse case managers. • Teams began implementing the new risk identification process as of 2/1/12. The monitoring team met with some IDT team members who were regularly involved in the at-risk process. Team members agreed that the facility was in the initial stages of implementing the new risk identification process. The QDDP Coordinator acknowledged that while teams were having much more integrated discussions around risks, the process was still fairly unwieldy for QDDPs and other team members. As noted in section F, the monitoring team did not find that IDTs were consistently completing assessments prior to the IDT meeting or updating assessments as needed. Teams could not adequately discuss risk factors without current, accurate assessments in place. Staff were not adequately trained on monitoring risk indicators and providing necessary supports. 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 IDTs to meet to discuss risks for each individual at the facility. The at-risk process was to be incorporated into the IDT meeting and the team was required to develop 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 when appropriate. A list of indicators for each of 21 risk areas had been identified by the 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. Observation of annual IDT meetings scheduled the week of the review showed that IDTs were still experimenting with how to integrate the new risk identification process with the new ISP development process. QDDPs 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. Although, teams were beginning to engage in more in-depth discussions regarding health indicators, there was still a strong reliance on guidelines developed by the state that did	Noncompliance

#	Provision	Assessment of Status	Compliance
		not take into consideration integrated risk factors. A sample of ISPs and the facility risk rating list were reviewed to determine if risks were being properly identified and addressed by IDTs. IDTs were holding much better discussions regarding risk and assessments were more accurate. The following are some examples where risks were not appropriately identified in documents reviewed. ▪ The IDT rated Individual #55 at medium risk for constipation and infections. His ISP did not address either risk. His medical assessments indicated that he had epilepsy and recurrent otitis media. Neither was addressed by his risk assessment or ISP. He was prescribed medication for osteoporosis and low vitamin D. His risk assessment indicated no history of osteoporosis and rated him as low risk. It did not appear that the team had an adequate integrated discussion regarding his risks levels. ▪ The risk assessment for Individual #96 indicated that he was at low risk for weight issues and fluid imbalance. He received his nutrition and fluids via g-tube. Without the appropriate supports in place, he was at high risk in both of these areas. He was considered medium risk for skin integrity, but was not mobile and was unable to reposition himself. He was considered medium risk for aspiration. He had a number of medical issues that would have placed him at high risk for aspiration. There was no evidence that his IDT had an integrated discussion regarding his complex medical needs to address all of his risk factors. His quarterly reviews were not data driven or sufficient for monitoring his risks. ▪ Individual #254 was rated as low risk for GI issues. A number of his assessments, including his nursing assessment, noted that he had GERD. He was also rated as low risk for dental issues. His dental assessments noted a long history of poor oral hygiene and gingivitis. His risk for constipation was rated as low, though he had a diagnosis of constipation on his nursing and other healthcare assessments. Lab work over the past year consistently revealed lab values in both the low and high range. There was no indication that the team discussed his lab work in relation to risk factors. The review of 21 sample individuals' records listed in section M revealed that one-third of the 21 individuals' records failed to have a risk assessment and risk action plan filed in their record at the time of the review. Also, across these records, it appeared as though changes in behavior were much more likely to trigger an ISPA and review of risk than changes in health. Overall, the assessment of individuals' health <u>risks</u> appeared to be confused with an assessment of their <u>acuity</u>, and it was usually not until individuals suffered actual untoward outcomes, such as fractures, repeated falls with serious injuries, life-threatening infections, bowel obstructions, etc. that their health risk levels were raised.	

#	Provision	Assessment of Status	Compliance
		Additional examples are listed in section M5. For both short and long range planning, the teams will need to: • Frequently gather and analyze data regarding health indicators (e.g., changes in medication, results from lab work, engagement levels, mobility). • Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • 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. • 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. The facility was not yet in compliance with this provision item. 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 At Risk policy required that when an individual was identified at high risk, or if referred by the IDT, 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 IDT within 14 working days of the completion of the plan, or sooner if indicated by risk status. In the sample reviewed, it was evident that teams were making referrals to the PNMT for review and recommendations. As noted throughout this report, it was still not evident that adequate plans were being developed to address identified risk or that all risks were appropriately identified by the IDT. The facility will have to have a system in place to accurately identify risks before achieving substantial compliance with I2. As noted in section F, the facility did not have an adequate monthly or quarterly review system in place to identify regression that may indicate the need for revisions of supports. The IDTs of several individuals who suffered significant changes in their health status and needs failed to conduct interdisciplinary assessments of the individuals' needs of services and supports and develop plans to meet those needs. 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	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>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 remained out of compliance with this provision item.</td><td></td></tr>
<tr><td>I3</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.</td><td>The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the IDT. It required that the IDT implement the plan within 14 working days of completion of the plan, or sooner if indicated by the risk status. A majority of the ISPs that were reviewed included general 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 IDT in response to risk categories identified by the team.

According to data provided to the monitoring team, of the 21 individuals rated at high risk for aspiration, only four (19%) had a care plan in place to address the risk. The following individuals did not have a plan in place: Individual #94, Individual #229, Individual #301, Individual #335, Individual #18, Individual #239, Individual #302, Individual #243, Individual #227, Individual #143, Individual #287, Individual #157, Individual #255, Individual #152, Individual #197, Individual #96, and Individual #99.

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. As noted in I1, accurate risk ratings were not necessarily being assigned, therefore, many other individuals not identified as being at high or medium risk did not have plans in place.
<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>25</td><td>4/16%</td></tr>
<tr><td>GERD</td><td>4</td><td>0/0%</td></tr>
<tr><td>Choking</td><td>4</td><td>1/25%</td></tr>
<tr><td>Falls</td><td>13</td><td>0/0%</td></tr>
<tr><td>Weight</td><td>24</td><td>1/4%</td></tr>
<tr><td>Skin Integrity</td><td>6</td><td>0/0%</td></tr>
<tr><td>Constipation</td><td>5</td><td>0/0%</td></tr>
<tr><td>Causing harm to others</td><td>11</td><td>0/0%</td></tr>
<tr><td>Seizures</td><td>22</td><td>0/0%</td></tr>
<tr><td>Dehydration</td><td>1</td><td>0/0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Osteoporosis	16	0/0%
Dental	82	19/23%

It will be necessary for the facility to have a system in place that accurately identifies risk prior to achieving substantial compliance with I3 requirements. As noted throughout this report, when intervention plan were developed, they often did not provide enough information for direct support staff to consistently implement support or were not carried out as written, therefore, individuals remained at risk.

See additional comments throughout this report regarding the monitoring of healthcare risks. The facility indicated that the facility was not in compliance with this provision. The monitoring team agreed with that assessment.

Recommendations:

1. Ensure assessments are completed prior to annual IDT meetings and results are available for team members to review (I1).

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

3. For both short and long range planning, the teams will need to (I1):
    a. Frequently gather and analyze data regarding health indicators.
    b. Consider and discuss the interrelatedness of risk factors in an interdisciplinary fashion.
    c. Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical.
    d. 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.
    e. 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.

4. All health issues should be addressed in ISPs 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).

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

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

7. Implement a monitoring system to ensure that direct support staff have ISPs 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 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 IDT meeting associated with the incident o Ten examples of documentation of psychiatric consultation regarding pretreatment sedation for dental or medical clinic o List of all individuals with medical/dental desensitization plans and date of implementation o Three examples of dental desensitization plans o Auditing/monitoring data and/or reports addressing the pretreatment sedation medication. o A description of any current process by which individuals receiving pretreatment sedation were 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 ISP review o A list of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use o A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use o A list of individuals diagnosed with tardive dyskinesia, including the name of the physician who was monitoring this condition, and the date and result of the most recent monitoring scale utilized o Documentation of inservice 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; Trazodone; beta blockers being used as a psychotropic medication;

	Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a REISS screen was completed o Spreadsheet of all individuals (both new admissions and existing residents) who 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 ISP addendums; Behavioral Support Plan; Human Rights Committee review of Behavioral Support Plan; Restraint Checklists for the previous six months; Annual Medical Summary; Quarterly Medical Review; Hospital section for the previous six months; X-ray, laboratory examinations and electrocardiogram for the previous six months.; Comprehensive psychiatric evaluation; Psychiatry clinic notes for the previous six months; MOSES/DISCUS examinations for the previous six months; Pharmacy Quarterly Drug Regimen Review for the previous six months; Consult section; Physician's orders for the previous six months; Integrated progress notes for the previous six months; Comprehensive Nursing Assessment; Dental Section including desensitization plan if available o A list of families/LARs who refused to authorize psychiatric treatments and/or medication recommendations o A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attended or might attend, including any information that is routinely collected concerning the Psychiatrists' attendance at the IDT, ISP, and BSP meetings o A list and copy of all forms used by the psychiatrists o All policies, protocols, procedures, and guidance that related to the role of psychiatrists o A list of all psychiatrists including board status; with indication who was designated as the facility's lead psychiatrist o CVs of all psychiatrists who worked in psychiatry, including any special training such as forensics, disabilities, etc. o Overview of psychiatrist's weekly schedule o Description of administrative support offered to the psychiatrists o Since the last onsite review, a list/summary of complaints about psychiatric and medical care made by any party to the facility o A list of continuing medical education activities attended by medical and psychiatry staff o A list of educational lectures and inservice training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who had a diagnosis of seizure disorder 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 <u>newly prescribed</u> 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 were revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who had a psychiatric assessment per Appendix B, with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Comprehensive psychiatric evaluations per Appendix B for the following individuals: • Individual #14, Individual #327, Individual #195, Individual #283, Individual #114, Individual #350, Individual #256, Individual #285, and Individual #183 o Documentation of psychiatry attendance at ISP, ISPA, BSP, or IDT meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months o Section J presentation book <u>Documents requested onsite:</u> o Information from Behavior Therapy Committee regarding review of medication change for Individual #184. o All data presented, physician consents, progress notes, and orders from Dr. Howland's clinics dated 2/16/12 regarding the following individuals: Individual #56, Individual #303. o Five examples of specific learning objectives for dental desensitization. o All data presented, doctor's progress notes, and doctor's orders from Dr. Howland's clinic 2/13/12 regarding the following individuals: Individual #106, Individual #14, Individual #184. o All data presented, doctor's progress notes, and doctor's orders from Dr. Howland's clinic 2/14/12 regarding the following individuals: Individual #42, Individual #140, Individual #97, and Individual #146. o All data presented, doctor's progress notes, and doctor's orders from Dr. Howland's clinic 2/15/12 regarding Individual #130. o Psychotropic medication classes o Lab matrix revision. o Dental Sedation list 7/1/11 through 12/31/11 o Names of all individuals who have had TIVA 7/1/11 through 12/31/11. o Review of the health record of individual #82 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, Megan Lynch, psychiatry assistant, and Carmen Mascarenhas, M.D., Medical Director o Daisy Ellison, M.A., Director of Psychology o George Howland, M.D., facility psychiatrist 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, Amy Jo Miller, R.D.H, Carmen Mascarenhas, M.D., and Russell Riddell, D.D.S., Dental Coordinator o Sharon Tramonte, Pharm.D., clinical pharmacist o Megan Lynch, psychiatry assistant <u>Observations Conducted</u>: o Behavior Therapy Committee/Peer Review regarding Individual #184 o Clinical Services Meeting 2/16/12 o Dr. Howland's clinic 2/13/12 regarding Individual #106, Individual #14. o Dr. Howland's emergency psychiatry clinic 2/13/12 o Dr. Howland's clinic 2/14/12 regarding Individual #42, Individual #140, Individual #97, and Individual #146. o Dr. Howland's emergency psychiatry clinic 2/15/12 regarding Individual #130 o Dr. Howland's clinic 2/16/12 regarding Individual #56, Individual #303. o Pharmacy and Therapeutics meeting

	Facility Self-Assessment: SASSLC submitted its self-assessment. In it, the facility lead psychiatrist listed relevant activities that she and the department conducted towards each of the provision items. They should instead describe what activities they engaged in to assess whether they were meeting each provision item. That is, it should not only include activities they engaged in to meet the provision item. This is a fine and sometimes difficult distinction to make. To take this process forward, the monitoring team recommends that the lead psychiatrist review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead them to a listing of "activities engaged in to conduct the self-assessment." Then, they can report the findings of their self-assessment, their self-rating, and a rationale for the self-rating. The facility self-rated itself as being in compliance with five of the provision items of section J. The monitoring team agreed with three of these ratings (J1, J2, and J12). With regard to J3, it was discussed with psychiatry staff during the monitoring visit that due to the paucity of non-pharmacological interventions, and the apparent over reliance on psychotropic medication, this provision would remain in noncompliance. With regard to J7, the monitoring team experienced difficulty with interpretation of the provided data and was, therefore, unable to determine if this provision was in substantial compliance.
	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 had implemented 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. 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 ongoing 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

	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 remained, however, in that the psychiatrists had little contact with psychology staff outside of clinic or the morning clinical services meeting. They were not provided appropriate 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.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications</u> The two current full time psychiatrists providing services at the facility, one of which had been designated as the lead psychiatrist, were board certified in adult psychiatry by the American Board of Psychiatry and Neurology. The lead psychiatrist was also board eligible in geriatric psychiatry. One issue was that although the second psychiatrist had some child and adolescent training, he was not board eligible in child and adolescent psychiatry. There were adolescents in residence at the facility, and consequently, the facility was in the process of attempting to contract with a local child and adolescent psychiatrist for the purposes of case consultation. A locum tenens psychiatrist, board certified in adult psychiatry, was temporarily providing services at the facility. Based on the qualifications of the current psychiatric staff, this item was rated as being in substantial compliance. Psychiatry staffing, administrative support, and the determination of required FTEs are addressed below in section J5. <u>Experience</u> The lead psychiatrist had practiced at the facility for approximately 19 months, the other full time provider for approximately one year. The locum tenens provider indicated previous experience in the field of developmental disabilities, however, this was not reflected in his curriculum vitae. While neither of the two full time 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 antipsychotic medications, Tardive Dyskinesia, chemical restraints, and psychopharmacology 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		stated in the previous monitoring report, and in this report, psychiatry will need administrative and interdisciplinary support in order to move forward. Monitoring Team's Compliance Rating Based on the qualifications of the FTE psychiatrists at SASSLC this item was rated as being in substantial compliance.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Number of Individuals Evaluated At SASSLC, 191 of the 276 individuals (69%) received psychopharmacologic intervention at the time of this onsite review. There were a limited number (30) of evaluations completed in Appendix B format (discussed in J6). There were concerns regarding the limited psychiatric resources (addressed in J5) expressed by the psychiatry team as one of the factors resulting in the insufficient number of completed evaluations. Evaluation and Diagnosis Procedures Via the monitoring team's observation of six psychiatry clinics during the monitoring review, it was apparent that the team members attending the visit were well meaning and interested in the treatment of the individual. There was also good discussion and documentation of diagnoses with review of the diagnostic criteria located in the clinic notes. For example: • Individual #196: The Quarterly Clinic Addendum Treatment Plan Review dated 11/21/11 reviewed the diagnostic criteria required for a particular diagnosis and indicated which of the required symptoms the team had observed. The document was signed by the psychiatrist and the IDT members (five of them) indicating their participation in the diagnostic assessment. This type of documentation was characteristic of what was noted in the 17 records reviewed. In addition, this document gave detailed information regarding the rationale for the prescription of psychotropic medication (examples included in J10, J11, and J13). Clinical Justification Psychiatry staff overall were doing a good job of evaluating and diagnosing individuals in a clinically justifiable manner. There was also evidence of appropriate clinical documentation with regard to the choice of a particular psychotropic medication regimen. For examples regarding this, see J11. There was one example, however, that, while providing appropriate diagnoses, did not demonstrate a thorough clinical justification for treatment. The treatment did not take into account the individual's desired activities and, in fact, appeared to be chosen in an effort to reduce her ability to perform those activities she enjoyed. Individual #82 was diagnosed with Autistic disorder, Primary Insomnia, and Tardive Dyskinesia. These diagnoses were appropriately justified with a full review of the required symptoms. Per the ISP, there	Substantial Compliance

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		was a history of behavioral challenges, however, the individual, "liked to move, enjoyed propelling her wheelchair, liked to be outdoors where there was room for her to propel her wheelchair, and she cannot live without [her freedom of movement]; they make her the happiest." Per the psychiatric clinic note dated 11/10/11, "Staff continue to report that patient self-propels and has injured herself in past. Wheelchair removed, but tries to self-propel lounge chair. Remeron increased last month to target self-propelling behavior. According to staff, patient may be calmer, but behavior unabated. Remeron to be increased to target this behavior." This treatment was concerning because it was an attempt to medicate the behavior that the individual was reported to enjoy. It should be incumbent upon the IDT to review the individuals psychotropic medication and discuss the regimen with the prescriber to ensure that it does not negatively impact enjoyed or preferred activities that are not dangerous to self or others (also see comments in M3 below). <u>Tracking Diagnoses and Updates</u> The facility did maintain a spreadsheet that indicated changes in Axis I diagnoses. The sheet noted the previous diagnosis, the new diagnosis, and documented the justification for the change in diagnosis. For example, for Individual #319, a diagnosis of Schizoaffective Disorder, Bipolar Type was added. Per the brief diagnostic justification included in the spreadsheet, "Noted to have paranoid thoughts and mood component." Given this information, and the review of 17 records, it was apparent that the psychiatric physicians were making good effort to justify diagnoses appropriately. <u>Monitoring Team's Compliance Rating</u> This provision was rated in substantial compliance during the previous monitoring period. As documentation of diagnoses and justification for treatment with medication had remained consistent (with the exception of the one example located documented above), this compliance rating will remain. In order to maintain this rating, the facility psychiatric staff must continue their current level of documentation and attend to the number of Appendix B comprehensive assessments that are currently outstanding. As discussed in J6, the completion of these assessments was likely hampered by a lack of sufficient psychiatric resources. In an effort to maintain the quality of documentation, the facility and DADS should consider the development of a psychiatric peer review process.	
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	<u>Treatment Program/Psychiatric Diagnosis</u> Per this provision item, individuals prescribed psychotropic medication must have a treatment program in order to avoid utilizing psychotropic medication in lieu of a program or in the absence of a diagnosis. Per the review of 17 records, all had diagnoses noted in the record inclusive of a review of symptoms and justification for said	Noncompliance

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	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.	diagnoses. 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 medication prescribing may have occurred in lieu of, and perhaps as an unintended substitute for, a comprehensive and adequate non-pharmacological 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 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. It will be important for ongoing collaboration to occur between psychology and psychiatry in case formulation, and in the joint determination of target symptoms and descriptors or definitions of the target symptoms, as well as the use of objective rating scales normed for the developmentally disabled population. It will be imperative that psychiatry and psychology staff continue to 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. It is also imperative that this information is documented in the individual's record in a timely manner. It was notable that the BSP documents did not include a signature from the treating psychiatrist, yet medication regimen, medication side effects, and medication changes were described in detail in the BSP. Although it was good to see this information in the BSP, it must be developed in consultation or collaboration with the individual's prescribing psychiatrist, and appropriately included in the comprehensive psychiatric assessment/quarterly psychiatric reviews. Review of the more recently completed comprehensive psychiatric assessments performed according to Appendix B revealed documentation of physician input into the BSP as well as IDT participation in the case	

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		formulation regarding the individual. Unfortunately, as discussed in J6 below, a paucity of these evaluations had been completed. Also, as noted in J9 below, PBSP documents reviewed for this monitoring period did not adequately identify non-pharmacological interventions outside of specific PBSP behavior supports. For instance, individuals require active engagement during the day. In walking around the facility during the daytime and early evening, the monitoring team noted individuals often milling about, not engaged in activities. This lack of engagement must be addressed because it can lead to increased behavioral challenges including, but not limited to, self-injurious behavior, self-stimulatory behavior, and exacerbations of mood disorders <u>Emergency use of Psychotropic Medications</u> It appeared that the facility use of emergency psychotropic medication for individuals during periods of agitation/aggression had increased. During the prior monitoring period, there were a total of 10 incidents involving seven different individuals. During this monitoring period, there were a total of 26 incidents involving nine individuals. 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 documentation of the IDT or BSP response to the individual's experience of behavioral challenges and the need for additional medications, however, in most instances, noted alterations to the individual's BSP was not noted as planned. For example, per the psychiatry clinic documentation regarding Individual #83 dated 10/6/11 two days following a chemical restraint, psychology documented, "has a long history of attempting to leave campus resulting in restraint…admitted that she was doing it so that she could get attention from her grandmother, whom she assumed would learn of the UD and restraint and then either call her or come see her." The document did not include any information regarding interventions that could be utilized to address this individual's challenges, such discussing how to appropriately obtain attention from her grandmother, or arranging for structured visitation time. 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 eight 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	

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		with medication polypharmacy. It was also discussed that in situations where the psychiatrist opines that multiple agents are necessary, this must be justified via clinical documentation. Per discussions with psychiatric treatment providers, the physicians were attempting to monitor the efficacy of the medications utilized for chemical restraint and attempting to utilize single agents. This was evident in the case of Individual #184 who had been treated with multi-agent restraints in the past, however, in more recent episodes requiring pharmacological intervention, single agent interventions had been trialed, though with marginal success. <u>Monitoring Team's Compliance Rating</u> Although the facility self-rated this item in substantial compliance, following discussion with facility staff, it was understood that due to the paucity of non-pharmacological interventions, and the apparent over reliance on psychotropic medication, this provision would remain in noncompliance.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pretreatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pretreatment sedation. The pretreatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Extent of Pretreatment Sedation</u> There was a listing of individuals who received pretreatment sedation for either medical or dental clinic. This listing indicated that from 7/6/11 to 1/12/12, 82 individuals received pretreatment sedation for dental clinic. Data regarding medical pretreatment sedation were not provided. It was not possible to determine if the individuals designated as receiving dental pretreatment sedation were the same individuals ultimately referred for TIVA. Of the 85 individuals listed receiving pretreatment sedation for dental treatment, 43 (50%) were enrolled in psychiatry clinic. The document provided to the monitoring team did not provide the information required for tabulating the extent of TIVA. Per interviews conducted during the monitoring review, TIVA had been utilized at the facility on a limited basis, with estimates of five or six completed cases. In order to evaluate the extent of pretreatment sedation utilized at SASSLC, the data should include one comprehensive list of individuals who have received pretreatment sedation medication <u>or</u> TIVA for <u>medical</u> or <u>dental</u> procedures that includes: individual's name, designation of whether it was medical or dental pretreatment sedation, date the pretreatment sedation was administered, name, dosage, and route of the medication, and date IDT review to minimize the need for the use of this medication. <u>Interdisciplinary Coordination</u> There were 10 examples provided of multidisciplinary consultation regarding the utilization of pretreatment sedation for individuals. This process was evident during the	Noncompliance

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		previous monitoring review, and had continued. Examples reviewed were comprehensive and included representatives from dentistry, primary care, psychiatry and clinical pharmacy. As discussed with staff during the monitoring visit, it was unclear how the clinical information gathered via the consultative process was vetted and implemented. The facility could consider adding a discussion regarding these consults to the monthly pharmacy meeting in order to determine the final treatment plan. During this meeting, adjustments to the individual's existing regimen could be made in an effort to reduce the duplication of medications administered. For example, individuals scheduled for pretreatment sedation may require a reduction in dosage of scheduled benzodiazepines in order to avoid over-medication. <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. A list of three individuals was provided with implementation dates included: Individual #169 plan implemented 1/28/11, Individual #77 plan implemented 1/11/12, and Individual #160 plan implemented 8/3/11. All three of these individuals were currently participating in psychiatry clinic. Discussions with facility staff revealed some level of frustration with desensitization plans, because the responsibility for this process was designated as belonging to psychology exclusively. The monitoring team discussed with facility staff that what was first necessary was a process to triage those individuals who would be immediately amenable to desensitization, and then an individualized assessment of the individual's abilities and where that individual would start desensitization on a continuum. For example, some individuals may be able to come to dental clinic and sit in the dental chair. Others may need to start with basic dental hygiene activities. What was needed was the development of individualized strategies and interventions that occurred according to a process inclusive of IDT involvement in the development of the protocol. The facility should understand that the goal of this provision item is that there be treatments or strategies to minimize or eliminate the need for pretreatment sedation. That is, formal desensitization programs may not be necessary for all individuals (though certainly will be necessary for some individuals). Processes have been developed at other DADS facilities (e.g., Lufkin SSLC) that may serve as a model. <u>Monitoring After Pretreatment Sedation</u> A review of provided documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs.	

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		Monitoring Team's Compliance Rating This item will remain in noncompliance because further effort must be made with respect to the development of desensitization protocols and/or other individualized treatments or strategies. Plans must be individualized according to the need and skill acquisition level of the individual, along with specific personalized reinforcers that would be desirable for the individual.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	Psychiatry Staffing Approximately 69% of the census (a total of 191 individuals) received psychopharmacologic intervention requiring psychiatric services at SASSLC as 2/13/12. There were two FTE psychiatrists providing services (one psychiatrist had been on leave, however, locum tenens services were obtained for a maximum of 25 hours per week during this scheduled absence). The two facility psychiatrists were scheduled to work 40 hours per week and were available after hours via telephone consultation. All psychiatrists currently employed or contracted at the facility were board certified. Administrative Support Psychiatry clinic staff included a former QDDP who began work as the psychiatry assistant on 11/16/11. This individual was organized and enthusiastic and apparently a good addition to the psychiatry clinic team. As this staff was just beginning to work in the psychiatry clinic, organizing and discovering her duties, the need for additional support staff will need to be addressed over time. Determination of Required FTEs It was questionable whether the current allotment of psychiatric clinical services will be sufficient to provide clinical services at the facility. At the time of the review, there were a total of 80 available clinical hours, with eight of these officially assigned to administrative duties. It was apparent, however, that the administrative responsibilities of the lead psychiatrist were more encompassing than the eight hours allotted. Ancillary psychiatry staff consisted of one psychiatry assistant. SASSLC should engage in an activity to determine the amount of psychiatry service FTEs required. This computation should consider hours for clinical responsibility, but also documentation of delivered care, such as quarterly reviews, Appendix B comprehensive evaluations, and required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility, participation in polypharmacy meetings). And then, add to this the need for improved coordination of psychiatric treatment with primary care, neurology, other medical consultants, pharmacy, and psychology. During this monitoring review, the use of psychiatric nurses and nurse practitioners was	Noncompliance

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		discussed. The addition of personnel from either of these disciplines to the psychiatry clinic would assist with workload. <u>Monitoring Team's Compliance Rating</u> Due to the lack of sufficient psychiatric resources to provide the services required, this provision remained in noncompliance.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	<u>Appendix B Evaluations Completed</u> SASSLC psychiatry staff reported a total of 30 individuals had psychiatric evaluations performed according to Appendix B. Given that 191 individuals received treatment via psychiatry clinic, 85% of the individuals still required a comprehensive psychiatric assessment. Of these 30, eight were completed by prior treatment providers and were not of acceptable quality. It was noted that seventeen evaluations had been completed during 2011. 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 that resulted in improvements in other areas (e.g., justification of psychotropic medication and determination of diagnoses). The facility had a facility-specific policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" implemented 11/17/11. It included a new psychiatry clinic form as well as quarterly addendum notes inclusive of treatment planning regarding the use of psychotropic medications. The comprehensive nature of psychiatry clinical consultation had been expanded to include all facility homes during the previous monitoring visit, and per observation and documentation reviewed, this comprehensive clinical process had been maintained. Given the changes in psychiatry clinic required by the new 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. Appendix B style evaluations were reviewed for the following nine individuals: Individual #14, Individual #327, Individual #195, Individual #283, Individual #114, Individual #350, Individual #256, Individual #285, and Individual #183. The comprehensive psychiatric evaluations 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, the evaluation performed 10/21/11 regarding Individual #283 provided a clear rationale for the diagnoses including the reasoning for excluding certain diagnoses. It also documented the participation of other team members in the formulation of the case including the psychologist, QDDP, and clinical pharmacist. Topics included history, observed symptoms (e.g., speech, sleep, irritability, distractibility), and possible responses to medication and medication changes. The evaluation addressed symptoms, or the lack thereof, related to diagnoses including pervasive developmental disorders, ADHD, PTSD, anxiety disorders, OCD, sleep disorders, eating disorders, and personality disorders. Diagnoses for this individual included Psychosis, NOS (provisional); Impulse Control Disorder, NOS; and rule out PTSD. The above case conceptualization provided a good review of the individual's presenting symptoms and a clear rationale for the diagnosis. All Appendix B evaluations reviewed included collaborative case conceptualizations that reviewed information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. In addition, treatment recommendations inclusive of non-pharmacological interventions were included in the documentation for Individual #283. These included the current psychopharmacological interventions, the symptoms that the psychiatrist was targeting, and his or her long range plans for the regimen. Collaboration in the PBSP process was documented, as were specific recommendations for non-pharmacological interventions. This finding was consistent in other comprehensive psychiatric evaluations reviewed. The psychiatrist must guide the IDT in a detailed fashion about intention of each medication and what to monitor in order to determine medication efficacy in an evidence-based manner. This is an area that would be amenable to quality assurance or peer review monitoring. <u>Monitoring Team's Compliance Rating</u> 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 self-rated noncompliance. The monitoring team, however, wishes to acknowledge the continued progress made by the psychiatrists in regard to diagnosis and review of treatments. The data indicated that an average of 1.5 Appendix B comprehensive assessments were completed each month. Even so, at this rate, it would take approximately nine years to complete the remainder of the Appendix B evaluations.	

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J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	<u>Reiss Screen Upon Admission</u> The Reiss screen, an instrument used to screen each individual for possible psychiatric disorders, was to be administered upon admission, and for those already at SASSLC who did not have a current psychiatric assessment. • The facility had five new admissions for the previous six months with all of these individuals being administered a Reiss screen an average of eight days following admission. • All newly admitted individuals received a comprehensive psychiatric evaluation. This evaluation occurred an average of 22.5 days following completion of the Reiss screen. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> This was a difficult item to assess due to the presentation of the data. The total facility census was 276 with 191 individuals enrolled in psychiatry clinic, therefore, 85 individuals were eligible for baseline Reiss screening. Documentation of Reiss screens completed December 2010 through December 2011 revealed the names of 11 individuals. Of these, seven were currently participating in psychiatry clinic with four of seven admitted to the facility during the previous monitoring period. The remaining three individuals were screened with one individual ultimately receiving a comprehensive psychiatric evaluation. Of the four individuals who were not identified as participating in psychiatry clinic, one individual was referred for a comprehensive psychiatric evaluation occurring 24 days following the Reiss screen. Given the data provided, it was difficult to determine which individuals were previously psychiatry clinic patients, which were referred and entered the clinic following a routine Reiss Screen, and which were screened due to a change in behavior or circumstance and then entered the clinic. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> The process entitled "psychiatry consult note procedure" had been implemented. 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." In the intervening period since the previous monitoring review, the procedure had been revised to add timelines, 30 days following a positive Reiss Screen for the initiation of a psychiatry consultation, and 30 days following receipt of the consultation request to the completion of the psychiatric evaluation. Given these time frames, an individual experiencing an exacerbation of mental health symptoms following a change in status could wait up to 60 days for consultation. Consideration should be given to more reasonable time lines (e.g., one week for initiation of consultation following a positive screen, 30 days to complete the comprehensive psychiatric evaluation).	Noncompliance

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		Monitoring Team's Compliance Rating Given the challenges with the data presentation, it was not possible to determine if this provision was in substantial 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.	Policy and Procedure The SSLC statewide policy and procedure dated 8/30/11 for psychiatry services had a title of "Integrated Care" summarizing that each state center must "develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation." Per the 11/17/11 SASSLC 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 been fully implemented at the facility. Interdisciplinary Collaboration Efforts The monitoring team observed six separate psychiatric clinics. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QDDP, direct care staff, and the individual). There were challenges noted with the receipt of information from psychology with regard to behavioral data. Data were presented in tabular format rather than graphs. While data were documented in the record as the impetus for medication adjustments, both psychiatry and psychology staff voiced concern regarding the accuracy of data collection. Also see section K below. Medication decisions made during clinic observations conducted during this onsite review were based on lengthy (minimum 40 minute) observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. In the six clinic observations, 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 medication regimen. As stated repeatedly in this report, an IDT process (i.e., ISPA) essentially occurred within the psychiatry clinic, with representatives from various disciplines participating. A review of the psychological and psychiatric documentation for 17 individual records revealed reviews of diagnostic criteria and justification of specific diagnoses. There were collaborative case formulations that tied the information regarding a particular individual's case together located in completed Appendix B comprehensive psychiatric evaluations (30 had been completed). Appendix B evaluations were performed via a separate psychiatry clinic where IDT members, including psychology, were present in	Noncompliance

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		order to contribute to the collaborative case formulation. Psychology and psychiatry need to formulate diagnoses and plans for the treatment of all individuals as a team. This type of collaboration should be evident in psychiatry clinic, the psychiatric treatment plan, psychiatric assessments, the ISP process, the PBSP process, and, hopefully, with other interventions and disciplines (e.g., speech, OT/PT, medical). Case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. There was minimal discussion during the psychiatric clinics regarding results of 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. <u>Integration of treatment efforts between psychology and psychiatry</u> There were noted attempts by both psychiatry and psychology leadership to improve and integrate treatment efforts. This was noted via the weekly integration meeting between the lead psychiatrist and the director of psychology. This meeting was on hiatus due to one attendee's leave, however, there were plans to reinstate this. The biggest challenge with regard to integration remained the accuracy and presentation of behavioral data, and completion of the collaborative case formulations for each individual enrolled in psychiatry clinic per Appendix B. Additional challenges included the need for the implementation of recommended non-pharmacological interventions. <u>Coordination of behavioral and pharmacological treatments</u> As noted in J9 below, there was cause for concern with regard to the coordination of behavioral and pharmacological treatments, specifically with regard to the focus of the BSP. There was documentation of specific interventions noted in Appendix B evaluations, but there was a lack of documentation regarding the implementation of these identified non-pharmacologic interventions. For example, in the Appendix B evaluation of Individual #130 performed 1/7/11, a provisional diagnosis of PTSD was considered due to history of rape and suggested the consideration of individual therapy. Subsequent psychiatric documentation, however, did not reveal further discussion regarding the PTSD diagnosis. A review of the BSP and ISP for this individual did not reveal documentation of individual therapy as an intervention to address the history of trauma. Additional issues regarding this individual are noted below in J9. <u>Monitoring Team's Compliance Rating</u> Due to the paucity of completed combined assessment and case formulation, this	

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		provision remained in noncompliance.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	<u>Psychiatry Participation in BSP and other IDT activities</u> Per interviews with the psychiatry staff, the prescribing psychiatric practitioners did not routinely attend meetings regarding behavioral support planning for individuals assigned to their caseload, therefore, psychiatry staff were not consistently involved in the development of the plans. During psychiatry clinic, the psychiatrist was noted to ask pertinent questions regarding behavioral challenges, how these were being addressed via the BSP, questioning the function of specific behaviors, and discussing non-pharmacological interventions. The psychiatrists stated a willingness to become formally involved, but indicated that a lack of clinical time and requirements of attendance at other meetings would likely make this impossible. 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 provision item J9, and that the required elements are included in the document. It was warranted for the treating psychiatrist to participate in the formulation of the behavior support plan via providing input or collaborating with the author of the plan. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral or psychiatric) in order to decrease the reliance on psychotropic medication. Facility psychology staff had developed a review document for psychiatry. This had not been implemented, and as discussed during the monitoring visit, the draft document, while thorough, was unnecessary. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed annually during regularly scheduled quarterly clinic, with additional reviews as clinically indicated. Documentation of psychiatric attendance at IDT, ISP, and BSP meetings was reviewed. There were 121 total meetings attended by psychiatry. Of those, 90 were IDT meetings that occurred during psychiatry clinic. The remaining meetings were cataloged as ISP meetings. There were no BSP meetings included in the listing. <u>Treatment via Behavioral, Pharmacology, or other Interventions</u> The following example highlighted difficulties with regard to the coordination of treatment among disciplines, and illustrated how psychiatry participation in the development of the BSP was necessary. Individual #130 – per the ISP authored 8/5/10, there were difficulties with regard to this individual refusing services and supports (medication and medical appointments). There was documentation noting a subsequent ISP in August 2011, however, this	Noncompliance

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		document was not included in the information available for review. This individual was seen during the monitoring review at an emergency psychiatry clinic. There was much discussion regarding her refusal of medical attention (specifically x-rays following an injury, and her regularly prescribed prescriptions). Given these difficulties, the treating psychiatrist and the IDT agreed to a trial of injectable antipsychotic medication. Review of HRC documents dated 8/11/11 revealed "refusals: refusing to attend work, refusing to take medications" were added to the list of target behaviors. A review of the BSP dated 8/10/11 revealed a goal of five or less refusals per week, with the intervention for refusals, "prompt…to attend work regularly. Negatively reinforce her non-attendance by continually asking her to go… medication refusals, prompt once and then ignore…will typically take her medications once she realizes that no one is paying attention to her." Psychiatry documentation reviewed revealed issues with compliance, specifically for medication administration, vital sign monitoring, and other health care related events (x-ray, laboratory examinations), however, there was no documentation of revision of the BSP to address these difficulties. Additionally, as of the clinical encounter of 12/29/11, refusals had not been added to target behaviors reviewed by psychiatry. Unfortunately, psychology progress notes presented in psychiatry clinic during the onsite monitoring visit included references to this individual using terms such as "lazy" and "slothful." It also noted that this individual complied with specific requests following "threat of restraint." A review of the BSP dated 8/2/11 did not include restraint as an intervention for refusals. Overall, this example was not indicative of a collaborative process to develop positive behavioral support measures to address this individual's refusal. As this individual's refusals were not appropriately addressed via the BSP, psychiatric and medical treatment was impeded, and additional medications (injectable antipsychotic medications), that possibly could have been avoided, were prescribed. <u>ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports</u> Non-pharmacological interventions were discussed during many of the psychiatric clinic encounters observed during the monitoring visit. These included references to behavioral supports, work programs, and outings. A review of documentation revealed that in each psychiatry clinic, specific target behaviors associated with medications were reviewed by psychiatry and the IDT present in psychiatry clinic. 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.	

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		There was evidence in the records reviewed that psychiatry and psychology, via the IDT present in psychiatry clinic, had collaborated with regard to specific target behaviors that were tracked for data collection and presentation. The psychiatrist gave feedback to the IDT during the psychiatry clinic, specifically with regard to the need for improved non-pharmacological interventions. Review of ISP documentation revealed identification of specific activities that individuals were interested in. Individual #128 had diagnoses, including social anxiety disorder. It was noted that he enjoyed bowling (he owned his own engraved bowling ball) and listening to his CD player. Further review of the ISP dated 10/28/10 revealed that he would have the opportunity to go bowling "at least once this year." Unfortunately, this would be far too infrequent to be classified as a non-pharmacological intervention (e.g., exposure therapy for social anxiety disorder). Psychiatry and psychology could collaborate to develop other non-pharmacological interventions that could be utilized on a routine basis. <u>Monitoring Team's Compliance Rating</u> To meet the requirements of this provision item, there needs to be an indication that the psychiatrist was involved in the development of the PBSP as specified in the wording of this provision item J9. As stated in other sections of this report regarding provision J, psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance. Per interviews of both psychiatrists and psychology staff, the psychiatrists were making efforts to attend annual ISP meetings, time permitting, for individual's deemed high risk with frequent behavioral challenges.	
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	<u>Policy and Procedure</u> A review of DADS policy and procedure entitled "Psychiatry Services," dated 8/30/11, noted that state center responsibilities included that the psychiatrist "must solicit input from and discuss with the IDT any proposed treatment with psychotropic medication…must determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of the psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications." Review of "SASSLC Psychiatry Clinical Services Policy" dated 11/17/11 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 versus benefit of treatment with a particular medication. <u>Quality of Risk-Benefit Analysis</u> A review of the records of 17 individuals at the facility who were prescribed various psychotropic medications as well as information provided regarding the psychiatric	Noncompliance

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	the medications.	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. The form also included signatures for the prescribing psychiatrist, psychologist, IDT members present in clinic, the review of the primary care provider, behavioral therapy committee members, and human rights committee. While it was positive that psychiatry was providing 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 with regard to the risk/benefit analysis; it only took new medications into account. Additionally, this form was utilized in the informed consent process and, in order to comply with generally accepted professional standard of care, must include documentation of a discussion regarding medication side effects (also see J14). It was understood that this form was only a piece of the informed consent process, and that additional documentation was being developed. The following are examples typical of acceptable documentation included on the "New Psychotropic Medication Justification Form." • Individual #7 – dated 11/7/11, the "New Psychotropic Medication Justification Form" indicated that the harmful effects of "Bipolar/Seizure" outweighed the possible harmful effects of Carbamazepine. Additional documentation stated, "previously, Carbamazepine used only for seizure disorder. Patient has bipolar illness with recent exacerbation and cannot increase SGA [second generation antipsychotic] because of QT prolongation." This example illustrated the indication of the prescribed medication and the rationale for the utilization of this medication rather than an alternate class of medications. • Individual #55 – dated 12/1/11, the "New Psychotropic Medication Justification Form" indicated that the harmful effects of "mood disorder secondary to Angelman's syndrome" were outweighed by the possible harmful effects of Oxcarbazepine. Additional documentation stated, "Divalproex has caused low platelets. Need to get him off this medication. Strattera is not effective to treat mood, hyperactivity. Benefits Oxcarbazepine improved mood, aggression. Risks hyponatremia, possible liver problems." This example illustrated the indication of the prescribed medication and the rationale for the use of this medication rather than an alternate class of medications. The risk/benefit documentation for treatment with a psychotropic medication should be the primary responsibility of the prescribing physician. The success of this process will require a continued collaborative approach from the individual's treatment team	

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		inclusive of the psychiatrist, primary care physician, and nurse. It will also require that appropriate data regarding the individual's target symptoms be provided to the physician, that these data are presented in a manner that is useful to the physician, that the physician reviews said data, and that this information is utilized in the risk/benefit analysis. The input of the various disciplines must be documented in order for the facility to meet the requirements of this provision item. Given the comprehensive manner in which psychiatry clinic was conducted during the review (inclusive of thorough interviews and team discussion), the elements necessary to this documentation appeared to be readily available. Given the improvement in staff attendance at psychiatry clinic, as well as the increased amount of time allotted for each clinical consultation, the development of the risk/benefit analysis should continue as a collaborative approach during psychiatry clinic. This documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Observation of Psychiatric Clinic</u> During the psychiatric clinics observed by the monitoring team, the psychiatrist was well prepared. The psychiatric rationale for a particular medication regimen was authored in advance and presented for discussion to the IDT. The development of the risk/benefit analysis was undertaken during psychiatry clinic. The team should consider reviewing this type of information together via a projector/screen and typing the information <u>during</u> the clinic process. The QDDP, psychologist, psychiatrist, and nursing staff must all contribute to the development of this section. Recommendations include accomplishing this goal together with the IDT currently participating in psychiatry clinic, access to equipment, and typing information received in the clinic setting. Of course, for the initial entry in the documentation, some prep time will be necessary to set up the shell of the document. The monitoring team is available to facilitate further discussion in regards to this recommendation, if requested. The documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected, and a reasonable estimate of the probability of success, and also compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Human Rights Committee Activities</u> A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e.,	

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		likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). A review of provided documentation revealed only the signatures of HRC members included on the "New Psychotropic Medication Justification Form." There was no additional documentation from HRC with regard to their discussion or review of the proposed treatment regimen. <u>Monitoring Team's Compliance Rating</u> As noted above, while the currently implemented form will address newly prescribed agents, it does not address previously prescribed agents, nor does it specifically address medication side effects, which are potential risks. Additionally, documentation from HRC, other than signatures on the form, was not located in the records available for review. Given these deficiencies, this provision will remain in noncompliance.	
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.	<u>Facility-Level Review System</u> The facility held a monthly Pharmacy and Therapeutics Committee meeting. At the time of this review, there was not a separate monthly meeting to review psychiatric polypharmacy. Instead, 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. There should be. <u>Review of Polypharmacy Data</u> Documentation presented during the polypharmacy oversight committee meeting 2/16/12 was reviewed. Per these data: • The total number of individuals residing at the facility prescribed two or more psychotropic medications of the same class was 38. This was a reduction from 49 individuals in December 2010. • The total number of individuals residing at the facility prescribed three or more psychotropic medications was 97. This was a reduction from 105 individuals in December 2010. • The total number of individuals residing at the facility prescribed any psychotropic medication was 186. Data regarding the number of individuals prescribed medications within a specific class (outside of those meeting the designation of intra-class polypharmacy) were not provided. In the intervening period since the last monitoring report, DADS had adopted a classification system for psychotropic medication that differed from the system previously developed and utilized at SASSLC. This new classification system,	Noncompliance

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		implemented in October 2011 resulted in an increase in polypharmacy designations at SASSLC. This was evident via the graph of polypharmacy data provided during polypharmacy oversight committee meeting. A review of the intraclass polypharmacy medication list by drug class revealed that there were 15 individuals meeting criteria for intraclass polypharmacy for antipsychotic medications, six individuals with intraclass polypharmacy for antidepressant medications, two individuals with intraclass polypharmacy for anxiolytic medications, and four individuals with intraclass polypharmacy under miscellaneous (inclusive of medications such as Atomoxetine, Clonidine, Naltrexone, Propranolol, Metoprolol, and Modafanil). There were eight individuals with intraclass polypharmacy for seizure medications (used for psychiatric indications in the absence of seizure disorder). There were a total of 32 individuals who met criteria for intra-class polypharmacy. Pharmacy quarterly drug regimen documents were located in 16 of 17 individual records. The available documentation revealed timely reviews, all completed within the last quarter. The reviews were comprehensive and offered appropriate guidance and recommendations to the psychiatrist. In all of these cases, the treating psychiatrist signed the review. In cases where recommendations were provided, the psychiatrist indicated their response (e.g., that specific labs recommended were ordered). During this monitoring visit, it was discovered that one clinical pharmacist had resigned. Given this lack of resources, it will be difficult for the pharmacy to maintain both the quality and timeliness of the quarterly drug regimen reviews. As was discussed during the onsite review, in some cases, individuals will require polypharmacy and treatment with multiple medications that may be absolutely appropriate and indicated. The prescriber must, however, <u>justify</u> the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. This forum should be the place for a lively discussion regarding reviews of the justification for polypharmacy derived during psychiatry clinic. This element was missing, as there was not an existing facility level review process in place. <u>Review of Polypharmacy Justifications</u> Documentation regarding polypharmacy in the record of Individual #342 (treated with psychotropic polypharmacy and intraclass polypharmacy consisting of two antipsychotic medications) dated 10/14/11 stated "history of…significant SIB…to eye area…has a detached retina that cannot be repaired…other eye has a cataract likely…self injury related…would like to remove intraclass polypharmacy of antipsychotics Abilify and Zyprexa…since Zyprexa is likely not being allowed to fully function with Abilify's presence…also like to reduce and d/c Klonopin…given that it could pose increased fall risk for this	

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		person who is essentially without sight at this time…this needs to be carefully coordinated with his recovery [from cataract surgery] because of the continued concern that he will reinjure the eye…drug regimen review identified that concurrent use of Zyprexa with Depakote can lead to a decrease in Zyprexa concentrations and effectiveness." This demonstrated a rationale for the use of polypharmacy as well as the psychiatrist's thought process with regard to the current regimen and future plans to simplify the regimen. It also illustrated a respect for specific side effects and acknowledgement of specific medication interactions to monitor when polypharmacy is implemented. Documentation regarding polypharmacy in the record of Individual #340 (treated with psychotropic polypharmacy and intraclass polypharmacy for miscellaneous medications) dated 12/13/11 stated, "Zyprexa…for irritability associated with Autism…Strattera…to treat his hyperactivity…clonidine…to treat ADHD symptoms…dose of his Cogentin…remained the same…long term goal may be to try and continue to lower this med [Cogentin] since it is not usually a good choice in the ID population since it can cause cognitive blunting. A short term goal is to try and find best dose of the Zyprexa to try and control…aggression, hyperactivity…" This example illustrated the identification of indications for specific medications as well as a description of the psychiatrist's thought processes and plans for future medication adjustments. <u>Monitoring Team's Compliance Rating</u> The facility had made strides with regard to this provision item, however, given the ongoing challenges noted above with regard to the need for a facility level review of polypharmacy justifications, this provision was rated in noncompliance.	
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.	<u>Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS)</u> In response to the document request for a spreadsheet of individuals who have been evaluated with MOSES and DISCUS scores, the facility provided information regarding scores and dates of completion of evaluations dated July 2011 through December 2011. Review of this information revealed timely completion of both evaluations in three-month intervals <u>Training</u> Per the response to the document request for information regarding inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations, a sheet was provided indicating "no evidence for file." The facility self-assessment reported an inservice training that occurred 6/22/11. This information was provided for the previous monitoring report where it was documented that, per the attendance	Substantial Compliance

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		signature page, 21 nurses attended. Quality of Completion of Side Effect Rating Scales In regard to the quality of the completion of the assessments, it appeared that for the set of scales reviewed (10 examples of each assessment tool), all were completed appropriately and included the signature of the psychiatrist. In the majority of cases, clinical correlation was documented on the evaluation form. For example, in the case of Individual #278, documentation included on the completed MOSES dated 10/17/11 stated, "tremor probably secondary to Lithium. Will continue to monitor Lithium level to ensure therapeutic range. This is fine tremor. Last Lithium level 0.81. Next due this month." In previous document review, the MOSES and DISCUS results were included on the "Psychiatry Clinic" form. This form was revised most recently in September 2011, and the requirement for the documentation of the results was removed from the form. This was curious because, in the previous monitoring report, the addition of this information in the progress note was a component resulting in the substantial compliance rating. Per this monitoring review, clinical correlation, while not included in the clinic note, was generally present on the MOSES or DISCUS evaluation form itself, which, per physician practice observed during this and previous monitoring visits, was reviewed during psychiatry clinic. Twelve individuals were noted to have the diagnosis of tardive dyskinesia (TD). All were being followed by psychiatry. Although medications, such as antipsychotics and metoclopramide may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Medication reduction or the absence of the antipsychotic or metoclopramide that occurred during a taper or discontinuation may result in increased involuntary movements, restlessness, and agitation. This presentation of symptoms may be confused with an exacerbation of an Axis I diagnosis, such as bipolar disorder. Therefore, all diagnoses inclusive of TD must be routinely reviewed and documented. Given the documentation provided, it was apparent that this routine review was occurring. Monitoring Team's Compliance Rating Given the documentation of clinical correlation present in the majority of MOSES and DISCUS evaluations presented for review, this area will remain in substantial compliance. It is recommended that the facility psychiatric leadership consider including prompts in the psychiatric clinic note regarding review of the MOSES and DISCUS evaluations so that this practice is reinforced.	

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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.	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 8/20/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." In section 7.b., the policy directly quoted the language in this provision item. The facility had implemented facility specific policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" that outlined the requirements for psychiatric practice consistent with statewide policy and procedure. The facility had implemented the "New Psychotropic Medication Justification Form" which included information, such as the medication dosage, indications, risk/benefit analysis, alternatives to treatment, symptoms/behavioral characteristics to be monitored, and the expected timeline for therapeutic effects to occur (for additional examples see J10 and J14). Diagnoses were addressed in the quarterly clinic notes. <u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 17 individuals, the information required to meet the requirements of this provision were included in the "New Psychotropic Medication Justification Form," quarterly clinic reviews, and in the documentation of medication justification. For example, in the record of Individual #75, the quarterly clinic addendum treatment plan review documentation revealed a review of the criteria required for each diagnosis. The rationale for prescription of psychotropic medication included the pharmacological hypothesis. Copious information was included in this document regarding medication side effect monitoring and the review of laboratory results. Documentation regarding the efficacy of the current regimen was included, "Trileptal not effective so far to treat SIB/aggression partially effective. Ativan, unsure if effective after increased Trileptal, may try to lower Ativan. Clonidine helps with aggression, Remeron helps with some SIB." A review of documentation did note inclusion of the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral/pharmacological treatment hypothesis). Other required elements (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) were consistently outlined in the "New Psychotropic Medication Justification Form." See provision J10 and J14 for examples. <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the ISP process. A review of the documentation revealed 121 examples of psychiatry participation in the ISP process between the dates of 7/1/11 and 12/27/11. Given the manner of the data request, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended. Of these 121 meetings, 90 where	Noncompliance

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		designated as either initial, follow-up, or emergency psychiatry clinic. The others were designated as ISP meetings. In an effort to utilize staff resources most effectively, the facility essentially created an IDT meeting during psychiatry clinic, thereby incorporating IDT meetings into the psychiatry clinic process. Given the interdisciplinary model utilized during psychiatry clinic, the integration of the IDT into psychiatry clinic had allowed for improvements in overall team cohesion, information sharing, collaborative case conceptualization, and management. <u>Psychiatry Clinic</u> During this monitoring review, six psychiatry clinics (for a total of 10 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, psychiatry) documented information into the clinic note format in preparation for the clinical encounter. The individual's record was present in clinic, and the psychiatrist reviewed certain information in the record. 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 addition, all staff verbalized concerns regarding the accuracy of data collection processes. In all observed clinical encounters (and in all documentation), the individual's weights and vital signs were documented and reviewed. The individual's record and laboratory examinations were reviewed during the clinical encounter and documented in clinic notes. This was consistently noted in documents reviewed. Per a review of documentation regarding individuals participation in psychiatry clinic. The majority of individuals were seen within the previous quarter. There were a total of eight individuals (of a total caseload of 191) who were delayed with regard to psychiatric follow-up. Of these, six were last seen in September 2011 and two were last seen in July 2011. <u>Medication Management and Changes</u> Medication dosage adjustments should be done thoughtfully, one medication at a time, so that based on the individual's response via a clinical encounter with the individual and a review of appropriate target data (both pre and post the medication adjustment), the	

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		physician can determine the benefit, or lack thereof, of a medication adjustment. This was standard practice at SASSLC. Monitoring Team's Compliance Rating As evidenced by the above, the facility psychiatry staff were making strides with regard to developing a treatment plan for psychotropic medication that identified a clinically justifiable diagnosis, the expected timeline for the therapeutic effects of the medication to occur, and the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy. They also initiated a psychiatric treatment planning process. What was notable was the documentation of a thoughtful, planned approach to psychopharmacological interventions. These practices had continued over the intervening period. A review of a sample of 17 records revealed appropriate documentation for the psychiatric reviews. Per a review of the facility self-assessment, this provision was rated in noncompliance. In order to improve the compliance rating, 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). Given the deficiencies with regard to data presentation and accuracy, the facility remained in noncompliance for this item.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure Per DADS policy and procedure "Psychiatry Services" dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." Per the facility policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" implemented 11/17/11, the procedure for prescribing psychotropic medication included: "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 policy went on to describe the process of obtaining HRC approval for treatment with medication. The draft policy did not address the procedure for annual psychotropic medication consent	Noncompliance

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		reviews. A review of the facility self-assessment revealed that a new consent form, the "San Antonio State Supported Living Center Psychiatry Department Consent for Use of Psychoactive Medication for Behavior Support" had been developed by psychiatry and psychology collaboratively and that this revised document was implemented facility wide on 11/15/11. Unfortunately, record review did not reveal an example of the utilization of this form, mention of this form was not included in facility level policy and procedure provided for review, and this form was not included in the list and examples of forms utilized by psychiatry at SASSLC. <u>Current Practices</u> A review of information provided regarding the four individuals enrolled in psychiatric clinic who were most recently admitted to the facility (Individual #285, Individual #183, Individual #283, and Individual #350) revealed only one set of records available for review, those of Individual #183, that included the "New Psychotropic Medication Justification Form." This form was complete, indicating the need to start Depakote ER on an emergency basis for aggression associated with Intermittent Explosive Disorder. This individual did not have an LAR, therefore, consent was obtained via a review by the facility director. The signature page associated with the form included signatures by the treating psychiatrist, assigned psychologist, IDT members, the primary care physician, Behavior Therapy Committee members, and Human Rights Committee members. Per a review of the drug regimen review profile for the other three individuals, all were prescribed psychotropic medication with start dates within the previous six months; however, documentation of psychiatric involvement in the consent process was not included. Each record did include information documented by psychology regarding consent included in the "Psychology Department Consent for Behavior Support Plan or Psychoactive Medication." The psychiatry documentation in the examples below may exist, but it was omitted from the records provided to the monitoring team. A review of records for 10 individuals residing at the facility most recently prescribed a new psychotropic medication revealed that for all 10 Individuals (Individual #7, Individual #209, Individual #191, Individual #55, Individual #302, Individual #144, Individual #347, Individual #166, Individual #252, and Individual #85) documentation included the New Psychotropic Medication Justification Form. In these 10 examples, only Individual #191 had a LAR and it was documented that the LAR was contacted. In all the other cases, the consent was obtained from the SASSLC Director and HRC/BTC. In all cases, the completed "New Psychotropic Medication Justification Forms" 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	

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		effects of medication to occur, and signatures of all involved parties. Side effect information was not included in any examples of this document reviewed. It was understood that the "New Psychotropic Medication Justification Form" was only one part of the planned informed consent process and that other documentation was necessary. A review of the documentation provided for the 10 individuals identified above revealed that information regarding potential medication side effects remained inappropriately in behavior support plans and in consent forms authored by psychology. 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. Monitoring Team's Compliance Rating Regardless of the improvements outlined above, current facility practice was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or guardian or party consenting to treatment) the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the record. This provision remained in noncompliance due to the inadequate informed consent practices noted above.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when the medications are prescribed to treat both seizures and a mental health disorder." There was facility specific policy and procedure in place entitled "Psychiatry Clinical Services Policy" dated 11/17/11. This policy included procedures for monitoring medications when used for both a psychiatric and neurological indication, for the addition of a psychiatric indication for a medication previously indicated only for seizures, and for requesting a neurology consultation. This policy also indicated that psychiatric physicians were required to attend neurology clinic for individuals assigned to their caseload, and outlined the process via which psychiatrists would communicate information obtained via neurology clinic with the IDT and the process by which recommendations would be implemented. Individuals with Seizure Disorder Enrolled in Psychiatry Clinic A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 68 individuals. At the time of the previous review, there were 67	Substantial Compliance

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		individuals listed that required neuropsychiatric intervention to coordinate the use of medications prescribed to treat both seizures and a mental health disorder. Of the 17 records available for review, three had a diagnosis of seizure disorder. A review of these three records revealed all three individuals received neurology consultations within the previous year, with two within the previous six months. • Individual #198 was evaluated in neurology clinic in March 2011 (documentation regarding this encounter was not included in the records available for review) and most recently 9/27/11. The 9/27/11 neurology consultation report was not dated; the date was obtained via a review of the integrated progress notes. The consultation report was signed by the consulting neurologist, the facility medical director, and the treating psychiatrist. A review of psychiatry clinic note dated 10/1/11 revealed documentation of a discussion of neurology clinic recommendations. Per documentation, psychiatry clinic follow-up had continued, and this individual was last seen in psychiatry clinic 12/7/11. A review of the drug regimen review profile for this individual revealed that no psychotropic medications were currently prescribed, as both Trileptal and Keppra were designated as indicated for seizures. This example illustrated documentation of the relay of information from neurology clinic to the IDT via psychiatry. It also demonstrated the appropriate transition of responsibility for medication monitoring from one medical specialty to another. • Individual #246 was seen in neurology clinic 10/6/11 and 10/13/11. Documentation was available for review regarding the 10/6/11 encounter. This was apparently an off campus consultation, as it was not signed by the facility's regular consulting psychiatrist. Recommendations included "…aggressive behavior, advise psych input re: medication to control outbursts." The next documented psychiatry clinic encounter was dated 11/15/11, and documented the utilization of Tegretol for seizure disorder and "mood control." There was no documentation regarding clinical consultation with neurology, nor was there transmission of information from neurology to the IDT. In addition, review of the Appendix B comprehensive psychiatric evaluation performed for this individual dated 11/15/11 revealed mention of seizure activity and treatment with Tegretol for both seizure and "mood control," but neurological consultation information was not included. <u>Adequacy of Current Neurology Resources</u> Per interviews with the facility psychiatrist and the facility medical director, there were monthly neurology clinics scheduled. Medical staff interviewed indicated that the current neurology resources were adequate. They indicated that there was not a waiting list for individuals to be seen via neurology clinic, "sometimes, we have to beat the	

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		bushes to find patients for that clinic." This was surprising, as per review of the provided documentation entitled "Seizure Disorder Diagnosis Currently Receiving Psychiatric Services" that included the date of the last neurology consultation, of 68 individuals, there was no data provided for eight individuals (indicating no recent neurology clinic evaluations). One individual was last seen in 2004, one individual was last seen in 2005, two individuals were last seen in 2006, one individual was last seen in 2007, seven individuals were last seen in 2008, three individuals were last seen in 2009, 17 individuals were last seen in 2010, and 30 individuals were seen in 2011. Given these data, it was apparent that there was an increase in services provided in the past year. It was also evident, however, of the need for additional clinical neurology consultation, as 44% of the individuals had not been seen in neurology clinic in the previous year. Given the above, it would be beneficial to review the cases of the individuals requiring neurology follow-up to ensure that they received annual neurology clinical consultation. As the physicians continue organizing and participating in this clinical consultation, they will need to determine if the current contract hours are sufficient (given a four hour clinic per month, 12 times per year, there would be a total of 48 hours of consultation time to allocate between 68 individuals currently prescribed both seizure and psychotropic medications, this would not include other individuals requiring neurology services). Regardless, the facility should make efforts to maximize the utilization of their current neurology consultative resources and continue the pursuit of options for increasing 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. Per documents received, the facility submitted a contract and awaiting approval for on-campus services from the Comprehensive Epilepsy Center. It was noted that this contract approval was pending during the previous monitoring period. <u>Monitoring Team's Compliance Rating</u> As SASSLC psychiatry had developed a clinic protocol where psychiatry clinics were integrated, requiring the participation of various IDT members, and allowing for a meeting of the IDT during psychiatry clinic, clinical coordination between neurology, psychiatry and the IDT had improved. 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 IDT. 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 the facility plan of improvement revealed a noncompliance rating for this paragraph. While the 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., record 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, their increased involvement 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. Formalize the process for the multidisciplinary review of individuals requiring pretreatment sedation via the creation of policy and procedure governing this process, this should culminate in a meeting to review the treatment recommendations gathered from various disciplines and to effect a treatment plan. In addition, this process must be expanded to include medical pre treatment sedation (J4).

6. Review the current data collection process for tabulating individuals receiving pretreatment sedation inclusive of dental pretreatment sedation, medical pretreatment sedation, and TIVA (J4).

7. Develop a process for the assessment, creation, and implementation of desensitization plans and/or other treatments or strategies for dental and medical clinic (J4).

8. 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).

9. 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).

10. Complete annual psychiatric evaluations following the requirements of the Settlement Agreement Appendix B (J6).

11. Consider revision of timelines for referral of individuals to psychiatry following a positive screen and for the completion of psychiatry consultation for individuals with Reiss screen results indicating the need for psychiatric intervention (J7).

12. Revise the data presentation regarding Reiss screen completion in order to designate that individuals not previously referred to psychiatry clinic received baseline screening, to identify those individuals who received the screen due to a change of status, and those individuals who received the screen at admission (J7).

13. 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).

14. 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).

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

16. Ensure that medication side effects are adequately addressed in the risk/benefit analysis review (J10).

17. HRC documentation should include a critical review of the proposed intervention (J10).

18. Institute a monthly psychiatric polypharmacy committee meeting for facility level review of the justification for the use of polypharmacy (J11).

19. Review data collection regarding psychotropic medication to determine if additional indices would be useful (e.g., number of individuals prescribed medication in a particular class)(J11).

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

21. 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, J10, J13).

22. Individualize the process for Informed Consent; ensuring that the prescribing practitioner obtains consent for all prescribed psychotropic medications, both newly prescribed and annual reviews. This would include a review of the risks, benefits, side effects, and alternatives to treatment with a particular medication (J14).

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

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

25. Ensure that all individuals prescribed medication treating both seizures and psychiatric disorders requiring neurological consultation are scheduled for clinic annually (J15).

26. Continue clinical consultation clinic for psychiatry and neurology. Documentation for both psychiatry and neurology participation as well as the communication of information to the IDT 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:** <u>Documents Reviewed</u>: o Functional Assessments for: • Individual #291 (10/2/11), Individual #97 (12/1/11), Individual #350 (1/12/12), Individual #77 (10/11/11), Individual #7 (1/5/12), Individual #74 (11/17/11), Individual #127 (9/22/11), Individual #148 (1/12/12) o Positive Behavior Support Plans (PBSPs) for: • Individual #234 (1/23/12), Individual #85 (10/3/11), Individual #54 (10/17/11), Individual #223 (11/28/11), Individual #127 (11/14/11), Individual #349 (12/12/11), Individual #291 (11/7/11), Individual #274 (11/28/11), Individual #83 (11/28/11), Individual #148 (1/23/12), Individual #43 (2/13/12), Individual #201 (2/13/12), Individual #298 (2/13/12) o Annual Psychological updates for: • Individual #272 (11/4/11), Individual #40 (11/29/11), Individual #64 (9/8/11), Individual #106 (11/30/11), Individual #252 (11/30/11), Individual #80 (12/22/11), Individual #127 (9/22/11), Individual #261 (9/23/11), Individual #235 (12/2/11), Individual #283 (10/17/11), Individual #350 (12/9/11), Individual #114 (10/21/11) o For the past six months, Behavior Therapy Committee/Peer Review minutes o For the past six months, minutes from meetings of the psychology department o PBSPs Format, dated 9/26/11 o Draft policy for data collection, undated o Data collection procedures, undated o Procedures for tracking staff training on PBSPs, 12/11/11 o Procedures for obtaining consent, 12/22/11 o Procedures for training PBSPs, 12/11/11 o Integration of clinical services for psychological services, 11/17/11 o Training on basic behavioral principles, 2/20/11 o A list of individuals with PBSPs, undated o A list of functional assessments completed in the last six months, undated o A list of individuals receiving counseling/psychotherapy, undated o A list of individuals with annual psychological assessments, undated o Procedures for updating graphs, dated 10/6/11 o SASSLC annual psychological evaluations completed August 2011 to present o A list of all training conducted on PBSPs, undated o Status of enrollment in BCBA coursework for each psychologist o Section K Presentation Book, undated o SASSLC self-assessment, 2/1/12

	Interviews and Meetings Held: o Daisy Ellison, Director of Psychology o Charlotte Fisher, Associate Psychologist o Mark Boozer, Associate Psychologist o Laura Lewis, Associate Psychologist Observations Conducted: o Behavior Therapy/Peer Review Committee meeting: • Staff present: Daisy Ellison, Psychology Director; Rosalia Rodriguez, Associate Psychologist; Mark Boozer, Associate Psychologist; Gary Sarli, Associate Psychologist; Steven Boncek, Associate Psychologist; Charles Obi, Associate Psychologist; Bill McCarthy, QDDP; Laura Lewis, Associate Psychologist; Melissa Steerman, Associate Psychologist; Charlotte Fisher, Associate Psychology • Individuals presented: Individual #298; Individual #43; Individual #201 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; Gary Sarli, 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. Howland, Psychiatrist; Laura Lewis, Associate Psychologist; Bill McCarthy, QDDP; Shewanda Granberry, DSP; Jessica Mireles PSDI; Sandra Fiores, RN Case Manager • Individuals presented: Individual #42, Individual #140 o Psychiatry Clinic: • Staff present: Dr. Howland, Psychiatrist; Laura Lewis, Associate Psychologist; Bill McCarthy, QDDP; Shewanda Granberry, DSP; Sandra Fiores, RN Case Manager, Mary Zapata, DCP • Individual presented: Individual #56 o Observations occurred in day programs and homes at SASSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.

	Facility Self-Assessment: SASSLC submitted its self-assessment, dated 2/1/12. In the comments/status 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 self-assessment did not describe what activities they engaged in to assess whether they were meeting each provision item. The self-assessment should include the activities used in the self-assessment, and indicate how these findings were used to determine the self-rating of each provision item. SASSLC's self-assessment 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 assessment. The self-assessment established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur 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: In the last six months, there had been progress in the following areas: • One psychologist became a certified applied behavior analyst (K1). • Increase in the percentage of functional assessments for individuals with PBSPs (K5) • Improvements in the quality of functional assessments (K5). • Introduction of a simplified PBSP format (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: • Establish internal and external peer review (K3). • Ensure the routine use of the graphing of data in intervals necessary to make treatment decisions (K4). • Increase the percentage of functional assessments that include all the necessary assessment components (K5). • Collect interobserver agreement data, establish target levels, and ensure that staff achieve those levels (K4, K10).

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because the psychologists at SASSLC were not demonstrably competent in applied behavior analysis (ABA) as evidenced by the absence of professional certification for the majority of psychologists who wrote positive behavior support plans (PBSPs). Since the last review (August 2011), one psychologist at SASSLC attained certification as a board certified applied behavior analyst (BCBA). Additionally, another psychologist completed BCBA coursework and was waiting to take the national examination for BCBA. Six of the department's remaining nine 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. 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, and demonstrate competence in ABA.	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 order to achieve compliance with this provision item, the director of psychology needs to be a certified behavior analyst, or possess 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 of PBSPs.	This item was rated as being in noncompliance because the Behavior Therapy Committee/Peer Review (BTC/PR) meetings consisted of only annual reviews of PBSPs, and did not occur weekly. Additionally, there was no evidence of monthly external peer review occurring at the facility. The facility had been conducting BTC/PR meetings that contained many elements of internal peer review necessary to attain substantial compliance with this provision item. During the BTC/PR meeting observed by the monitoring team, the majority of psychologists attended, there was active discussion, and many examples of psychologists sharing strategies and suggestions to better improve the effectiveness of the PBSPs presented. The BTC/PR meetings, however, reviewed only PBSPs that required annual	Noncompliance

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		approval. Missing from the peer review meetings was the opportunity to present cases that were not progressing as expected, or PBSPs for individuals new to the facility. It is recommended that peer review meetings be extended, from only annual reviews, to include any case that a psychologist (or his or her supervisor) believe would benefit from the input of other psychologists. Additionally, the minutes of the BTC/PR meetings indicated that these meetings did not consistently occur weekly. It is recommended that peer review meetings be scheduled and occur weekly. Finally, at the time of the onsite review, external peer review meetings were not occurring at SASSLC. 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 and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	In order to achieve substantial compliance with this provision item, the facility needs to demonstrate that the data are reliable, that target and replacement behaviors are consistently graphed in increments that promote data based treatment decisions, and that some action (e.g., modification of the PBSP, retraining of staff, additional functional assessment) had occurred for any individual not making expected progress. At the time of the onsite review, the facility was conducting 30-minute target behavior data collection in all residential and day programming sites. Additionally, in the majority of homes, 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. One psychologist told the monitoring team that she did not require the DCPs in her home to record in every interval. By requiring the recording of a target behavior, or a mark indicating that no target behavior occurred, it increases the likelihood that the absence of target behaviors in any given interval did not occur because staff forgot or neglected to record 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 or psychological assistants to review data sheets and determine if DCPs were recording data in the intervals specified (e.g., every 30 minutes). As in the last report, the monitoring team did its own data collection reliability in each	Noncompliance

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		residence by sampling individual data books, and noting if data were recorded up to the previous hour for target behaviors, and if replacement behaviors were recorded. The results continued to be disappointing: • None of the seven data sheets (0%) reviewed were completed up to the previous hour. This was less then than the percentage of completed data sheets reported in the last review (i.e., 14%). • The recording of replacement behaviors was found in only one (Individual #316's) of individual notebooks reviewed (14%). These observations indicated that DCPs were not consistently recording target and replacement behaviors, and support the concerns of several psychologists who reported to the monitoring team that they did not have confidence in the reliability of their data. 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 the facility initiate its own data collection reliability for all target and replacement behaviors collected in each residence and day/vocational site. Finally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals. One reason that data collection reliability was poor could be that the individual notebooks (which contain data sheets) were not consistently available to DCPs. As reported in the last two reports, the majority of data books remained behind locked doors. It is recommended that SASSLC ensure that data sheets are more accessible to DCPs so that they can record target and replacement behaviors as soon as possible after they occur. 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, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target 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. SASSLC demonstrated some flexibility of their data system by continuing to use Antecedent-Behavior-Consequences (ABC) data to better understand and track individuals' target behavior. During this onsite review, the monitoring team noted several examples of ABC data (e.g., Individual #7, Individual #74) to better understand	

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		the variable or variables maintaining target behaviors (see K5). All target behaviors, however, collected by DCPs appeared to be collected with the use of a frequency within a 30-minute time sample. Some target behaviors may require other measures, such as duration (when it is important to note the length of time of a behavior rather than the frequency). Additionally, the interval of some behaviors could be increased if the behavior occurs at a low frequency. 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. The monitoring team found only one example (i.e., Individual #148) of target behaviors graphed in increments other than monthly, and no examples of replacement behaviors being graphed. It is recommended that the facility graph target and replacement data in intervals necessary to make data based decisions. Additionally, as discussed in the last report, graphs of target behaviors were not consistently available to assist in making data based treatment decisions. For example: • In two psychiatric clinics observed by the monitoring team, the psychiatrist wanted to evaluate the effects of a recent medication change. Weekly target behavior 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 order to achieve substantial compliance with this provision item, the psychology department needs to ensure that all treatment decisions are data based. Specifically, the facility needs to demonstrate the value of data by consistently graphing and presenting data in increments that encourage data based treatment decisions. Finally, in reviewing at least six months of PBSP data of severe behavior for 13 individuals, eight (Individual #127, Individual #148, Individual #234, Individual #54, Individual #43, Individual #223, Individual #349, and Individual #83), or 62%, indicated no obvious improvement in severe behavior. This is the same percentage of individuals judged to be not progressing during the last review. The monitoring team was encouraged, however, to find in the progress notes of one of these individuals (Individual #223), a plan to retrain staff on the plan's implementation. The monitoring team expects that the progress note or PBSP would indicate that some activity (e.g., modification of the PBSP, retraining of staff, additional functional assessment, etc.) had occurred for any individual not making expected progress. 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.	

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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 and functional assessments, and the lack of comprehensiveness of the functional assessments. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had initial psychological assessments. No initial psychological assessments were reviewed because none were completed in the last six months. All initial psychological assessments should include an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and an assessment of medical status. All individuals at SASSLC should have an initial (full) psychological assessment. <u>Functional Assessments</u> A spreadsheet of individuals with PBSPs and functional assessments indicated that 206 individuals at SASSLC had a PBSP, and146 of those (71%), had functional assessments. This represents an improvement from the last review when 54% of individuals with a PBSP had a functional assessment. All individuals with a PBSP, however, should have a functional assessment of the variable or variables affecting the individual's target behaviors. Another spreadsheet indicated that 34 functional assessments were completed since the last review. Eight of those functional assessments (24%) were reviewed to assess compliance with this provision item. As discussed in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. As discussed below, the quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual, and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures help to understand why a target behavior occurred by conducting questionnaires, interviews, or rating scales. All of the functional assessments reviewed included acceptable indirect procedures. In five (i.e., Individual #77, Individual #7, Individual #74, Individual #148, and Individual #127) of the eight functional assessments reviewed (62%), direct observation procedures were rated as complete. This represented an improvement in the number of	Noncompliance

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		complete direct assessment procedures compared to the last review (August 2011) when 36% of direct procedures were judged to be acceptable. An example of a complete direct observation was: • Individual #7's functional assessment included several dates and times of observations, and the occurrence of target behaviors, antecedents, and consequences. Three of the eight functional assessments reviewed, however, did not clearly include direct observations. For example: • Individual #291's functional assessment did not include a direct observation. • Individual #97's functional assessment consisted of direct observations, but the target behavior did not occur, so the assessment did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. Direct and repeated observations of target behaviors in the natural environment are an important component of an effective functional assessment. All functional assessments should attempt to include direct observations of target behaviors and provide additional information about the antecedents and consequences affecting the target behavior. The accuracy and usefulness of these direct observations is greatly enhanced by recording the relevant antecedents, behaviors, and consequences as they occur. 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. In order to be useful, however, ABC data need to be collected for a duration long enough to observe several examples of the of the target behavior, and sufficiently repeated so that patterns of antecedents and consequences could be identified. In situations where the target behaviors occur very infrequently (e.g., a few times a year), and therefore do not lend themselves to direct observation, a statement documenting the frequency and attempts to observe the behavior should be included in the functional assessment. Seven of the eight functional assessments reviewed (88%) identified potential antecedents and consequences of undesired behavior that would likely be useful for developing effective PBSPs for reducing undesired behaviors (Individual #350 was the one exception). This represents an improvement from the last review when only 55% of the functional assessments reviewed included potential antecedents or consequences of target behaviors. 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	

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		observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. Five (Individual #291, Individual #350, Individual #77, Individual #7, and Individual #74) of the eight functional assessments reviewed (62%) included a concise summary statement. This represented a decrease from the last review when 78% 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 during this review 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 (with a maximum of one year between reviews). Three (i.e., Individual #77, Individual #7, and Individual #74) of the eight functional assessments reviewed (38%) were evaluated to be comprehensive and clear. This represented an improvement from the last review when only 14% of the functional assessments were determined to be complete. The monitoring team was pleased with the progress SASSLC was making in the quality of functional assessments. It is recommended that the facility now develop a plan to ensure that all individuals with a PBSP have a current functional assessment.	
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.	Because no initial (full) psychological assessments were available for review, it could not be determined if they were current and complete. Therefore, this provision item was rated as being in noncompliance.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's	In addition to the initial or full psychological assessment, an annual psychological update should be completed each year for each individual. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	standard psychological assessment procedures.	A list of annual assessments indicated that they were completed for 111 individuals at SASSLC (40%). Additionally, the list indicated that 13 annual assessments were more than 12 months old. This compares to the last review when (39%) of all individuals had annual reviews. All individuals at SASSLC should have annual assessments. The monitoring team reviewed 12 annual psychological assessments completed in the last six months to assess their compliance with this provision. The findings are reported below: • All 12 psychological updates (100%) contained a review of personal history • Nine (75%) contained a review of standardized assessment of intellectual and adaptive ability • Ten (83%) contained a review of behavioral/psychiatric status. • Three of 12 psychological updates (25%) contained a review of medical status. These numbers are comparable to those reported in the last review. In order to achieve compliance with this item of the Settlement Agreement, all psychological updates will need to contain all of the components described in K5. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of three recent admissions to the facility in the last six months (i.e., Individual #283, Individual #114, and Individual #350) indicated that this component of this provision item was in substantial compliance.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided 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 continued to be rated as being in noncompliance. In order to achieve substantial compliance with this provision item the facility needs to ensure that all psychological services (other than PBSPs) 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

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K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	This item was rated as being in noncompliance because not all PBSPs reviewed contained adequate use of all of the components necessary for an effective plan, and many of the interventions did not appear to be based on functional assessment results. A list of individuals with PBSPs indicated that 206 individuals at SASSLC had PBSPs, and 92 of these were completed since the last review. Thirteen (14%) of these 92 PBSPs were reviewed to evaluate compliance with this provision item. All 13 of the PBSPs reviewed had the necessary consent and approvals. All PBSPs reviewed included descriptions of target behaviors, and 12 of these were operational (92%). This represented a slight decrease in operational definitions from the last report when 100% of the target behaviors were operationally defined. The one example of a definition that was not operational was: • Individual #148's PBSP defined physical assault as "… *trying* to hurt others… and is *unresponsive* to verbal interventions." This definition required the reader to infer if Individual #148 was indeed trying to hurt others, and was not responding to others. An example of a well written operational definition was: • Individual #43's target behavior of aggression was defined as "…slapping, hitting, pinching, and pushing." All PBSPs should include operational definitions of target behaviors. All 13 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but four (i.e., Individual #148, Individual #201, Individual #43, and Individual #83) of these (31%) identified antecedents and/or 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 undesired behavior. This is similar to the percentage of PBSPs reviewed last time (i.e., August 2011) that was judged to be inconsistent with the stated function (i.e., 29%). An example of a consequent intervention not related to the hypothesized function was: • Individual #201's PBSP hypothesized that her oppositional behavior was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). Her PBSP, however, included offering her an alternative activity (e.g., going for a walk) following the occurrence of undesired behavior. If avoiding undesired activities was reinforcing for Individual #201, then this intervention would likely increase the likelihood of her oppositional behavior. Ideally, after the targeted behavior occurred, Individual #201 should not be allowed to escape the undesired activity until she appropriately requests it. If the nature of her	Noncompliance

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		undesired behavior is such that it is dangerous to maintain her in the activity, then the PBSP should specify her return to the activity when she is calm, and again encourage her to escape or avoid the demand by using desired forms of communication (i.e., replacement behavior). The PBSP needs to clearly state that removal of the undesired activity should be avoided whenever possible, because it encourages future undesired behavior. An 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 #223's PBSP hypothesized that his self-injurious behavior (SIB) functioned to gain tangible items (primarily food). Antecedent interventions included giving him second portions of food. His intervention following SIB included prompting him to use his communication folder to tell staff what he wanted. 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 11 of the 13 (85%) PBSPs reviewed (Individual #291 and Individual #298 were the exceptions). This represented a decrease in the percentage of PBSPs with replacement behaviors reported in the last review (i.e., 100%). All PBSPs should include replacement behaviors. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. That is, when the reinforcer for the target behavior is identified and providing the reinforcer for alternative behavior is practical. The monitoring team found that replacement behaviors were not functional in six (i.e., Individual #148, Individual #85, Individual #54, Individual #201, Individual #145, and Individual #83) of the 10 (60%) PBSPs with replacement behaviors that could be functional. This represented a decrease from the last report, when 45% of all replacement behaviors that could be functional were not functional. An example of a replacement behavior that was not functional was: • Individual #148's PBSP hypothesized that his undesired behaviors were maintained by negative reinforcement. His replacement behavior was doing activities on his assignment sheet. These behaviors may be important for Individual #148 to acquire, however, they do not appear to be functional. An example of a functional replacement behavior could include teaching/reinforcing another way to escape or avoid unpleasant activities, such as asking for a break.	

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		In all four of the PBSPs with functional replacement behaviors, it appeared that they required the acquisition of a new skill. For example: • Individual #234's replacement behavior consisted of teaching her to operate her communication device, to indicate her desires. The monitoring team was encouraged to find at least two functional replacement behaviors included in skill acquisition plans (i.e., SAPs, see S1) for training (i.e., Individual #234 and Individual #316). It is recommended that all replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training. Overall, four (Individual #127, Individual #234, Individual #223, and Individual #349) of the 13 PBSPs reviewed (31%) represented examples of complete plans that contained operational definitions of target behaviors, functional replacement behaviors, and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a decrease over the last review when 50% of the PBSPs reviewed were judged to be acceptable.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Interobserver agreement measures were not collected for target and replacement behaviors at the time of the onsite review (see K4). A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment and for achieving substantial compliance of this provision item. As discussed in K4, target behaviors were not consistently graphed at SASSLC, and replacement behaviors were not graphed at all. As discussed in K4, it is recommended that the facility ensure that all target and replacement behaviors are consistently graphed 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). 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.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can	SASSLC had made some improvements toward simplifying PBSPs, and therefore increasing the likelihood that PBSPs are understood and implemented as written by DCPs. This provision item was rated as being in noncompliance, however, because at the time of the onsite review, the facility did not demonstrate that PBSPs were reliably implemented by DCPs.	Noncompliance

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	be understood and implemented by direct care staff.	Since the last review, the facility had introduced a simplified PBSP format that reduced the size of many of the PBSPs reviewed. The facility also reported that they attempted to decrease the number of target behaviors, and ensure that the language used was not above a sixth grade level. These interventions would likely increase the probability that PBSPs would be implemented as written by DCPs. Despite these efforts, the monitoring team encountered two PBSPs that had, what were, an excessive number of target behaviors. Individual #43's PBSP had eight target behaviors and Individual #216's PBSP had 12 target behaviors. Additionally, as reported in the last review, the monitoring team continued to encounter PBSPs containing language that appeared to be written at a level substantially above the reading level of many DCPs. For example: • In the instructions to staff of how to prevent Individual #83's undesired behavior, the PBSP states "Do not let the environment become overly chaotic or *cacophonic*." It is likely that these efforts to reduce the length and simply language would increase the likelihood that PBSPs are understood and implemented by DCPs however, as the examples above indicate, the facility had much more work to do in this area. The only way to ensure that PBSPs are understood and implemented as written is to implement a system to monitor treatment integrity. 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.	
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.	Each psychologist at SASSLC maintained logs documenting DCP training on each individual's PBSP. The trainings were reported to be conducted by psychologists and psychology assistants prior to PBSP implementation and whenever plans changed. There was no system, however, in place to ensure that all staff (including relief staff) had been trained. Additionally, there was no systematic way to identify all of the staff who required remedial training. Therefore, this item is rated as being in noncompliance. The monitoring team could not observe any staff training of PBSPs because none were scheduled during the onsite review. The monitoring team will observe and comment on the strengths and weaknesses of the current training procedures during subsequent onsite reviews. 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 276 individuals and employed 11 psychologists responsible for writing PBSPs. Additionally, the facility employed five psychology assistants and two psychology technicians. Only one 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 ten psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists at SASSLC writing PBSPs attain BCBA certification (K1).
2. Establish weekly peer review meetings that include the review of PBSPs that are not progressing as expected (K3).
3. Establish monthly external peer review meetings (K3).
4. The facility should initiate data collection reliability for all target and replacement behaviors collected in each residence and day/vocational site. Finally, specific reliability goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4).
5. Ensure that data sheets are accessible to DCPs so that they can record target and replacement behaviors as soon as possible after they occur (K4).
6. 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 (K4).
7. SASSLC should expand the flexibility of its data collection to ensure that all measures are sensitive to individual need (K4).
8. It is recommended that the facility graph target and replacement data in intervals necessary to make data based decisions (K4).
9. Ensure that some action (e.g., modification of the PBSP, retraining of staff, additional functional assessment, etc.) had occurred for any individual not making expected progress (K4).
10. All individuals should have an initial (full) psychological assessment (K5).

11. All individuals with a PBSP should have a functional assessment (K5).

12. Functional assessments should attempt to include direct observations of target behaviors (K5).

13. All functional assessments should include a summary statement that integrates the results of the various assessments into a comprehensive statement of the variables affecting the target behaviors (K5).

14. Functional assessments should be revised when new information is learned concerning the variables affecting an individual's target behaviors, with a maximum of one year between reviews (K5).

15. All individuals at should have annual assessments (K7).

16. Ensure that psychological updates contain all of the components described in K5 (K7).

17. Ensure that all psychological services (other than PBSPs) 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).

18. All PBSPs should include operational definitions of target behaviors (K9).

19. 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).

20. Ensure that replacement behaviors are functional when practical and possible (K9).

21. All replacement behaviors that require the acquisition of new behaviors should include skill acquisition plans (SAPs) for training (K9).

22. It is recommended that all graphs contain clear demarcation of changes in medication, health status, or other relevant events (K10).

23. An effective treatment integrity system should be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established (K11).

24. The facility needs to provide documentation that all staff assigned to work with an individual have 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 Preventive Health Care Guidelines, 8/30/11 o DADS Policy #006.2: At Risk Individuals, 12/29/10 o DADS Policy #09-001: Clinical Death Review, 3/09 o DADS Policy #09-002: Administrative Death Review, 3/09 o DADS Policy #044.2: Emergency Response, 9/7/11 o SASSLC Self-Assessment, 2/12/12 o Presentation Book for Section L o SASSLC Organizational Charts o SASSLC Nursing Protocol: Seizure Management Guidelines, 2/11 o SASSLC Standard Operating Procedure: 200-5A: Facility Medical Services Policy, 11/22/10, revised 12/28/11 o SASSLC Standard Operating Procedure: 200-5B Facility Medical Services Consultation Procedures, 10/8/11 o Annual Medical Assessment and Quarterly Review Procedure, 8/22/11 o Medical Department Quality Audits: • Aspiration Pneumonia • Diabetes Mellitus • Seizure Management o DADS Clinical Guidelines: • Aspiration Risk Reduction • Enteral Feedings • Constipation • Bowel Management • Urinary Tract Infections o SASSLC Facility Specific Guidelines for Management: • Anaphylaxis • Aspiration Pneumonia • Clostridium Difficile • Diabetes Mellitus • Osteoporosis • Seizure Management • Urinary Tract Infections 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 and internal medical reviews conducted in October and December 2011 o Medical Caseload Data o Mortality Review Documents o Daily Clinical Services Meeting Notes, August 2011 – January 2012 o Primary Care Physician Meeting Notes, 12/14/11, 12/29/11, 1/5/12 o Infection Control Committee Meeting Minutes, 7/13/11, 9/14/11, 11/30/11 o Pneumonia Review Committee Meeting Notes, 2/2/12 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 ISPs, and ISP addendums for the following individuals: • Individual #311, Individual #301, Individual #294, Individual #42, Individual #302, Individual #116, Individual #265, Individual #342, Individual #276, Individual #283 o Neurology Notes for the following individuals: • Individual #264, Individual #255, Individual #267, Individual #124, Individual #347, Individual #241, Individual #104, Individual #89, Individual #191, Individual #245, Individual #336, Individual #256, Individual #30, Individual #165, Individual #115 <u>Interviews and Meetings Held</u>: o Carmen Mascarenhas, MD, Medical Director o Liesl Schott, MD, Primary Care Physician o Yenni Michel, DO, Primary Care Physician o Lilani Muthali, MD, DADS Medical Services Coordinator o JoAnn Smith, RN, Medical Compliance Nurse o Marla Lanni, RN, JD, Chief Nurse Executive o Mandy Pena, RN, QA Nurse <u>Observations Conducted</u>: o Daily Clinical Services Meeting o Risk Assessment Meeting o Informal observations of sick call rounds o Informal observations of cottages and day services areas

	Facility Self-Assessment: The facility submitted its self-assessment. For each of the provision items, the self-assessment listed the actions that had occurred in order to achieve substantial compliance. This provided a useful snapshot to the monitoring team of activities that had occurred, but it was not a self –assessment. The self-assessment should help the facility gain some sense of where it stands relative to achieving substantial compliance. In moving forward, the medical director should read each provision item in this report noting (1) the activities the monitoring team described that were used in the assessment of the provision item, (2) the topics that the monitoring team commented on, and (3) suggestions and recommendations contained in the body of the report as well as the recommendations section. This approach should assist the medical director in developing a series of activities that can be completed in order for SASSLC to conduct a self-assessment. Completion of the self-assessment should provide a reasonable sense of where the provision stands relative to substantial compliance. Thus, the medical director would report a self-rating of substantial compliance or noncompliance and provide a concrete reason for that determination. The facility found itself in noncompliance with provisions L1, L2, and L3. It found itself in substantial compliance with provision L4. The monitoring team found noncompliance for all four provision items.
	Summary of Monitor's Assessment: Continued progress was noted in the provision of medical services in spite of multiple changes in physician staffing. Much of the progress was seen in the development and implementation of systems and processes, but much work remained to be done. Improvement was observed in preventive services, such as vaccinations and breast cancer screening. In other areas, such as colorectal cancer screening, compliance remained low. The format of several required assessments improved the overall usefulness and quality, but many of the documents reviewed were either lacking important information or included inaccurate information. Many individuals who needed screening for osteoporosis, such as those who used high risk AEDs, had not been tested, and the medical director had addressed this by implementing osteoporosis clinical guidelines. The facility's quality audits revealed low compliance scores for several diabetes indicators. Many individuals were diagnosed with pneumonia, but the facility's data related to pneumonia were not accurate. It appeared that the Pneumonia Review Committee was not an effective means of reviewing pneumonia. There were no formal written criteria for the process and the monitoring team found that some individuals with serious respiratory issues were not included in the pneumonia listing and some that were had the pneumonia incorrectly categorized. This was a serious failure given the morbidity and mortality associated with pneumonia. Moreover, the facility had adopted the standard that no small bowel feeding was permitted in the facility. This was contradictory to state issued guidelines that recommended consideration of small bowel feedings for those with recurrent aspiration. Individuals who had J-tubes

	inserted in the hospital were sent to live in other types of long term care facilities. Neurology services were primarily provided on campus. Clinic was conducted monthly for approximately two and a half hours. This seemed inadequate for providing services for the number of individuals diagnosed with seizure disorders. The neurological care was not comprehensive. Documentation lacked vital signs and neurology exams. There was little attention given to side effect monitoring and bone health. Ten percent of individuals living at the facility had active DNR orders and the rationale for many of those orders was not clear. The medical director insisted that these were all done at the request of the families. Nonetheless, many individuals had this status for years. External reviews were completed and progress was noted in the nonessential elements of care. The follow-up audit was scheduled for March 2012. Mortality reviews continued to be completed per state guidelines. One of five reviews generated recommendations. Quality nursing reviews indicated a continued pattern with regards to nursing care and one corrective action plan was provided. The medical department completed several quality audits, including audits of diabetes care, aspiration pneumonia, and seizure disorder. The audits focused primarily on processes and were a good source of information for the facility. The results of these audits were reported to the QAQI Council. Overall, this program lacked structure in terms of how audit criteria were selected and how corrective actions were implemented and followed-up. Finally, the medical department implemented many new policies, procedures, and guidelines. While physicians were held accountable for following processes, such as completion of summaries and notes, the medical director stated they were not obligated to follow the clinical guidelines. The value and effectiveness of the clinical guidelines will be assessed with future quality audits and reviews.

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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	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the documents reviewed section. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in sub-sections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical department continued to undergo staffing changes since the August 2011 review. Several locum tenens physicians had provided services over a period of months. In November 2011, a second full time primary care physician was hired. A new medical compliance nurse started in January 2012 replacing the previous nurse who departed in	Noncompliance

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	professional standards of care with regard to this provision in a separate monitoring plan.	December 2011. At the time of the onsite review, the medical staff was comprised of a full time medical director and two full time primary care physicians. The medical director maintained a caseload of 72 individuals while each primary care physician had a caseload slightly over 100 individuals. The medical program compliance nurse reported directly to the medical director. Two full time psychiatrists normally provided psychiatric services. At the time of the review, the psychiatry director had been on leave for several months so services were provided by one full time psychiatrist and one part time locum tenens psychiatrist. The primary care physicians were not provided any clerical support and, therefore, were responsible for dictating assessments as well as uploading and downloading those documents. Observations also revealed that documenting responses to QDRRs and consults in the IPN was cumbersome because no good tracking systems were in place. Consults were sent to the offices where they were reviewed. The physicians then traveled to the homes where the records were located to document responses in the IPN. The medical director stated that this process, in part, contributed to some of the deficiencies noted. **Physician Participation In Team Process** The daily clinical services meetings continued to serve as one forum for an integrated discussion of care. The medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacist, medical program compliance nurse, habilitation staff and psychologist attended this morning review. The events of the past 24 hours were discussed including hospital admissions, transfers, use of emergency drugs, and restraints. The dental director usually attended the Tuesday meetings to discuss upcoming dental sedation cases. Following this meeting, physicians completed rounds and participated in other activities, such as ISPs, ISP addendums, various meetings, and some clinics. The medical department did not track physician attendance at ISPs, but the medical compliance nurse indicated that a plan for doing so was in progress. The monitoring team attended several of these meetings and observed that valuable information was exchanged during this collaborative process. Meeting notes, dated August 2011 through January 2012, documented issues related to clinical care, as well as systems and process issues, such as stocking emergency kits with epinephrine and problems receiving hospital discharge information. Unfortunately, the notes did not document the resolution and follow-up for most issues. In fact, the notes from the 8/19/11 meeting indicated that the medical program compliance nurse would be requesting follow-up in future meetings on many issues, but this did not appear to consistently occur. The minutes for this meeting were cited as documentary evidence of discussions related	

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		to the use of stat drugs as well as medical and dental sedation. The notes were not completed for every meeting. Minutes were not recorded for several days during the months of October 2011, November 2011, and December 2011. The monitoring team recommends that the format for the meeting notes be revised, such that discussions, action steps, responsible persons, and timelines can be documented. **Overview of the Provision of Medical Services** Medical care was provided in the sick call format. Each PCP visited all assigned homes on a daily basis. Nurses maintained logs of the individuals requiring attention. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite neurology, dental, eye, podiatry, dermatology, gynecology, and psychiatry clinics. Orthopedic clinic was no longer conducted onsite and this service along with other specialty services was provided at the university health sciences center or by community physicians. The local pulmonary group at Methodist Hospital that provided continuity of care to the individuals for inpatient treatment for some 20 years no longer provided primary care services. Individuals were admitted to the hospitalist and pulmonary consulted as needed. Individuals were also admitted to Mission Trails Baptist Hospital. 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. Report copies were sent by mail and received within a week. EKGs were done at the facility and a computer generated interpretation provided. A vast array of services were provided to the individuals supported by the facility. Many of these individuals had very complicated medical problems that required intense supports from medical, nursing, and allied health services. The caseloads for physicians were heavy given the needs of the individuals and the requirements placed on physicians. Unfortunately, the changes in medical staff resulted in frequent transitioning of care and the two newest physicians were still learning about the individuals they cared for. For the most part, individuals received care and physicians responded to their needs. Individuals who were acutely ill were transferred to acute care facilities. Even so, there were instances in which gaps in the provision of care were noted. Compliance with some cancer screenings was low. Many individuals who were at risk for osteoporosis	

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		did not complete appropriate screening and some who were treated did not have follow-up consistent with guidelines. Individuals with recurrent aspiration and G-tubes were not evaluated for more aggressive interventions and neurology follow-up was not always timely. While observations, interviews, data and record audits revealed problems, the monitoring team also noted a trend of improvement in recent months in some areas, and those improvements will be discussed. **Documentation of Care** In August 2011, a procedure was implemented that specified the requirements for completion of the Annual Medical Summaries, Quarterly Medical Summaries, and Active Problem Lists. The new guidelines were effective in September 2011. The revised AMS formats were implemented at the time of completion of the annual assessment. The assessments were completed and submitted two weeks prior to the ISP. This was a transition from the use of the birthdate as the anniversary date. <u>Annual Medical Assessments</u> The standardized template included multiple components, such as interval history, current diagnoses, immunizations, preventive care summary, and the physical examination. The new guidelines required that each medical problem have a plan of care. This was a significant improvement. Even so, the documents presented findings in a manner that sometimes failed to link problems, such as dysphagia, aspiration, and pneumonia. Moreover, there were some assessments that failed to acknowledge important medical problems. A few summaries included notes signed by the medical compliance nurse. These were explanations related to issues, such as smoking history and drug allergies. The notes indicated they were being added on behalf of the PCP or the medical director, but were never signed by a physician. It was not an acceptable practice to have the annual medical summary amended by a non-medical practitioner. With improvements in the format of the AMS, the monitoring team expects that, as physicians use this format and become more familiar with the individuals, additional improvements will be seen. <u>Active Problem List</u> All but one of the records in the sample contained an Active Problem List. The APL was being produced on heavy yellow card stock and the location was moved from the IPN to the front of the physician orders for better accessibility. Most of the documents reviewed were updated and signed and this was a significant improvement since the last review. The medical staff will need to work on improving accuracy of the information. Some of the APLs reviewed omitted important diagnoses, such as pneumonia, status	

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		epilepticus, and G-tube insertion. Quarterly Medical Summaries Quarterly Medical Summaries were found in all of the records, but they were not done consistently every quarter. In many instances, the documents were simply a listing of medications and problems that were added to each quarter. Additional work will be needed to make this a more helpful document. Use of a consultation tracking log might improve documentation of clinic appointments and diagnostics completed. Integrated Progress Notes Physicians documented in the IPN in SOAP format. The notes were usually signed, dated, and timed. Pre-hospital and post-hospital notes were usually written. Documentation of follow-up care was sometimes lacking. There were instances where labs, x-rays, and other studies were ordered, but were not documented in a timely manner or at all. Physician Orders Physician orders were usually signed and dated. There were multiple entries that were not timed, but this appeared to be a very practitioner specific pattern. Incomplete orders or orders that required clarification or correction of dosages, routes, and stop dates were not infrequent. Consultation Referrals The consultation referral forms usually included the information needed for completion of the consultation. For the most part, the records in the sample indicated significant improvement in the documentation of consults in the IPN. This was particularly evident in the months just prior to the review. Nonetheless, there were problems with several of the consults reviewed. The date of the actual consult was, at times, difficult to determine and consultants frequently noted that labs, x-ray reports, MARs, and seizure logs were not provided for review. A lack of information had the potential to, and sometimes did, limit the response of the consultant. **Routine and Preventive Care** Routine and preventive services were available to all individuals supported by the facility. Vision and hearing screenings were provided with high rates of compliance. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. Documentation of varicella status was found in most records. The Preventive Care Flowsheets were found in all of the records reviewed. It covered the basic areas of prevention and overall was adequate. The guidelines were generally	

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		consistent with state issued guidelines. It was obvious that the medical staff made efforts to update these documents. An occasional order was written requesting that a PCFS be placed in the record. The monitoring team recommends that the sections for hearing and dental exams direct the reader to the consult by including the date of the most recent exam rather than simply state "See audiology evaluation in the chart." Databases were developed to track preventive care services, such as cancer screenings and osteoporosis. The medical department also maintained a seizure database. Nursing maintained an immunization database and the medical director reported that a centralized immunization database was in development. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Immunizations</u> • 10 of 10 (100%) individuals received the pneumococcal, influenza and hepatitis B vaccinations • 10 of 10 (100%) individuals had documentation of varicella status <u>Screenings</u> • 9 of 10 (90%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 2 of 5 males met criteria for PSA testing • 2 of 2 (100%) males had appropriate PSA testing A list of males greater than 50 was provided. The list contained 72 individuals: • 72 of 72 (100%) males had PSA results documented within the past year <u>Breast Cancer Screening</u> • 3 of 5 females met criteria for breast cancer screening • 3 of 3 (100%) females had current breast cancer screenings A list of all females age 40 and older was provided. The list contained the names of 82 females, the date of screening, and explanations for lack of testing: • 37 of 82 (45%) females completed mammography in 2010 or 2011 • 34 of 82 (42%) females completed breast ultrasonography in 2010 or 2011	

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		• 1 of 82 (1%) females completed breast ultrasonography in 2008
		• 10 of 82 (12%) had no breast cancer screening
		  o 4 of 10 were to be scheduled
		  o 3 of 10 were uncooperative or had positioning problems
		  o 1 of 10 had an no reason listed
		  o 1 of 10 had guardian refusal
		  o 1 of 10 had a bilateral mastectomy
		
		<u>Cervical Cancer Screening</u>
		• 5 of 5 females met criteria for cervical cancer screening
		• 4 of 5 (80%) females completed cervical cancer screening in 2011
		• 1 of 5 (20%) females had no documentation of cervical cancer screening
		
		A list of all females age 18 and older was provided. The list contained the names of 94 females, the date of the last pap smear, and explanations for lack of testing:
		• 43 of 94 (46%) females completed cervical cancer screening in 2010 or 2011
		• 12 of 94 (13%) females completed cervical cancer screening in 2008 or 2009
		• 15 of 94 (16%) females completed screening prior to 2008
		• 24 of 94 (26%) females had no documentation of cervical cancer screening
		  o 10 of 24 were uncooperative or positioning problems
		  o 5 of 24 were due to refusal
		  o 3 of 24 were post hysterectomy
		  o 6 of 24 had no documented reason
		
		<u>Colorectal Cancer Screening</u>
		• 3 of 10 individuals met criteria for colorectal cancer screening
		• 0 of 3 (0%) individuals had undergone colonoscopy for colorectal cancer screening
		
		A list of individuals age 50 and older was provided. The list contained 123 individuals:
		• 43 of 123 (35%) individuals had completed colonoscopies
		• 78 of 123 (63%) individuals did not have documentation of colonoscopy
		  o 55 of 78 (71%) had no reason documented
		  o 19 of 78 (24%) had “will not do” documented
		  o 4 of 78 (5%) were scheduled for colonoscopy
		• 2 of 123 (2%) of individuals had completed a colonoscopy more than 10 years ago	

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		Medical Management State office issued numerous multidisciplinary clinical guidelines. The medical director also developed several guidelines for disease management. These are discussed in further detail in section L4. The monitoring team reviewed records and facility documents to assess overall care provided for osteoporosis, GERD, and pneumonia. These areas are discussed further in the case reviews. Data derived from record audits and the facility reports are summarized below. <u>Osteoporosis</u> • 2 of 10 individuals were diagnosed with osteoporosis • 1 of 2 (50%) individuals received appropriate treatment with calcium, vitamin D, and alendronate. • 1 of 2 (50%) individuals received no supplementation or treatment, but had a pending DEXA scan. A list of 40 individuals with the diagnosis of osteoporosis or osteopenia was provided. For those 28 (65%) individuals with a diagnosis of osteoporosis: • 24 of 28 (86%) individuals received calcium and vitamin D supplementation • 4 of 28 (14%) individuals did not receive supplementation • 13 of 28 (46%) individuals received treatment with bisphosphonates • 15 of 28 (54%) individuals did not receive additional treatment • 12 of 28 (43%) individuals completed DEXA scans in 2010 or 2011 • 3 of 28 (11%) individuals completed DEXA scans in 2008 or 2009 • 12 of 28 (43%) individuals completed DEXA scans more than four years ago • 1 of 28 (3%) individuals did not have documentation of a DEXA scan For those 11 (26%) individuals with osteopenia: • 10 of 11 (91%) received calcium and Vitamin D • 1 of 11 (9%) received no supplementation • 5 of 11 (45%) individuals completed DEXA scans in 2010 or 2011 • 2 of 11 (18%) individuals completed DEXA scans in 2008 or 2009 • 2 of 11 (18%) individuals completed DEXA scans in 2007 • 2 of 11 (18%) individuals completed scans more than 10 years ago The medical director indicated that work was needed in the area of bone health. She reported that many individuals had the diagnosis of osteoporosis or osteopenia, but had never undergone bone mineral density testing. Record audits corroborated this finding.	

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		Individual #116 and Individual #276 were at risk for osteoporosis due to treatment with AEDs. Neither had completed bone mineral density testing. <u>GERD</u> • 2 of 10 (20%) individuals were diagnosed with GERD • 1 of 2 (50%) received appropriate treatments with a PPIs • 1 of 2 (50%) individuals had no medical treatment documented Individual #116 received treatment with famotidine for GERD, but did not appear on the GERD listing or have GERD as an active diagnosis. There were several other individuals who received PPIs, possibly long term for the diagnosis of gastritis. The medical director should review the accuracy of the data submitted for GERD and ensure that individuals receive appropriate treatment. <u>Pneumonia</u> The facility submitted a list of persons with the diagnosis of pneumonia. The list contained 42 names. Following discussion with the medical director, an amended list of 32 individuals was submitted. Even with revision of the list, the monitoring team had serious concern about the accuracy of the data provided. The revised list, which covered all of 2011, did not appear to accurately define those with pneumonia. For example, Individual #149 was admitted to the intensive care unit in early December 2011 and required mechanical ventilation due to respiratory failure and pneumonia. This individual did not appear on the pneumonia list. Individual #311 was reported to have bacterial pneumonia. Record documentation clearly indicated evidence of aspiration. Individual #169 was reported to have hospital-acquired pneumonia. Hospital records indicated evidence of pneumonia at the time of admission. The medical director reported that the Pneumonia Review Committee was an interdisciplinary group created to discuss issues related to pneumonia. This committee was formed after the August 2011 monitoring review. There were no written guidelines for this committee, but it was reported that participants included the medical director, infection control nurse, QA nurse, habilitation representative, a primary care physician, and the facility director/designee. Hospital data were reviewed, including the discharge summary, x-ray reports, and labs. The group then made a determination about the type of pneumonia. Only one set of notes was available for review and important details were absent for several individuals. This committee must conduct a through review of clinical events, laboratory, and x-ray findings. The notes reviewed did not document sufficient information to warrant a change in the diagnosis from aspiration to bacterial pneumonia.	

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		The state-issued Aspiration Risk Reduction Guidelines suggested that individuals with documented aspiration or persistent feeding intolerance be considered for small bowel feedings, potentially below the Ligament of Treitz. The medical director and CNE both indicated that J-tubes (small bowel feedings) were not used at SASSLC. The CNE believed this practice was due to a lack of an infirmary and nursing resources. Notes from the morning clinical meeting, dated 10/12/11, documented that with regards to J-tubes "we do not manage them here." Data showed that many of the individuals with pneumonia experienced recurrent aspiration and received enteral nutrition through G-tubes. The monitoring team acknowledges both the difficulty of management of aspiration and the higher complication rates for use of small bowel feeding tubes. Even so, current literature suggests that small bowel feedings decrease the risk of aspiration. The monitoring team highly encourages that, in addition to maximizing special supports, consideration be given to development of guidelines for management of individuals with recurrent aspiration. These guidelines should include the full armamentarium of diagnostic and therapeutic modalities including, but not limited to, fundoplication, small bowel feedings, assessment for salivary aspiration, and reduction of salivation. With development of guidelines, it is critical that an adequate risk/benefit analysis be completed and appropriate specialty consultations occur so that guidelines are applied to those who might benefit from these interventions. During discussions with the medical director, it was not evident that all treatment options were discussed with individuals and/or their legally authorized representatives. Informed refusal requires that information on potential treatments, the risks and benefits be provided to those involved in the decision making process. **Case Reviews** <u>Individual #301</u> had an extensive medical history that included seizure disorder and aspiration pneumonia. Medical management was complicated by issues, such as dilantin toxicity, subtherapeutic dilantin levels related to medication errors, failure to obtain labs due to "miscommunication," and status epilepticus. Moreover, it was not clear that all medical issues were addressed in a prompt manner. In mid-August 2011, this individual experienced inadequate urine output. An order, which was reported to be misinterpreted, resulted in the individual receiving 150 cc of water every hour per gastric tube. This continued until 1050 cc was administered at which time the direct care nurse requested a second nursing opinion because the individual had no urine output. An ultrasound of the kidneys and bladder was ordered, but the QMS dated 9/12/11 stated that the results of the ultrasound could not be found. Documentation for this individual was also problematic with incomplete or inaccurate	

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		documentation observed in several documents. The APL, updated on 12/1/11, failed to include aspiration pneumonia, status epilepticus, and gastric tube insertion. The QMS failed to note that dilantin was discontinued on 10/31/11. The AMS was signed on 6/1/11. Based on information provided, the PCP who signed the document was not working at the facility during that time. Individual #311 had a history of recurrent aspiration and required gastric tube insertion in January 2011. Pneumonia was documented in June 2011, September 2011, and December 2011. The records did not provide an adequate plan for this individual with a G-tube and recurrent aspiration. The individual was sent to the emergency department on 12/12/11 after experiencing respiratory problems while bathing. It was documented that cough produced formula type secretions. Upon return from the hospital on 12/8/11, the physician documented that dietary would be consulted for advice on management of enteral meals. The actual consult occurred on 12/12/11. The APL, signed on 1/3/12, did not include pneumonia as a problem. The individual's DNR status was based on the diagnoses of Down Syndrome and heart disease. The last cardiology consult in 2009 noted no acute cardiac concerns, but did indicate there was mild valvular insufficiency. This individual also was diagnosed in 2009 with hydrocephalus. The follow-up for that condition was not clear from the documentation provided. Individual #302 had a history of seizure disorder, constipation, dysphagia, recurrent aspiration, and latent TB infection. The individual had multiple prolonged hospitalizations due to pneumonia and in 2003 required a right thoracotomy for decortication of an empyema. The AMS stated the individual had multiple swallow studies and aspiration was felt to be the etiology of the repeated respiratory problems. A 2008 CT scan showed GERD with a large amount of fluid in the esophagus. Placement of a gastric tube was deferred due to behavioral issues. The individual continued oral intake with an altered texture. In 2010, the individual was diagnosed with community acquired pneumonia. A 30 pound weight loss had been noted over the past year. In January 2012, the individual was referred to GI for a screening colonoscopy and a 15 pound weight loss. The gastroenterologist noted the results of the MBSS and absence of a G-tube. It was documented that "I am not sure it would be safe to do prep due to aspiration risk. I would not do a screening colonoscopy as risk are greater than the benefits." The PCP concurred with this finding in the IPN and referred the consultation to the IDT. The IDT appeared to review the issue and the ISPA noted agreement. This individual had an IDT meeting on 1/10/12 and the PNMP was revised. There was no medical participation and the exact reason for the meeting was not clear. The PNMT had not reviewed this individual at the time of the onsite review. An IPN entry, dated 2/12/12, noted the recent weight loss, and considered the individual a possible PMT	

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		candidate. The dietician and PCP were to address weight. Individual #294 had multiple problems including seizure disorder, hypertension, hyperlipidemia, and a hip fracture. The hypertension had been difficult to control and required three hospitalizations in 2011. The individual was seen on 1/18/12 due to respiratory problems. The physician documented crackles in the lungs and noted that the right ear was injected. Vital signs were "noted," but not documented in the IPN. The assessment was allergic rhinitis. Guiafenesin and Zithromax were prescribed for bronchitis. The IPN did not include that diagnosis. A chest x-ray was completed on 1/19/12 and a health management plan was implemented for bronchitis. The next physician IPN entry on 1/26/12 was written to document assessment of the lungs. The chest x-ray done on 1/19/11 reported decreased lung volumes with findings suggestive of interstitial pulmonary edema, possible bilateral pleural effusions versus scarring, bibasilar atelectasis, and diffuse osteopenia. Vital signs were again "noted" and the lungs were clear. An EKG, echocardiogram were requested. The EKG done on 1/27/12 was normal. The individual had a cardiology evaluation on 2/14/12 that indicated stable valvular heart disease. Medical documentation on 12/9/11 indicated that DEXA scans were reviewed and the last was done in 2009 with no significant change in scores. The physicians stated the hip fracture that occurred in June 2011 was not a fragility fracture, but a repeat DEXA was scheduled to determine if a change in therapy was warranted. On 12/19/11, it was noted that the external review indicated need for colonoscopy and this would be assessed at the time of the annual physical since the individual was undergoing rehabilitation for the hip fracture. In the QMS dated 12/31/11, the physician documented that this individual had gallstones and the surgical consult "advised against surgical intervention." The consult did not advise against surgery, but stated, "I do not think it is unreasonable to remove gallbladder given the symptoms. I cannot definitely say that the GB is the culprit in this. The doctor at the state school will discuss with the family and decided if they would like the individual to undergo surgery." There was no further discussion documented in the records provided. **Seizure Management** Neurology clinic was held onsite. The medical director reported that clinic was conducted one to two times each month. A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 139 individuals with a diagnosis of seizure disorder. Thirteen individuals were	

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		documented to have refractory seizure disorder and 11 individuals had vagal nerve stimulators. Two individuals required hospitalization for prolonged seizures. Two individuals had experienced status epilepticus. The seizure database maintained by the medical department provided information on the medications received by individuals for management of seizure disorders: • 22 of 139 (16%) received 0 AEDs • 60 of 139 (43%) received 1 AEDs • 32 of 139 (23%) received 2 AEDs • 18 of 139 (13%) received 3 AEDs • 5 of 139 (36%) received 4 AEDs • 2 of 139 (1%) received 5 AEDs • 33 of 139 (23%) of individuals received the older more toxic drugs The number of individuals seen in the on-campus clinic and by the epileptologist is summarized in the table. The on-campus clinic was conducted by a general neurologist consultant to SASSLC for 2½ hours once per month (this was a reduction from last year). In addition, for approximately the past year, SASSLC was sending some individuals to the epileptologist, typically those individuals whose seizures were refractory and those individuals who had a VNS.	

Neurology Clinic Appointments 2011		
	On-Campus	Epileptologist
July	--	3
August	6	1
Sept	6	4
Oct	6	3
Nov	7	2
Dec	0	0
Jan	--	5
Total	25	18

A total of 35 visits occurred during the months of August 2011 through December 2011. The facility supported 139 individuals with a diagnosis of seizure disorder. One hundred seventeen individuals received AEDs with 57 of 117 (48%) receiving two or more drugs.

Seizure management notes for 10 individuals evaluated in the SASSLC neurology clinic, as well as notes from the epileptologist, were submitted for review. The notes reviewed were brief. Only one SASSLC note was signed and two did not include the date of the consult. For individuals with seizure disorder, the notes did not consistently document drug dosages, severity of seizures, date of last seizure, results of drug monitoring, and

#	Provision	Assessment of Status	Compliance
		the impact of the seizure disorder and AEDs on the quality of life. There was never any documentation of vital signs, weights, or a neurologic exam. The results of the MOSES and DISCUS evaluations were not documented and little was said about medication side effects. There were usually no recommendations to monitor for drug side effects. For example, individuals who received topiramate were not followed specifically for the presence of metabolic acidosis, although labs frequently indicated this occurred. Moreover, the individuals who had evidence of a suspected compensated acidosis (low serum carbon dioxide) were not evaluated or screened for the presence of kidney stones. The recommendations were vague and instructions for drug tapers were not provided. Timeframes for follow-up were not specified in the recommendations. The notes from the epileptologist were also brief, but specific instructions were provided for drug tapers and titrations. A timeframe for follow-up was also given. Multiple notes indicated that seizure logs were not provided for the clinic visit or labs had not been obtained as requested. The following are some examples of information noted in the record sample and clinic consultations submitted. Individual #302 was diagnosed with seizure disorder, but had been seizure free since 1985 and remained on tegretol. The neurology note 4/26/11 documented that discontinuation of the tegretol would be considered after chromosomal studies and an EEG were completed. The genetic studies were normal, but the EEG was not completed due to behavioral issues. EEGs in 1985 and 1991 were normal. Ten months after the recommendation was made, the individual had not returned to neurology clinic for follow-up. Individual #265 was treated with valproic acid for seizure disorder. It was reported that the last seizure occurred in 2004. Documentation of the last neurology assessment was not found in the records provided. Individual #104 was seen in clinic on 11/29/11 with a history of seizures and a psychiatric disorder. Seizure activity had increased in recent months and some were documented as violent. The 2008 EEG was abnormal. There was no documentation of laboratory results or drug levels in the note. The recommendation was to add Vimpat to the regimen of clonazepam and Depakote. There was no recommendation for follow-up. The medical director should develop a clinic template that includes key data elements related to seizure management. The consultants should be requested to utilize the template in an effort to provide the IDT with adequate information related to care. The facility must assess the adequacy of the neurology clinic hours provided. Although it	

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		was reported that clinic occurred one to two times each month, the clinic data submitted showed that clinic occurred once a month. **Do Not Resuscitate** The facility submitted a list of 27 persons with current DNR orders. The reason for each DNR and 2011 renewal dates were also provided. No new DNRs were implemented since the last review. There was no documentation submitted for the renewal of any of these orders. The notes and orders for DNRs and rescinding of DNR were also requested, but documentation was not provided. One individual remained on the list with the diagnosis of PKU. Since PKU was not considered terminal, the medical director should document additional rationale for the DNR. The medical director must evaluate each DNR and determine if it is appropriate to continue implementation of the order. The monitoring team's understanding was that new state policy was in development to help guide the facilities in the application of DNR orders. **Infection Control** In August 2011, one individual developed a pan colitis and toxic megacolon secondary to Clostridium difficile. A review of the infection control minutes from September 2011 was pertinent for the fact that this incident was never discussed. The facility did not provide any aggregate data on the cases of this infectious disease in the document request for information on infection control issues. Nonetheless, a review of the daily clinical meeting notes documented that several individuals subsequently developed C. difficile infections, some of which were resistant to eradication. Daily clinical meeting minutes at one time reflected that one of the primary care physicians was going to do research on control of C. difficile in institutions, but there was never any follow-up on the topic. During discussions with the medical director, it was reported that individuals were placed on contact isolation and guidelines were developed for medical management. There was no documentation of any special infection control meeting being called and the Infection Control Committee minutes did not document the number of cases, the living areas involved or other information that would be relevant for appropriate infection control surveillance. The individual cases were treated and individuals were referred to an infectious disease specialist. The overall management of this issue however, seemed to fall short of standard practices for institutional infection control.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td>Medical Reviews
External medical reviewers, from sister SSLCs and state office, conducted medical reviews in October 2011 and December 2011. A five percent sample of 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 to be in place, in addition to receiving a score of 80% on nonessential items.

Following each review, corrective action plans were developed and data showed that 100% of the plans were completed following each review. Nonetheless, facility generated data indicated no appreciable improvement in compliance with the essential elements while improvement was noted in compliance with nonessential elements.

<table>
<tr><td colspan="4">External Medical Reviews 2011
Compliance (%)</td></tr>
<tr><td></td><td>March</td><td>October</td><td>December</td></tr>
<tr><td>Essential</td><td>94</td><td>74</td><td>72</td></tr>
<tr><td>Nonessential</td><td>70</td><td>81</td><td>88</td></tr>
</table>

The most recent two reviews documented continued low compliance (<70%) for issues related to
• Reviewing, updating and signing the APL
• Inclusion of adequate histories and plans of care in the AMS
• Documentation regarding tobacco use
• Documentation for not providing preventive services
• Documentation of a rationale for not following the recommendations of pharmacists

Minutes from the PCP meetings indicated that the medical director shared this information with the medical staff and discussed corrective actions. Internal audits were also completed, but overall cumulative scores were not provided. According to the medical director, the fourth external audit was scheduled for March 2012. In order to asses clinical outcomes, the management of three medical problems would be assessed with all future internal and external audits. External audits were scheduled to occur every six months while internal audits would be completed quarterly. External audits would occur at the same time as internal audits to assess inter-rater reliability.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Mortality Management at SASSLC Seven deaths occurred in 2011. The average age at death was 57 years. Three of the seven deaths occurred since the last onsite review. Two deaths occurred in January 2012 with the average age at death being 63.5 years. Mortality documents for those deaths occurring since the August 2011 were provided for review. The administrative and clinical death reviews occurred per state policy. The administrative death review for the most recent death had not occurred. The causes of death were urosepsis, congestive heart failure, and aspiration pneumonia for three individuals. The administrative death reviews concurred with the clinical death reviews presentation of no recommendations for three of the reviews. Recommendations related to infection control were made for one death. The monitoring team met with the chief nurse executive and QA nurse to discuss mortality management at the facility. It was reported that corrective actions occurred, but there was no organized process for ensuring implementation and follow-up.	
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 developed a structured medical quality program. A comprehensive set of measures had not been identified. In fact, all external reviews had focused on processes and excluded clinical outcomes. The delay in selection of measures of outcomes was largely due to the need to develop clinical guidelines. The monitoring team met with the medical director and medical program compliance nurse and discussed in some detail the medical department's quality initiatives. Audits of diabetes quality indicators were completed in September 2011. A list of individuals with the diagnosis of diabetes was provided by the records department. A total of 16 record audits were completed for compliance with the selected measures. High compliance scores were noted for the administration of influenza and pneumococcal vaccinations. Other indicators, such as annual eye exam, podiatry exams, and completion of urine microalbumin achieved relatively low scores. The facility was unable to assess compliance with achieving target blood pressures due to a lack of documentation. With the exception of blood pressure, all of the measures audited were related to processes. Each indicated that an action, diagnostic or therapeutic, had occurred. The only consequence of treatment (blood pressure) could not be assessed. While this mix of measures would not be ideal in the determination of health care quality, it served the purpose of providing information to the medical director on potential problems and opportunities for improvement regarding the provision of medical care.	Noncompliance

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		The following are a few examples of the barriers the facility identified in its report: • Some labs ordered by physicians were not carried out. • There was not a standard monitoring of blood pressures for those individuals with diabetes. • Physicians may have been waiting to be prompted by nurses to obtain appointments and labs. • There were no vital signs sheets to determine if physicians addressed blood pressures. • There was no diabetic record in each home so that physicians could periodically review blood sugars in between lab draws. • There was not a clear system for tracking missed appointments so that refusals or missed appointments could be rescheduled. • There was not a clear system for monitoring those with diabetes. Corrective actions included ordering missing consults and developing a new consult tracking system. Matters related to nursing were referred to the nursing operations officer. The deficiencies noted in this review required corrective action and some of these should have occurred immediately as "quick fixes." The follow-up audits were scheduled for March 2012. As discussed in Section L1, the monitoring team observed a lack of follow-up on numerous issues presented in the morning clinical meetings. A potential solution to this is to ensure that a formal plan of correction is created that includes the actions steps, responsible persons, how progress will be monitored, and timelines for completion. In October 2011, audits for aspiration pneumonia were conducted. The medical program compliance nurse developed an audit tool based on suggested questions from the draft policy State Office Medical Quality Audits. The records of eight individuals with the diagnosis of pneumonia and one high risk individual were audited. Multiple processes were assessed, such as obtaining GI consults, elevating the head of the bed, and obtaining a PNMT evaluation. The facility concluded the following based on data presented in the report: • There was strong involvement of all disciplines in care. • Treatments were reevaluated following aspiration and efforts made to minimize risks. • Compliance with completion of MBSS was low, but records indicated studies were performed in the past. • PNMT involvement was strong. • Trigger data sheets were not completed accurately and there was not consistent nursing review of this information.	

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		• The APL did not include the history of aspiration. In response to these findings, the APL was revised and the location made more accessible in the records. New guidelines were also developed for the AMS which required that a plan of care be developed and documented for each active problem. Additional audits were completed on seizure management. As was the case with the two audits described, additional work was needed to determine a reasonable mix of performance measures and to ensure that a corrective action plan was developed based on deficiencies discovered. In spite of lacking some key elements, completion of these audits represented continued and strong efforts on the part of the medical department to move towards substantial compliance with this provision item. The ongoing work in state office to expand the external reviews to include clinical outcomes should be of great assistance in establishing the necessary framework for data collection and analysis and the implementation of corrective actions.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility's medical services policy was revised in December 2011. It outlined the fundamental concepts related to the provision of medical services based on state issued policy. It provided information on facility specific processes including physician duties and responsibilities, documentation requirements and ancillary services provided by the facility. Moreover, the policy offered more detailed guidance to the medical staff on the schedule of preventive care and immunizations. The general recommendations for adult immunizations were very nicely summarized in tabular format with explanations provided below the table. In addition to the revision of the medical services policy, the facility implemented several clinical protocols issued from state office including those related to aspiration, enteral feedings, constipation, seizure management, and urinary tract infections. As part of the localization of these protocols, and in an effort to provide more physician focused information, the medical director developed several clinical guidelines. They included constipation, aspiration pneumonia, clostridium difficile infections, diabetes mellitus, osteoporosis, seizure disorder, and urinary tract infections. An anaphylaxis protocol was also developed. Each guideline highlighted the tenets of medical care and treatment and provided the references utilized in development. The osteoporosis protocol provided a clear set of guidelines related to risk assessment, initial evaluation, medical management, and monitoring of response to treatment. This was an excellent set of guidelines based on	Noncompliance

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		current literature. The facility aspiration pneumonia guideline expanded on the state issued guideline by providing direction to physicians on more specific medical care issues, such as clinical signs of aspiration, the work-up, and general treatment. The guideline lacked direction related to the management of individuals with recurrent aspiration syndromes. This was an area of great importance given the number of individuals who experienced recurrent aspiration and the morbidity associated with this condition. As discussed in Section L1, considerable work is needed in this area. While the content of these documents was overall good, their use and implementation presented concerns. The locally developed guidelines and protocol did not require review by state office and were not required to go through any facility approval process. The medical director explained that these were just guidelines and the physicians were not obligated to follow them. There was documentation that the medical staff participated in an inservice on most of these guidelines, but there was no policy or procedure that explained how these documents were to be used or that outlined the expectations for physicians. It is a well understood concept that physicians have a duty and an obligation to exercise clinical judgment when protocols and guidelines are implemented. The purpose of the facility's protocols and guidelines was not clear given the explanation that physicians did not have to use them. That approach is distinctly different from implementing guidelines and having the expectation that physicians exercise good clinical judgment in the application of the guidelines. Clinical guidelines can only be effective if they are perceived to be helpful and are used. While the facility issued guidelines, state office issued protocols. The facility needs a process for development of guidelines and protocols to ensure that they are appropriately implemented, assessed for effectiveness, and are regularly reviewed and revised. This is even more important because the facility was in the process of developing measures to assess quality. The quality process will be linked to actions described in adopted protocols and guidelines. The overall value and importance of quality reviews will be diminished if expectations are not clearly delineated.	

Recommendations:

1. The medical director should explore mechanisms for providing some assistance to the primary care physicians with clerical work (L1).

2. Sick call rounds should be evaluated to ensure that supports are in place to allow PCPs to have productive work hours. Consideration should be given to changing the format of sick call if necessary to improve efficiency (L1).

3. The medical director should track physician attendance at ISPs, possibly using data that are already collected (L1).

4. Minutes should be completed for every morning clinical services meeting. The format should allow for documentation of discussion, action steps, responsible persons, and timelines for completion. Those items should be briefly addressed as appropriate in the subsequent meetings and closure should be documented (L1).

5. The medial director should work with the PCPs in order to improve the quality and accuracy of required documents, such as the Annual Medical Summaries, Quarterly Medical Summaries, and Active Problem Lists as discussed in the body of the report (L1).

6. The medical director must address the issue of incomplete and vague physician orders. Collaboration with the clinical pharmacist to obtain information from the State Hospital might be helpful (L1).

7. The medical director should implement a comprehensive consultation-tracking log. It should include the type of consult or diagnostic test, the date of the consult and the date the report is received. Someone should be assigned to track this information to ensure that physicians are receiving reports in a timely manner (L1).

8. The medical director should determine why consultants are not receiving all required information to complete consultations (L1).

9. The medical director should ensure that a thorough risk benefit analysis is completed when determining the appropriateness of preventive screenings. Input should be solicited from the entire team including the individual/legally authorized representative when appropriate (L1).

10. The medical director should reinforce with the primary care physicians that all individuals at risk receive screening for osteoporosis in accordance with the issued guidelines (L1).

11. The facility must focus on the management of aspiration and aspiration pneumonia and assign a high priority to addressing the following:
    a. The accuracy of the pneumonia data must be examined.
    b. The Pneumonia Review Committee should be formally adopted and include a process for assessing and classifying pneumonia cases. Consideration should be given to development of a checklist to review every case of pneumonia. The checklist would attempt to better define an individual's risk and determine the likelihood of an aspiration event. This can only be accomplished through a rather rigorous review of risk, diagnostics and the clinical events that occurred prior to the onset of illness.
    c. A process to ensure that every episode of pneumonia is captured should be developed. This may involve a monthly review of multiple data sets, such as a list of all individuals who received antibiotics for the diagnosis of pneumonia. This is necessary because not all individuals with a diagnosis of pneumonia are hospitalized or sent to the emergency department.
    d. A comprehensive set of guidelines is needed to provide guidance to the medical staff on the management of recurrent aspiration (L2).

12. Clarification is needed on the facility's policy on the use of enteral tubes for small bowel feeding. The facility should seek guidance on this from state office as other SSLCs have not prohibited and do use small bowel feedings for individuals with recurrent aspiration syndromes (L2).

13. The facility should assess whether the current hours of neurologic services are adequate to meet the needs of the individuals served (L1).

14. In order to improve the quality of the documentation of neurology care, and ensure that individuals are receiving appropriate and timely care, the medical director should consider the use of a template that includes the key information that is needed in providing care to those with seizure disorders (L1).

15. With 10% of individuals living at the facility having DNR orders, the facility must review the criteria and determine if DNRs are being appropriately implemented (L1).

16. The medical director in collaboration with the DADS medical services coordinator will need to define the set of criteria that will be used to complete the internal quality audits. Attention should be given to developing a robust mix of process and outcome indicators. Selected measures should be meaningful, measurable, valid, reliable, and amenable to improvement (L2).

17. The facility should review its mortality management and ensure that appropriate corrective actions have occurred particularly when reviews present recurrent issues related to the provision of care. The nursing department should track all corrective actions recommended and implemented. (L2).

18. The facility should consider having an external physician review, such as a physician from another SSLC provide an in depth medical review (L2).

19. The medical director should develop formal corrective action plans to address deficiencies documented with the quality audits. These plans should provide a specific set of actions, define the persons responsible for those actions, and provide timelines for completion of the actions. Since these actions may involve other disciplines, the existing quality department will need to have involvement in this process (L3).

20. There needs to be oversight of the clinical guidelines development process. That is, a process is needed to determine how the guidelines will be utilized, implemented, reviewed, and updated (L4).

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 QDDP 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 ISP, 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 inservice staff training o The curricula for ongoing inservice 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 Nursing Department Corrective Action Plans to address QI Death Review of Nursing recommendations o Job descriptions of NOO, CM Supervisor, and Lab Coordinator o CNE investigation of DFPS Case #40310945 o CNE Analysis and Evaluation of Nursing Staff and Deployment o TB Surveillance Policy/Procedure o Infection Control Monthly Rounds 9/1/11 – 1/31/12 o Hand Hygiene Surveillance Monitoring 9/1/11 – 1/31/12 o Infection Control Monitoring Log for Terminal Cleaning 9/1/11 – 1/31/12 o Individual Resident Infection Worksheets 9/1/11 – 1/31/12 o Employee Health Surveillance Forms 9/1/11 – 1/31/12 o SASSLC Self-Assessment: updated 2/1/12 o SASSLC Meeting Schedule updated 2/13/12, updated o Records and MARs/TARs of: • Individual #270, Individual #220, Individual #233, Individual #144, Individual #324, Individual #82, Individual #283, Individual #159, Individual #339, Individual #50, Individual #111, Individual #99, Individual #128, Individual #276, Individual #227, Individual #217, Individual #35, Individual #343, Individual #58, Individual #4, Individual #116 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Marla Lanni, RN o Nursing Operations Officer, Suri Phanhtharath, RN o Quality Assurance Nurse, Mandy Pena, RN o Program Compliance Nurse, Robert Sertuci, RN o Infection Control Nurse, Sam Lee, RN o Nurse Educator, Clara Wallace, PhD, RN o Hospital Liaison/Skin Integrity Nurse, Gayindria Collier, RN o PNMT RN, Patricia Delgado, RN o Lab Coordinator, Jeff Pittman, RN o Nurse Manager, Lola Faulkner, RN o Nurse Manager, Kim Godfredson, RN

	o Nurse Manager, Tina Rivera o Informal interviews with 8 direct care nurses (LVNs and RNs) o Dietician, Roberta Washburn, RD Observations Conducted: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 2/14/12 ISP for Individual #31 o 2/14/12 Risk Process Meeting o 2/15/12 Nurse Case Manager Meeting o 2/15/12 Medication Variance Committee Meeting o 2/16/12 Nurse Manager Meeting
	Facility Self-Assessment: SASSLC submitted its self-assessment, which was updated on 2/1/12. This document included a list of the activities the nursing department had completed and partially implemented across the six provision items of this section. Although this 20-page list of activities described a number of tasks related to staff development, training sessions, policy/procedure reviews and revisions, etc. that were in various stages of completion, it did not describe what it is that the department did to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. In other words, the self-assessment, to a degree, described what the department did to conduct compliance-related activities, but it did not describe what the department did to assess whether the nursing department was in substantial compliance with the requirements of each provision item. The monitoring team recommends that the Center Lead for section M, the Chief Nurse Executive, review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. The understanding of the monitoring team was that SASSLC will implement the new style self-assessment that is being used at other SSLCs by the time of the next onsite review. The facility self-rated itself as being in noncompliance with all six of the provision items of section M. The monitoring team agreed.

	Summary of Monitor's Assessment: Since the prior review, with the leadership and hard work of the Chief Nurse Executive (CNE), and with assistance from other nurses and support from the facility's administration and other department heads, the nursing department achieved additional structural and procedural improvements, conducted re-evaluation and re-deployment of nursing staff members, filled vacant leadership positions, and established a manageable and reasonable allocation and assignment of individuals to RN case managers. Old nursing policies were revised and lines of communication within the department and outside the department were opened, developed, and nurtured. Expectations for organization, order, and accountability within the nursing department were re-established and regularly reaffirmed. Over the past six months, the CNE led the nursing department by example and followed her own advice and "did not ask anyone to do what she would not or could not do." There continued to be improvements in the collaboration and communication between nurses and QDDPs, and the CNE and QDDP Coordinator worked together to address barriers standing in the way of timely assessment and planning process and improved the level of quality of both. Under the CNE's leadership, and with her direct involvement, there were specific, focused changes and significant improvements in the delivery of diet and nutrition services to individuals, and, again, order and accountability to this aspect of healthcare was restored. During the conduct of the review, the CNE accurately and efficiently summed up the challenges faced by the nursing department and articulated what stood in the way of their achievement of substantial compliance with the provisions of the Settlement Agreement. In her words, "processes and people" continued to need significant improvement. Thus, despite the positive changes in a number of procedures, such as hiring and reviewing/revising policies, articulating expectations, and achieving success in focused endeavors that were under the direct control of the CNE, the review of the documents submitted to the monitoring team and the onsite review activities revealed a continued and pervasive pattern of problems in nursing practices across all aspects of care. For example, nurses failed to perform timely, complete, accurate assessments and failed to develop acute and chronic health management plans to address individuals' health problems. Nurses failed to implement basic infection control procedures as simple and as basic as proper hand washing. Nurses were not knowledgeable of the health problems, needs, and/or reasons for prescribed medications and treatments of the individuals assigned to them. Nurses failed to properly perform procedures, such as catheterization, management of gastrostomy tubes, and oral and enteral administration of medications. Nurses also failed to ensure that the basic health care needs of medically fragile and vulnerable individuals were met. It was disturbing for the monitoring team to easily find and identify an individual, who was suffering from an infection of her colon for over three months, isolated and confined to her room for over three months without any documented clinical justification. In addition, her nurses failed to carry out her physician's

	order to schedule appointments with medical specialists until the monitoring team requested the dates of the appointments. Also, there was no evidence that even one of the many nurses assigned to and responsible for her care helped to ensure that her basic needs were met. Thus, over the course of two days, during different shifts and when different staff members were on duty, observations revealed this individual was sitting slumped over in her wheelchair and alone in her room. These observations, and others, occurred when nurses were completely aware that their care was being observed and evaluated, which raised question and concern regarding their conduct when they were not being observed and supervised.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	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 on the job for only two and three months, respectively, five RN positions were lost to other SASSLC departments, one of the nursing department's three nurse managers was on extended leave, and high turnover of both RNs and LVNs continued to setback efforts to implement interventions to achieve compliance with provisions of the Settlement Agreement. Since the prior monitoring review, the CNE held fast to her commitments to reestablish leadership, develop lines of authority and accountability, and address the more immediate and pressing needs of the nursing department. For example, the CNE immediately responded to the recommendations in the prior monitoring review report and reviewed and revised SASSLC's 11-year-old policy Nursing Coverage Policy to help ensure that there were 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. The CNE also reported that since the prior review, focused improvements in nurses' deployment and education were made, and procedural changes in medication administration practices were implemented. Thus, during the facility's 2/13/12 presentation for section M, the CNE noted, "Although much work remains, the foundation has been laid for substantial compliance in section M." During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, residential areas were visited, daily observations of nursing care were made, 20 nurses were interviewed, and 21 individuals' records were reviewed. All told, and consistent with the CNE's findings, it was clear that there was much work to be done by the nursing department in order to achieve substantial compliance with the provisions of section M. The review also revealed,	Noncompliance

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		however, that the new "foundation" for substantial compliance with the provisions of section M was not completely arranged and set in place, and in several areas, especially infection control and prevention and hospital liaison practices and procedures (which were critically important to SASSLC's achievement of substantial compliance) showed signs of gradual and worsening decline since the prior review. As noted during each of the prior monitoring reviews, there continued to be a persistent pattern of problems ensuring that nurses' adequately identified of health care problems, performed complete assessments, implemented planned interventions, conducted appropriate follow-up, and kept appropriate records to sufficiently and readily identify and address the significant changes in individuals' health status and needs. Thus, a rating of noncompliance was made in this area. <u>Recordkeeping and Documentation</u> As noted in the prior review, all individuals' records were organized in a unified form/format. Individuals' notebooks were present on their homes and available to direct caregivers. Notwithstanding these positive findings, there were a number of recordkeeping and documentation problems found in the 21 records selected and submitted by the facility for review. For example: • Two of the 21 individuals' records had whole sections of their record that were missing information. • One-third of the 21 individuals either failed to have current, annual ISP filed in their records (3), failed to have any ISP whatsoever filed in their records (3), or had an ISP that referenced another individual's name (1). • Nurses' notes were not consistently in the SOAP format, some entries were illegible, other entries were out of date/time sequence on the same page and/or double-entered for certain days/times of day across several pages of the IPNs. • Occasionally, entries were documented on the margins of the IPNs versus starting a new page. • Errors in entries were not consistently and properly identified as such. There continued to be obliterated and partially obliterated entries usually due to nurses' who attempted to write over incorrect entries of dates, times, and findings with corrected/revised information. • As noted in prior reviews, a number of nurses' names and credentials continued to be illegible. • Medical terminology and spelling errors were noted across a number of IPNs and comprehensive nursing assessments. The persistent errors in terminology and spelling in nursing assessments often appeared to be related to the practice of copying and using former, incorrect assessments as the templates for new, current assessments without an adequate review and correction of old errors.	

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		Hospitalization and Hospital Liaison Activities According to the state's 5/11/11 Nursing Services Policy, "The State Center Nursing Department will ensure continuity of the planning, development, coordination, and evaluation of nursing/medical needs for all individuals admitted to or discharged from the hospital to the infirmary or moving between facilities. The hospital liaison will make periodic visits to a hospitalized individual to obtain as much up-to-date information as possible from the hospital nurse responsible for care of the individual. Information gained will include but not be limited to diagnosis, symptoms, medications being given, lab work, radiological studies, procedures done or scheduled with outcomes, and plans for discharge back to the State Center." Also, according to SASSLC's Hospital Liaison Report form, it specifically instruct that the report should be filed in the individual's IPNs in chronological order. Six of the 21 individuals selected for in-depth review were hospitalized one or more times during the period of 9/1/11 – 2/13/12 for treatment of significant changes in their health. Despite the state's clear policy directives, SASSLC's instructions for documentation sufficient to readily identify hospital care and treatment of individuals with significant changes in health status, and the CNE's expectations for clear communication and documentation of significant changes in individuals' health status, not one of the six individuals who were hospitalized had a Hospital Liaison Report filed in their record, not one had an entry in their record by the nurse Hospital Liaison, and not one record revealed evidence that the individual was visited by either the nurse Hospital Liaison or his/her designated back-up, reportedly the NOO, during his/her hospitalization. Thus, it was not surprising that the reviews of individuals' records revealed that some tertiary care providers were unaware of individuals' relevant health information, such as their current medication regimens, and some SASSLC physicians, nurses, and other clinical professionals were not consistently apprised of the course of individuals' hospital care, medical specialists' recommendations, estimated discharge dates and needs for services upon discharge. • For example, a review of Individual #324's record revealed that her tertiary care provider called SASSLC in search of information to clarify the individuals' current medications. Individual #324's record also included a note by her SASSLC nurse that stated, "Unknown as to what treatment would be implemented or when or if [Individual #324] would be released." • Another example of this problem was noted during the review of Individual #339's record when his SASSLC physician noted during his/her post-hospital assessment that, "Will try to get [hospital] records," to help inform his/her medical care planning process.	

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		These findings, which were both unanticipated and unacceptable, indicated that the six individuals who were hospitalized failed to have adequate procedures in place to ensure their health and safety and raised serious concern regarding the health and safety of all other individuals at the facility that were hospitalized and/or at risk of hospitalization. <u>Wound/Skin Integrity</u> According to the state's 5/11/11 Nursing Services Policy, "Individuals will be provided with nursing services in accordance with their identified needs...[and] nursing services includes participation in a Skin Integrity Committee that includes medical, dietary, nursing, specialized therapy, pharmacy, quality assurance, and residential services staff. The committee reviews data related to skin integrity issues, analyzes data for patterns and formulates recommendations for preventative measures and management." During the prior review, it was candidly reported that this aspect of delivery of nursing services was disjointed and had fallen far short of where it had been and needed to be. This shortfall reportedly occurred in part due to the nurse Hospital Liaison's inability to cover this important aspect of individuals' health, nursing, and medical care in addition to his/her hospital liaison duties and demands on him/her to "help out nursing operations." Nonetheless, as noted in the prior review and despite the nurse Hospital Liaison's reports of too little time and too many other competing demands for her time and attention, he/she continued to be assigned the responsibility to lead SASSLC's Skin Integrity Committee. Since the prior review, two Skin Integrity Committee meetings were held and attended by representatives from medical, nursing, dietary, housekeeping, and programs/residential services departments. Glaringly absent were representatives from the habilitation therapy department. According to a review of the one-page notes recorded during these two meetings, individuals with alteration in skin integrity due to pressure were identified and reported to the Committee. However, the only other information provided were the stage of the wound and month and year of the occurrence/resolution of the individuals' wounds. There was no evidence of a review of data for patterns and/or trends, no evidence of an interdisciplinary discussion, and little to no recommendations for preventative measures and management, save for the general recommendations that "the habilitation therapy department should institute therapy as determined by the habilitation team" and that someone should "continue to ensure PNMP is sent to the hospital." Of note, individuals with other skin integrity problems and risks such as melanomas, Bowen's Disease, facial cellulitis, etc. were not included in the monthly tracking data, reviewed, and/or discussed	

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		by the Committee. All of the above-referenced proceedings occurred, or failed to occur, in the absence of a facility policy/procedure to guide and direct the development and implementation of an effective skin integrity program and committee. According to the 11/30/11 meeting minutes there was some "discussion of draft policy regarding skin care – [Hospital Liaison] to work on this." However, the nature and outcomes of this "discussion" was not documented, and, as of the review, there continued to be no policy/procedure in place. <u>Infirmary</u> According to SASSLC's document submission, "SASSLC does not have an on-campus infirmary." However, according to interviews with the CNE, the Nurse Manager of the medically fragile homes – 673 and 674, and the nurses who regularly worked on unit 673, there were a number of individuals, referred to as "boarders," who were regularly transferred to/from unit 673. Individuals boarded on unit 673 either because they needed to use the only isolation room/bed at the facility and/or because they were referred to unit 673 for temporary stays in one or more of the unit's other rooms/beds for close monitoring and/or for "medical monitoring," as ordered by the individuals' physicians. The monitoring team's review of the 21 sample individuals' records corroborated the nurses' reports. The review of these records also revealed that, for all intents and purposes, there was indeed a place at SASSLC, notably on unit 673, where, apart from their home unit, sick and/or injured individuals were cared for on a time-limited basis. For example, during the period of 9/1/11-2/13/12, Individual #195, who resided on unit 670 and was hospitalized on three occasions, spent several days "boarding" on unit 673, both in and out of the isolation room, post-hospitalization. None of the nurses who were interviewed by the monitoring team identified this issue as a problem. Rather, all seemed to portray that the routine use of beds on unit 673 as a temporary residence for individuals who were sick, recovering post-hospitalization, infectious, contagious, etc. was standard operating procedure. But, this ongoing practice was occurring without procedures, policies, protocols, standards, guidelines, etc. in place to (1) safeguard the individuals with significant changes in their health who were briefly staying on unit 673 and expected to be closely, "medically" monitored, and to (2) protect the "medically fragile" individuals who were living on unit 673 and potentially regularly exposed to the health risks that were associated with "boarders" on the unit. <u>Infection Control</u> During the prior review, the Infection Control Nurse reported that he/she had received the state's Infection Control Manual, but had not yet ensured that SASSLC's infection	

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		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/her other duties. Regrettably, for purposes of the current review, the 2008 SASSLC infection control policies and procedures were again submitted to the monitoring team as evidence of the facility's policies, procedures, protocols, etc. that addressed infection control. Thus, as noted during the prior review, there continued to be no evidence that the facility's policies and procedures were reviewed in over four years. In addition, the content of SASSLC's infection control policies and procedures was not consistent with the relevant statewide policies and procedures, not reviewed by state office subject matter experts to assure consistency with statewide policies and procedures, and not adequate to address the infection prevention and control needs of the individuals and problems at the facility. According to the infection control documents submitted to the monitoring team for review, there were at least five regularly occurring infection control measures, surveillance, and monitoring activities, which included: (1) infection control monthly rounds, (2) hand hygiene surveillance, (3) infection control monitoring log for terminal cleaning of private/isolation rooms, (4) individual resident infection monitoring worksheets, and (5) employee health surveillance forms. All of the data captured through these various surveillance and monitoring activities for the five-month period of 9/1/11 – 1/31/12 were requested. A review of these data for the five-month period revealed many serious problems. For example: • There was only one monthly infection control round conducted on only one unit, and although problems were identified, there was no evidence of follow-up. • There was no evidence of hand hygiene surveillance for the month of November 2011, and a total of only 28 observations of hand washing performance conducted during the five-month period. • Despite the well-documented occurrences of infections, contagious illnesses, and uses of the isolation room at the facility, which occurred during the five-month period, there was evidence of a total of only three cleanings of two individuals' rooms during the five-month period. • The data submitted to provide evidence of surveillance, tracking, and monitoring of individual resident's infections were in complete disarray. There was no evidence whatsoever of "transmission-based management interventions" as called for by the worksheets. Rather, there were a number of incomplete "Individual Resident Infection Worksheets," hand-written, cryptic notes documented on blank sheets of paper, email message(s) from RN case manager to the Infection Control Nurse, and individuals' lab test results that were	

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		submitted as evidence of this critically important component of what was purportedly an "active program for the prevention, control, and investigation of infection and communicable diseases." • The data submitted to provide evidence of surveillance, tracking, and monitoring of employee health was equally disorganized and consisted of a hodge-podge of documents, which included an individual's acute hepatitis profile, an employee's supervisor's report on an employee's injury, an interdepartmental memorandum entitled "Notification of Responsibility" from SASSLC's Worker's Compensation Claims Coordinator to an employee, two requests from the Alamo City Medical Group for an individual's lab test results, and several TB Surveillance reports. The findings noted above were unexpected and indicative of a concerning decline in the infection prevention and control program that was in place six months ago. The impact of this decline was noted across the 21 individuals who were selected for in-depth review. The individuals who suffered significant changes in their health as a result of infections and/or contagious diseases were especially negatively affected by the facility's failure to provide an adequate infection control program. For example: • The records of two of the 21 individuals selected for review referenced physician's orders for treatment of scabies, a highly contagious condition. Neither of these records revealed evidence that the facility's "Scabies Protocol" was followed, and the Infection Control Nurse's "Individual Resident Infection Worksheets" captured neither case. Rather, for both individuals, their nurses documented that the skin treatments were administered as ordered, but they failed to document any measure of an assessment of the individuals' skin, their response to treatment, or follow-up to this significant change in health status. • Individual #99 suffered boils, cellulitis, and MRSA positive infections of his nose/face. His IDT believed that his frequent infections were related to his "continual contact with trash and bacteria found at this job site." There was no evidence that the Infection Control Nurse was notified of the infections or the correlates to the infections, or that the Infection Control Nurse participated with the IDT to assure implementation of appropriate, planned interventions to reduce the likelihood of frequent, hi-risk, bacterial infections. • Although the physician for Individual #4 and Individual #144 ordered that they receive Zostavax vaccinations to help their immune systems protect them against shingles, there was no evidence that they were vaccinated. • Individual #35's physician was not notified of the vesicles on her flank until over 72 hours after the vesicles emerged. Thus, Individual #35's diagnosis of herpes zoster (shingles) and treatment of this significant change in her health was delayed. It was also not evident in Individual #35's record, or other relevant documents, that proper infection control procedures were implemented to ensure the health and safety of Individual #35 and others who were at special	

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		risks (e.g., pregnant women, individuals who were currently ill, individuals with weakened immune systems) and/or who may have been exposed to the fluid in her shingles blisters. <u>Emergency Response</u> During the prior review, a number of serious problems were noted with the facility's conduct of medical emergency drills. For example, staff members failed to respond to over half of the drills conducted, none of the drills included bringing medical emergency equipment to the scene, and none of the problematic drills referenced a plan of action to address these serious problems. Thus, six months ago, on or about 8/8/11, the State Office Nursing Coordinator, Valerie Kipfer, immediately intervened and worked closely with the CNE and Nurse Educator and 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. Notwithstanding the state's immediate response to this serious matter and the cooperation and collaboration received from the CNE and Nurse Educator, a review of the facility's current state of affairs regarding medical emergency equipment and medical emergency drills conducted during 8/11 – 12/11 continued to reveal a number of problems. For example, across the entire facility, medical emergency equipment was stored in locked rooms, save for unit 673. Of the 134 drills conducted during 8/11-12/11, only one drill was designated as a "failed" drill. The drill reportedly failed because it was aborted by the drill instructor when he/she found only one staff member present and on-duty at the time of the drill. The rest of the 133 drills were affirmed as "passed" drills despite the drill instructors' documented concerns related to the majority of these drills. For example, drill instructors concerns included staff members failure to respond to drills, staff members left the scene without permission to do so, staff members did not know what an AED was, multiple steps associated with the drill were not performed or not successfully performed, and medical emergency supplies were locked in nurses' stations/medication rooms, not available during the drill, and not brought to the scene. In addition, approximately 10 of the 134 drills, which were affirmed as passed drills, were conducted during the night shift when only one direct care staff member was present and no clinical professional responded to the drill. When the monitoring team interviewed the Nurse Educator/Drill Instructor regarding the conduct of the drills and attempted to clarify what criteria would constitute a failed drill, the Nurse Educator was unable to do so because a failed drill had not been defined by the state's or the facility's policies. There was also no clarity regarding what was expected from drill instructors when no clinical professional responded to the drill, and, thus no RN or PCP arrived on the scene to control the emergency, as indicated by the state's policy. These appeared to be significant oversights that should be addressed.	

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		Of note, the only corrective action put forward to address the problems identified by the drill instructors was, "Will be referred to QAQI Committee." As of the review, it was unclear, what, if any corrective actions were planned and/or implemented vis a vis the QAQI Committee. During the onsite review, when the monitoring team reported the above-mentioned health and safety problems to the CNE, the CNE immediately responded and took steps to ensure that medical emergency equipment was readily available to all staff members and especially direct care staff members, who were often the first responders. <u>Other Significant Changes in Individuals' Health Status</u> According to the Health Care Guidelines, all health care issues must be identified and followed to resolution. In addition, documentation in 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 state's Nursing Services Policy stipulated that nursing staff members must document all health care issues and must 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. The Nursing Department's self-assessment referenced that additional training was provided to nurses to improve their practices related to identifying changes in individuals' health status and responding adequately and appropriately with the development and implementation of Acute Care Plan (ACPs). The CNE, NOO, QA Nurse, Program Compliance Nurse, and Nurse Managers met weekly to review all ACPs, especially those developed in response to acute illness, injury, and recent hospitalizations. Across the 21 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. In an effort to continue to address this problem, the CNE and NOO implemented daily	

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		morning rounds on all units. During morning rounds, the CNE and/or NOO reviewed the On Duty RN's 24-hour Report Log with the nurses present on the units to affirm that the direct care nurses were knowledgeable of the identified changes in individuals' health and aware of their role/responsibility to communicate and collaborate with the individuals' physicians, take appropriate actions, and evaluate the individuals response to treatment at least once per day until the problem has resolved. Notwithstanding these requirements and daily monitoring by the CNE and/or NOO, as noted in the prior review, across all 21 sample individuals reviewed, comprehensive documentation in the individuals' records of their significant changes in health status from identification to resolution was inconsistent and incomplete. • During the period of 9/1/11 – 2/13/11, Individual #343's record referenced numerous episodes of significant changes in her health. During each and every one of these episodes, her nurses failed to document complete assessments and put forward reasonably adequate plans to address her health and safety needs. For example, when Individual #343 "refused to eat," her nurse's plan was to "Monitor;" when she "had not voided," her nurse's plan was to "Continue to monitor;" when her "hair was falling off the right side of her head," her nurse's plan was to "Monitor;" and when she suffered a "low grade temperature, cough, and green nasal drainage," her nurse's plan was to "Continue monitoring." • During the period of 10/14/11 – 12/1/11, Individual #283 was hospitalized three times for treatment of reoccurring paralytic ileus. During these times of significant change in Individual #283's health status, her SASSLC physicians closely monitored her status and ordered her nurses to closely monitor her, too. For example, Individual #283's physicians provided several orders for her nurses to "obtain vital signs every shift until further notice," "obtain vital signs every four hours while awake," "push six ounces of fluids three times a day," and "review her bowel movements daily with the physician during rounds." There was no evidence that these orders were consistently implemented. There were also periods of time, from one to six days, when there was no evidence that Individual #283 was monitored by her nurses as ordered. • Individual #233 was diagnosed with multiple chronic medical problems. During the period of 9/1/11 – 2/13/12, her record referenced that she suffered episodes of meal refusal and vomiting and that she received at least four weeks of direct physical therapy due to her unsafe ambulation, decline in balance, and "general debilitation." Notwithstanding these significant changes in Individual #233's health, there was no evidence that nursing assessment, intervention, and monitoring to resolution had occurred. Of note, there were only seven pages of IPNs filed in Individual #233's record for the entire six-month period.	

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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 21 sample individuals' records. However, one-third of the 21 nursing assessments were not current. That is, three individuals had not received a comprehensive nursing assessment in over four months, two individuals had not received a comprehensive nursing assessment in over six months, one individual had not received a comprehensive nursing assessment over seven months, and one individual, who had suffered an especially significant change in her health status, needs, and risks, was not afforded a comprehensive nursing assessment. A review of the 14 individuals with currently dated nursing assessments revealed that their 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. 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. These findings represented a significant decline in performance since the prior review. As a result, a rating of noncompliance was given to this provision item. Across the 14 sample individuals' assessments reviewed, similar to prior reviews, their comprehensive nursing assessments had most of the deficiencies described below: • Lists of current active medical diagnoses were incomplete and not up-to-date, • Most failed to reference meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments,	Noncompliance

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		• A number of assessments failed to include a set of vital sign measurements, • Dates and results of mealtime monitoring were occasionally blank or documented with limited, uninformative phrases, such as "No problems noted." • 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 and often missing important information that would clarify why the individuals were hospitalized or otherwise treated by tertiary care professionals, • 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 frequently failed to reference an assessment of individuals' pain. On occasion, although the FLACC scale was referenced as a tool that was used to evaluate pain, there was no further information provided in the nurses' assessment about the individuals' pain, such as their FLACC score and the location, intensity, onset, duration, quality, etc. of the individuals' pain, and none explained how, where, when, and what verbalizations, behaviors, and/or gestures were associated with the individuals' communication of pain. • Individuals' persistent, recurring problems, such as alteration in skin integrity, infection, vomiting, diarrhea, constipation, and insomnia 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 plans. • Frequently, the conditions of individuals with severe contractures, spasticity, scoliosis, and other deformities were not accurately portrayed. Rather, the musculoskeletal sections of the nursing assessments were either missing information, blank, or erroneously 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 • Nursing summaries were uninformative, confusing paragraphs of incomplete, run-on sentences, with cut/copied and pasted lists of discrete events, medication changes, appointments, lab test results, clinic visits, etc. Typographical errors were frequent and not corrected from one assessment to the next. Overall, the summaries failed to provide any measure of an organized, thoughtful, recapitulation of the individuals' health status over the quarterly/annual review period and failed to put forward nursing interventions/recommendations to	

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		address the individuals' progress/lack of progress toward the achievement of their desired health outcomes. The following examples from the sample of 14 individuals with currently dated nursing assessments indicated the seriousness of this problem at SASSLC. • Individual #58 was a 47-year-old woman diagnosed with several chronic health problems, such as seizure disorder, neurogenic bladder, constipation, and several musculoskeletal problems that included spastic quadriplegia, osteoporosis, and osteoarthritis. On 10/18/11, she suffered a fractured foot and then developed several complications, such as pitting edema and alteration in skin integrity of her foot/ankle that was attributed to the donning of her ace bandage and failure to keep her foot/leg elevated. On 12/10/11, Individual #85 suffered another fracture. This time, her left arm was fractured and immobilized. Her 12/19/11 nursing assessment, however, failed to include her fractures as part of her current, active medical diagnoses. In addition, her assessment failed to reference her osteoarthritis, constipation, and recurrent urinary tract infections. Also, important sections of her assessment were blank, such as bowel elimination pattern, frequency of urinary tract infections, assessment of upper and lower extremities, etc. and/or missing key elements of important assessments, such as the assessment of her neurological system. • Individual #144 was a 68-year-old woman with multiple medical and behavioral health problems. Over the past several months, she had an excision of a recurrence of squamous cell carcinoma, suffered an unplanned 10-pound weight loss, and was prescribed multiple changes in her psychotropic medication regimen in attempts to address her increased target behaviors, which included episodes of tantrums, yelling, and crying. Despite her multiple interrelated health problems, needs, and risks, her nursing assessment failed to reference one of her more salient health problems – Bowen's Disease – as a current, active medical problem, failed to reference her history of adenocarcinoma of her uterus and ovaries with total abdominal hysterectomy and bilateral salpingo-oophorectomy, left the entire section entitled, "Cancer," blank, and failed to reference her weight loss. Rather, her nursing assessment curiously noted, "Her weight has been up somewhat stable this year (sic)."	
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,	According to the Health Care Guidelines and the state's Nursing Services Policy, 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	Noncompliance

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	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.	a specified timeline of implementation of the interventions. In addition, the state's 12/30/11 guidelines for the routine responsibilities of the RN case managers reaffirmed that, with regarding to planning, they must actively participate in ISPA meetings and IDT meetings to discuss and formulate plans of care to address the health risks, as well as other chronic and acute health needs or issues as they arise, for the individuals' served by the facility. The guidelines also indicated that RN case mangers were not to provide RN coverage for the unit/campus on any shift, not to be scheduled to work or provide RN coverage for the unit/campus on weekends or holidays, not to work as a campus RN, RN supervisor or Office on Duty, and not to provide supervision to other nurses. Thus, while the guidelines confirmed expectations for RN case managers, they also sought to ensure that RN case managers would be afforded adequate time and attention to focus on their main task – the quality, clinically optimal, and cost-effective management of the health care status and health care needs of individuals on their assigned caseloads. According to the facility's self-assessment, since the prior review, the RN case managers received additional training and guidance that included detailed instructions regarding SASSLC's expectations for the individualization of care plan interventions and development of planned interventions to address individuals' medium and high risk categories of health problems. In addition, plans were made to schedule and coordinate the quarterly reviews of Health Management Plans (HMPs) with the interdisciplinary teams' reviews of the individuals' ISPs. The CNE reported that she also "raised the bar" with regard to her expectations for the timely development and implementation of Acute Care Plans (ACPs). The CNE explained that when individuals suffered significant changes in their health status and/or when individuals' levels of health risks were raised, there were expectations for the RN case managers to ensure that ACPs were developed, reviewed by the individuals' Nurse Managers, implemented, and evaluated for their effectiveness in achieving the individuals' desired health goals. At SASSLC, the individual's RN Case Manager were usually the nurses who assembled ACPs and HMPs Health Management Plans in response to individuals' identified health needs, identified risks, and/or significant changes in their health status. Almost all of the 21 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). One individual, #233, failed to have an HMP/ACP filed in her record. 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. As a result, a rating of noncompliance was given to this provision item.	

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		Some general comments regarding the 20 sample individuals' care plans are below. Of note, most of these same comments were made during the prior review. • Individuals were more likely during the review to have ACPs filed in their records than they were during the prior review, but, in general, the ACPs continued to need improvement. • A number of the HMPs and ACPs submitted to the monitoring team were missing one or more pages. It was unclear whether this was due to a problem that occurred during copying or whether this was the actual state of the plans as they existed in the individuals' records. If the latter was the explanation for this problem, it should be addressed and corrected as soon as possible. • Individuals' records often continued to contain 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. It was unclear whether these were typographical errors, carelessness on the part of the nurse who filed the plan in the record, or a misunderstanding of the expected timeframes for "baseline" assessments versus "implementation" dates of plans. • 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, as documented in the IPNs. • Plans continued to be generic, "stock" mini-plans that did not provide individualized person-centered interventions as a foundation for positive, desired health outcomes. In addition, the interventions failed to reveal that they were developed using current, evidence-based practices in order to make the best clinical decisions and recommendations for interventions to enhance and improve the individuals' outcomes. • Although direct care staff members were assigned the lion's share of individuals' personal care, across the HMPs and ACPs, the "instructions for direct care staff" and "criteria for consultation with the RN/LPN" and "criteria for prompt or immediate referral to the PCP" were exceedingly limited and failed to provide direct care staff members with minimally adequate direction, guidance, and support to help keep the individuals safe. • There were no timelines referenced in the plans, save for the generic phrase of "...over the next 12 months," upon which nurses could conduct adequate and appropriate criterion-based evaluations of outcomes in relation to the structures and processes prescribed by the individuals' plans of care. • Thus, it was not surprising that, 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 result in revisions to their HMPs and ACPs.	

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		• The goals, objectives, and/or expected outcomes referenced in many of the HMPs and ACPs were usually not appropriate and not based upon evidence-based practices and sound clinical judgment. For example, an individual who was at high risk of aspiration and aspiration-related illnesses had a pica plan with a goal that he "will have no more than 10 incidents [of pica] in the next 12 months." An individual who suffered from GERD and was at high-risk for gastrointestinal problems had a plan with a goal that he "will have 12 or fewer episodes of vomiting in the next 12 months." These undesirable health goals, which were clearly not based upon evidence-based practice and sound clinical judgment, were only two examples of a problem found in many HMPs and ACPs. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #217 was a 35-year-old woman who resided on SASSLC's medically fragile unit. She was diagnosed with multiple chronic medical problems, which included recurrent pneumonia, and she had a permanent tracheotomy tube. At the time of the review, Individual #217 had almost a dozen HMPs filed in her record, all of which were dated almost one year prior to the review. These HMPs fell far short of meeting her needs. For example, her oral hygiene plan was not developed for an individual with a tracheotomy; her osteoporosis plan did not address bone loss, rather it addressed an acute fracture; her impaired skin integrity plan failed to address her current medical plan of care and prescribed treatment; and her pneumonia plan provided no guidance or direction for direct care staff members to follow when they cared for her. • Individual #339 was a 69-year-old man who was diagnosed with, among other things, tuberous sclerosis. He was hospitalized from 11/23/11 – 11/26/11 for incision, drainage, and treatment of a complication of his disorder - facial cellulitis with adenoma sebaceum of the right side of his face. Individual #339 had an ACP developed for facial cellulitis, however, the ACP failed to reference all relevant treatment interventions that were ordered by his physician. Also, his "Tuberous Sclerosis with Adenoma Sebaceum and Bradycardia" HMP referenced only one generic instruction for his direct care staff – "Report any signs of illness to nurse." There was also only one generic nursing recommendation – "Administer medications/treatment for symptoms as ordered by MD, monitor for health complications related to disease, and inform PCP of any change in condition." In combination, these planned interventions were not adequate to address Individual #339's health needs and risks and certainly not sufficient to inform his caregivers, who were most likely not knowledgeable of this disease. • Individual #82 was a 68-year-old woman diagnosed with many medical needs and behavioral health challenges. According to Individual #82's annual ISP, she	

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		had a history of severe behavior problems, but "she liked to move, enjoyed propelling her wheelchair, liked to be outdoors where there was room for her to propel her wheelchair, and she cannot live without [her freedom of movement]; they make her the happiest (emphasis added)." Over the past year, consistent with Individual #82's preferences and needs, her physician wrote 180-day orders that she "may engage in gross motor activities." Curiously however, a review of Individual #82's psychiatry clinic reports revealed that on 11/10/11, "Staff continue to report that patient self-propels and has injured herself in past. Wheelchair removed, but tries to self-propel lounge chair. Remeron increased last month to target self-propelling behavior. According to staff, patient may be calmer, but behavior unabated. Remeron to be increased to target this behavior." This finding was of serious concern since, for all intents and purposes, it appeared as though psychotropic medications were prescribed and administered to chemically restrain Individual #82 and purposefully restrict her freedom of movement without evidence that all other possible interventions were tried and failed. There were also no HMPs filed in Individual #82's record to shed light on what, if any, health and safety risks were present, save for the risk of side effects from her psychotropic medications, that would have necessitated taking away her wheelchair. There was also no evidence whatsoever that Individual #82's RN case manager, who was present during the 11/10/11 psychiatry clinic, made any attempts to actively advocate on behalf of Individual #82 and communicate to the IDT a plan that was responsive to Individual #82's goals, wants, and needs, while ensuring her 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 continued to change and grow. The Chief Nursing Executive, who had been on the job only eight months, had implemented several positive changes in the Nursing Department. But, as noted in the prior review, 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. As a result, a rating of noncompliance was given to 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 continued with the addition of nurses in critical places, such as the recent hiring of a new nurse manager for the medically fragile unit, much needed revisions of the Nursing Coverage Policy, and the CNE's continued collaboration and communication with other department heads, such as the ADOP and the Campus Supervisor. According to the facility's self-assessment, since the prior review, "the nursing	Noncompliance

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		department initiated training a direct care staff course titled, 'Observing and Reporting Clinical Indicators of Health Status Change,'" "standardized nursing protocols [were] received from state office," and "a plan was developed and implemented to laminate these in packet size and provide them to all nursing staff." These were positive, albeit very small, steps taken in the direction of establishing and implementing nursing assessment and reporting protocols sufficient to address the health status of the individuals served. The CNE was well aware that while laminating standardized nursing protocols may have helped trigger nurses' memory of the essential elements of documenting their assessment and care of individuals with seizure activity, vomiting, etc., it was only a focused activity with limited results, and, in and of itself, had not ensured that nursing care was consistently delivered in a manner that would help produce the desired health goals and outcomes of the individuals served by the facility. It was clear that the CNE and nursing department needed to do much more to make the implementation of nursing assessment and reporting protocols a reality in the daily delivery of nursing care. The Nursing Operations Officer continued to work closely with the CNE, and he fully supported the implementation of all new operational and procedural changes in the nursing department. During the interview with the NOO, he reported, "The standard of care in the nursing milieu had changed [for the better]." Over the past six months, he reported the implementation of several systems to address problems with staffing, morale, and nursing conduct and performance. For example, since the prior review, the NOO, and sometimes the CNE, conducted daily morning rounds on all units. During their rounds, they ensured that Nurse Managers and direct care nurses were aware of individuals who were identified on the On-Duty RN Shift Report, in need of follow-up interventions, such as medical attention, blood test, etc., and/or should have a care plan developed. The CNE, NOO, and Nurse Managers continued to meet weekly. During these meetings, staffing issues, policies and procedures, nurses' education and training topics, plans of correction, and other management matters were discussed. However, during the review, the monitoring team attended one of the weekly meetings and observed that the meeting continued to focus on basic processes and procedures, such as the process of interviewing and hiring prospective nurses, process for ordering supplies, process for getting equipment fixed or replaced, process for cleaning out supply sheds, etc. There was little to no discussion of a strategic plan to meet the provisions of section M. Thus, the Nurse Managers were not assigned specific tasks to achieve an identified outcome that would move the nursing department closer to substantial compliance with the Health Care Guidelines and Settlement Agreement. This appeared to be a missed opportunity for nurses in leadership positions to become directly involved and part of	

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		the plan to bring about substantial compliance in section M. The CNE reported that she continued to spend considerable time and effort overseeing and supervising other, non-nursing departments, such as pharmacy and dietary. Although without a doubt the CNE made positive contributions to these departments, it remained unclear to the monitoring team why the CNE was assigned supervisory duties and oversight of these two departments. The CNE continued to effectively work 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 Program Compliance Nurse's collaboration with the QA 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 continued to receive regular reports of the results of monitoring of performance across 12 areas of nursing care. Although the monitoring had continued, they also moved forward with correcting problems identified vis a vis monitoring and evaluating the effectiveness of their corrections. For example, over the past six months, the Nursing and QA Departments focused on the development, implementation, and effectiveness of Acute Care Plans. Through this process, they were able to identify nurses who needed more education and coaching, and individuals who benefitted from the timely development and implementation of strategies to address significant changes in their health status. They continued to move the monitoring process forward toward a focus on outcomes for individuals and system-wide improvements. As noted in the prior report, this was an outstanding feature of the development of assessment and reporting protocols and a model for other facilities to follow. 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 nursing leadership should develop strategies to improve the (1) documentation of nursing interventions, (2) follow through with nursing interventions to ensure that preventative measures were taken, (3) adjustment of levels of health risks in response to changes in individuals' health status, (4) timeliness of nurses' notifications of physicians	

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		of significant changes in individuals' health status, (5) process of review and revision of HMPs/ACPs, (6) quality of nursing assessments, and (7) consistency of complete tracking of health status indicators, such as bowel movements, etc. As of the review, there was evidence that several training sessions were held and a Corrective Action Plan was developed to respond to the recommendations referenced in one individual's death review. A review of this plan revealed that the "concerns" identified and "corrective actions taken" failed to completely address the problems identified in the individual's death review. In addition, there was no evidence of follow-up to ensure that the "corrective actions taken" were adequate to correct the problems and reduce the likelihood that they would happen again. 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 2012 Annual Nurse Competencies test scores revealed a tremendous improvement from the 2011 test scores. For example, in 2011, 80% percent of the nurses who were tested scored less than 80%, but in 2012 none of the nurses who were tested scored less than 80%. Given that most of the test-takers were the same nurses, the monitoring team asked the Nurse Educator to explain the magnitude of improvement. The Nurse Educator explained that in the weeks prior to the nurses' training and testing, the CNE declared in no uncertain terms that no nurse would score less than 80%. If, by chance, a nurse achieved a score less than 80%, it was the responsibility of the Nurse Educator to provide whatever education and training was needed to help the nurse get a score of 80% or better. The undoing of this significant accomplishment occurred when it became the Nurse Managers' responsibility to ensure that the nurses they supervised maintained their competence and the skill levels they achieved during testing by referring the nurses who needed restoration of competence and skills to the Nurse Educator for additional, remedial training. It was clear to the monitoring team that the Nurse Educator was ready, willing, and able to educate, re-educate, train, and re-train nurses to maintain their competence. It was also clear that the breakdown occurred when (1) Nurse	

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		Managers failed to identify nurses who needed training, and (2) when nurses, who were identified by their Nurse Managers as needing training, failed to show up for their assigned training sessions, and there were no consequences for these actions. The absence of a successful competency-based training and education program continued to contribute to the problems noted in Sections M1 through M6. <u>Nursing Peer Review (NPR)</u> On 5/9/11, a Nursing Peer Review Policy was implemented statewide. According to the policy, the CNE or a NPR Committee may determine that an incident was "minor" and, therefore, an investigative peer review committee or the Board of Nursing was not required to conduct an investigation. For example, an incident may be considered minor when, or if, the significance of the event in the particular practice setting, the situation in which the event occurred, and/or the presence of contributing or mitigating circumstances in the nursing care delivery system in relation to the nurse's conduct failed to meet the reporting requirements or constituted a minor incident that could be remediated. One case deserves mention: On 10/15/11, at 5:18 pm, the CNE received a call from an Adult Protective Services investigator who reported an intake regarding Individual #35. Allegedly, Individual #35's nurse got into an argument with a staff member and threatened to make the staff member's life "difficult." The staff member reported the nurse to APS, and alleged that the nurse poured some kind of medication down Individual #35's and other unknown individuals' feeding tubes and caused them to get diarrhea in an attempt to punish staff members who were forced to clean Individual #35 and the other unknown individuals' feces. Reportedly, this incident occurred a week or so prior to the report, but was described as an ongoing situation on unit 673's west wing. The CNE reported that she immediately informed the facility administrator, campus coordinator, and on-duty RN of the situation. She also instructed the on-duty RN to conduct a physical assessment of Individual #35, as well as all other potential victims. In addition, the CNE reported that she instructed the Program Compliance Nurse to check Individual #35's and all other potential victims' medication administration records for "any medication errors." During the interview with the CNE, she reported that on the basis of (1) the on-duty RN's report that there were no abnormal findings revealed during her physical assessments, (2) the fact that Individual #35 did not have a gastrostomy tube, and (3) the Program Compliance Nurse's report that his review of the individuals' MARs revealed that the individuals were prescribed routine laxatives and that there were no errors, she concluded that no peer review was needed. In addition, on the basis of the information referenced above, she concluded, "Based on the lack of evidence to support a deviation	

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		from the standard of nursing care. No further action is warranted with respect to [nurse]." Notwithstanding the CNE's immediate response to the allegation, which was referred back to the facility from APS for possible peer review as a clinical issue, the CNE failed to implement the facility's policy and procedure for conducting reviews of untoward incidents or allegations involving clinical practices referred back to the facility for possible peer review as a clinical issue (i.e., there was no documented evidence that this occurred). Also, there were no records and/or first-hand reports documented by the nurses who performed the physical assessments and reviews of the records of Individual #35 and the other potential victims. Thus, their findings, which were heavily relied upon by the CNE to conclude no deviation from the standard of nursing care and no criteria for peer review, were unconfirmed reports of unfounded information.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	At the time of the monitoring review, SASSLC had completed the first year of its implementation of the state approved health risk assessment rating tool and assessment of risk as part of the ISP process. According to the facility's self-assessment, since the prior monitoring review, "no new initiatives [in this provision item] were implemented." Notwithstanding this report, the monitoring team identified several initiatives, which were developed and implemented by the nursing department to achieve compliance with this provision. These initiatives, however, were listed under provision item M3 instead of M5. For example, the facility's self-assessment reported that steps were taken to ensure that all relevant data were available and accessible to the IDT prior to the annual ISP meeting and all high-risk areas were addressed by an HMP that was consistent with the integrated risk assessments and risk action plans. During the conduct of the review, the monitoring team attended one ISP meeting and one meeting to discuss the risk review process, which was held at the request of the monitoring team so that the team could learn more about SASSLC's implementation of the at risk policies and procedures. The ISP meeting was held on behalf of Individual #31. The QDDP who chaired the meeting was somewhat prepared, but lacked the skills needed to keep the meeting participants focused and engaged in the process. This was especially problematic when the individual's health risks were discussed. The review and assignment of health risks was awkwardly placed at the very beginning of the meeting and segregated from the team's review and discussion of other relevant aspects of the individual's life. Although all relevant team members, including clinical	Noncompliance

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		professionals, attended the ISP meeting, there were long lapses in the discussion, too many occasions when the QDDP needed to push team members to offer their expertise and provide information, opinions, and recommendations to the team, and an apparent overall lack of participation in this important process. Thus, the risk review and assessment portion of the ISP meeting, which took well over two hours, failed to result in a comprehensive plan to address Individual #31's health risks. The conduct of the RN case manager who participated in the ISP meeting continued to need improvement. For example, the RN case manager frequently did not offer well-informed and/or well-formulated opinions regarding the individual's level of risk for particular areas of his health status. And, it was only when he/she was specifically called upon to provide specific diagnostic information and/or medical history that he/she was forthcoming with important health information. Also, it was of concern to the monitoring team that although it was reported that the individual's oral hygiene had declined significantly from good to poor, his "low" risk for oral hygiene problems was not going to be re-evaluated by the team until the monitoring team intervened and requested additional information, data, review, and further discussion of this health problem. There were other problems noted during the conduct of this risk review. For example, "triggers" were often confused with interventions, and although Individual #31's QDDP frequently stated that he needed to be considered as a "whole person," the interrelatedness of certain risk areas was not appreciated. Specifically, although Individual #31 was overweight, diagnosed with hypertension, was immobile and used a wheelchair as primary means of mobility, and had a significant family history of heart disease and diabetes, his team failed to acknowledge the significance and potential impact of these conditions on his risk of developing circulatory problems. 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 21 of the sample individuals reviewed had multiple risks related to their health and/or behavior, and several individuals' physicians referred to them as having one or more "high" health risks. However, of the 21 sample individuals whose records were reviewed, almost one-third failed to have current ISPs, risk assessments, and, as applicable, risk action plans filed in their records. Also, a review of the 15 individuals who had an, at least, annual health risk assessment filed in their record, revealed that their levels of risk were not consistently revised when significant changes in individuals'	

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		health status and needs occurred. Therefore, this provision item was rated as being in noncompliance. Examples included the following: • Individual #283 had many chronic medical conditions, as well as acute health problems. Recently, she was hospitalized three times in less than two months for re-occurring ileus. Thus, it was not surprising that her risk of gastrointestinal problems and constipation were scored "high." In addition, she was often noncompliant with clinical professionals' recommendations. For example, she often refused to have her vital signs monitored and accept increased fluids, as ordered by her physician. Over the past several months, her dentist repeatedly noted her very poor oral hygiene. Thus, on 12/22/11, her dentist noted that she had severe dental disease with a hopeless prognosis and was most likely headed to total tooth loss and at risk of developing acute problems due to her dental disease. There was no evidence that Individual #283's other pressing and equally serious and high-risk health issues were assessed or that risk action plans were developed to address these problems. • On 12/10/11, Individual #220 slipped in a puddle of urine, fell to the floor face first, and broke two teeth. According to her record notes, her team members planned to follow-up with bath mats and address the problem of urine on the floor. This unfortunate accident, however, was only one of several injuries suffered by Individual #220. During the months preceding this accident, she was found with a black eye, abrasion across her nose, swollen lip, etc. Notwithstanding these incidents and the potentially increasing trend in severity of injury, as of this review, there was no evidence that Individual #220's team met to re-evaluate her health risks and no evidence that a plan was developed to ensure her safety. Of note, there was no evidence that Individual #220's team addressed the problem of urine on the floor or followed-up with bath mats.	
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	During the prior review, improvements were noted in the administration of medication and the management of the medication administration system at SASSLC. Regrettably, since the prior review, the system of medication reconciliation and accountability at the facility, though imperfect and a work in progress was surreptitiously discontinued. Although meeting minutes from the newly established Medication Variance Committee indicated that the Committee put an end to nurses' bagging and wrapping medications received from the pharmacy, they failed to reveal that the Committee had discontinued all expectations for nurses to reconcile medications received from the pharmacy at the time of delivery to the units. This was a significant setback to the facility's efforts to ensure that medications were administered and accounted for in accordance with generally accepted professional standards of care and the Health Care Guidelines. Thus,	Noncompliance

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	Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	this provision item was rated as being in noncompliance. During the review, medication administration observations were conducted on various units across the facility. The names/numbers of the units are not included in order to help the facility refrain from focusing only on those units/nurses versus focusing on the problems. Observations of medication administration revealed numerous problems with nurses' practices and a significant pattern of failure to comply with basic 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. • When some nurses washed their hands, they did so in less than five seconds. • Nurses did not change their soiled gloves between contact with individuals' ostomy sites/dressings and contact with the individuals' medications and clean supplies. • Stethoscopes, which were used to check for placement of gastrostomy tubes, were never cleaned between contacts with individuals. • During one nurse's check for placement of an individual's gastrostomy tube, he/she aspirated stomach contents and instead of returning the individual's stomach contents back to his/her stomach, the nurse emptied the syringe/stomach contents into the sink. • Nurses did not review or properly reference the individuals' Medication Administration Records (MARs) during the assembling and administration of medications. • Nurses documented individuals' receipt of medications on the MARs prior to administration. • 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. A review of the 21 sample individuals' MARs/TARs for the period of 1/1/12 – 2/13/12, revealed that four individuals had missing entries in their MARs/TARs, which were indicative of potential medication errors in the administration of seizure medications, calcium/vitamin D, drops, skin treatments, breathing treatments, enteral feedings/fluids, etc. These potential errors were not represented as such or captured by the facility's medication variance database.	

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		Notwithstanding the problems noted above, as noted in the prior review, a review of the results of the facility's monitoring of medication administration and documentation revealed that problems almost never occurred. It remained unclear to the monitoring team how the facility's monitoring review protocol could continue to fail to reveal such significant problems in practice, especially since the monitoring team's observations of medication administration took place across different units, days, and times and involved several different nurses. On 10/26/11, the newly formed Medication Variance Committee conducted its first meeting. The Committee members included the CNE, NOO, Medical Director, Nurse Managers, Director of Pharmacy, Program Compliance Nurse, and the Quality Assurance Nurse. During this review, the monitoring team attended the 2/15/12 Medication Variance Committee meeting. During this meeting, old and new business was discussed and medication error reports were presented. During the Committee's review of medication errors over the six-month period of August 2011 to January 2012, it was revealed that the numbers of reported medication errors dramatically decreased from a high of 115 reported errors to a low of 1 reported error. Coincidentally, during the above-mentioned period of dramatic reduction in reported medication errors, nurses were told that they were to stop counting/reconciling medications upon delivery from the pharmacy. The monitoring team voiced their concern that the facility had abandoned the only process it had in place to ostensibly ensure the accountability of the facility's medication administration system in favor of no system. Nonetheless, the CNE reported that she and the other members of the Committee were aware that the facility "Still has issues," but "We're not going back to that [counting medications upon delivery from the pharmacy]." Further, the CNE reported that there was a plan in place to hire a Pharmacy Technician, whose job would include medication reconciliation, but there was no approval from the state to do so. During the Medication Variance Committee meeting, the following initiatives were put forward for consideration and approval by the Committee: • Bring to the next/higher level (Dr. Pittman, state office pharmacy coordinator) the facility's persistent problem with obtaining revised labels for medications when changes occurred in dosage, frequency, route, etc., • Obtain information on the status of completion of the Master Legend (for nurses' names/initials/signature), • Account for medications returned to the pharmacy and determine whether or not medication errors occurred, • Take steps to plan how to reconcile medications while awaiting the state's	

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		approval to hire a Pharmacy Technician, • Obtain "fill sheets" from the pharmacy for nurses to sign upon the delivery of medications, and • Read the state's Medication Variance Policy As of the monitoring review, the above initiatives were pending further review.	

Recommendations:

1. Review and clarify the expectations for the Infection Control and Prevention Program, Hospital Liaison, and Wound/Skin Integrity program, and ensure that these programs are re-established as soon as possible (M1-M6).

2. Re-establish a medication reconciliation system at the facility to ensure that medications are safely and accountably administered (M6).

3. Ensure that all individuals have a current annual ISP, current comprehensive nursing assessments, and HMPs/ACPs that address and meet their needs filed in their active medical records (M1).

4. Review the situation of "boarders" on unit 673, and if it should continue to be used for close/medical monitoring of individuals, especially those who are ill, recovering from hospitalization, etc., consider developing policies/procedures to effectively safeguard all individuals who reside on unit 673 (M1).

5. Consider developing a plan and set of expectations for how nurses will become present, visible, and involved partners in care on the units (M1-M6).

6. Stop the current practice of permitting nurses to carry out procedures and/or accepting the assignment of duties that they are not competent to perform (M1-M6).

7. Provide the Nurse Educator with an adequate place with sufficient space to conduct competency-based training and education, preferably a place/space with a sink (M4).

8. 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).

9. Consider assigning each member of the nursing leadership group and the specialty nurses, that is the Nurse Educator, Infection Control Nurse, Hospital Liaison, and Program Compliance Nurse, specific tasks with specific objectives and outcomes that will move the Nursing Department closer to the achievement of substantial compliance with the provisions of section M (M1-M6).

10. 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).

11. 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).

12. 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).

13. All nurses at the facility should become familiar with and knowledgeable of the statewide Nursing Peer Review Policy (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 DADS Policy #011: Pharmacy Services, 10/14/11 o DADS Policy #053: Medication Variances, 9/23/11 o SASSLC Standard Operating Procedure: 400-11: Pharmacy and Therapeutics Committee, 12/1/11 o SASSLC Standard Operating Procedure: SASSLC Drug Utilization Evaluation, 1/1/12 o SASSLC Self-Assessment o SASSLC Organizational QDDPs o SASSLC Lab Matrix, 12/22/11 o Pharmacy and Therapeutics Committee Meeting Minutes, 8/16/11, 9/28/11, 10/27/11, 12/22/11 o Medication Review Committee Meeting Notes, 10/26/11, 11/30/11, 12/28/11, 1/25/12 o Daily Clinical Services Meeting Notes, August 2011 – January 2012 o Single Patient Interventions, August 2011 – December 2011 o Notes Extracts, August 2011 – December 2011 o Adverse Drug Reactions Reports o Medication Variance Data, December 2010 – January 2012 o Quarterly Drug Regimen Reviews for the following individuals: • Individual #301, Individual #294, Individual #42, Individual #349, Individual #302, Individual #108 Individual #65, Individual #141, Individual #12 Individual #252, Individual #86, Individual #48, Individual #81, Individual #85, Individual #116, Individual #82, Individual #264, Individual #151, Individual #23, Individual #178, Individual #265, Individual #342, Individual #340, Individual #226, Individual #276, Individual #345, Individual #283, Individual #303, Individual #228 o MOSES evaluations for the following individuals: • Individual #245, Individual #163, Individual #45, Individual #119, Individual #138, Individual #301, Individual #87, Individual #294, Individual #198, Individual #304, Individual #83, Individual #335, Individual #3, Individual #145, Individual #97, Individual #146, Individual #209, Individual #279, Individual #291, Individual #191, Individual #295, Individual #292, Individual #015, Individual #205, Individual #302, Individual #276, Individual #173, Individual #294, Individual #283, Individual #42, Individual #342, Individual #311, Individual #301, Individual #265 o DISCUS evaluations for the following individuals: • Individual #245, Individual #163, Individual #45, Individual #119, Individual #138, Individual #301, Individual #87, Individual #294, Individual #198, Individual #304, Individual #83, Individual #335, Individual #3, Individual #145, Individual #97, Individual

	#146, Individual #209, Individual #279, Individual #291, Individual #191, Individual #295, Individual #292, Individual #015, Individual #205, Individual #302, Individual #276, Individual #173, Individual #294, Individual #283, Individual #42, Individual #342, Individual #301 Interviews and Meetings Held: o Sharon Tramonte, Pharm.D, Clinical Pharmacist o Carmen Mascarenhas, MD, Medical Director o Marla Lanni, RN, JD, Chief Nurse Executive o Assistant Pharmacy Director, SASH Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Daily Clinical Services Meeting o San Antonio State Hospital Pharmacy Department
	Facility Self-Assessment: SASSLC submitted its self-assessment, which was updated on 2/1/12. For each of the eight provision items, the documents listed a series of actions that had occurred in order to achieve substantial compliance with the Settlement Agreement. A few provision items listed audit data. The series of actions helped the monitoring team to gain on overall sense of where the facility was for each provision item. The self-assessment is intended to provide the facility with a sense of where it stands relative to compliance with the provision. It should describe the types of activities that were engaged in to make that determination as well as the results or findings of the activities. A typical self-assessment might describe the types of audits, record reviews, documents reviews, data reviews, observations, and interviews that were completed in addition to reporting the outcomes or findings of each activity or review. Thus, the self-rating of substantial compliance or noncompliance would be determined by the overall findings of the activities. The facility found itself in substantial compliance with provisions N2, N4, N5, and N7. It rated itself in noncompliance with provisions N1, N3, N6, and N8. The monitoring team found substantial compliance for N2, N4, and N5.
	Summary of Monitor's Assessment: Since the last review, the provision of pharmacy services and safe medication practices demonstrated a mix of continued progress, lack of progress, and even regression. Many issues that were noted in the August 2011 and previous reports still had not been addressed. The pharmacy department appeared to have little supervision as the CNE reported that the clinical pharmacist reported to, but was not supervised by her.

	This lack of supervision could not be attributed entirely to the CNE because many of the issues and practices related to pharmacy would not normally come under the purview of nursing services. None of the other SSLCS placed pharmacy under the supervision of nursing and such an arrangement is not standard practice. Moreover, the current organizational structure resulted in the medical director having a diminished role in several areas where a strong medical presence is necessary. The facility had to work with the limitations that resulted from the use of an outsourced pharmacy. These were not insurmountable limitations, but there was very little demonstrated effort to overcome them, particularly with regards to provision N1. The lack of appropriate oversight combined with the described limitations resulted in an overall lack of significant forward movement for this provision. The loss of a clinical pharmacist in December 2011 will only make maintaining achieved progress more difficult. There was no progress noted with regards to documenting communication between the pharmacists and the prescribers. Although a small number of single patient interventions were documented, this was clearly inadequate both in content and number. There were discussions, just prior to and during the onsite review, regarding potential solutions to the barriers of having an outsourced pharmacy. Clinical pharmacists continued to complete QDRRs. The sample submitted by the facility to the monitoring team indicated that these were completed thoroughly and in a timely manner. The monthly audits conducted by the clinical pharmacist showed overall compliance rates of less than 80% and quarterly compliance of approximately 75%. At the time of the onsite review, the facility employed one clinical pharmacist, which will make compliance with quarterly requirements even more challenging. The facility reviewed polypharmacy during the Pharmacy and Therapeutics Committee meeting. This review was limited to aggregate data and each individual's use of multiple drugs was not assessed. In fact, there was no psychiatry participation in the meeting attended by the monitoring team and, therefore, no appropriate discussion could occur. Based on the documents reviewed, the physicians acknowledged the recommendations included in the QDRRs. Record reviews appeared to indicate that appropriate actions were taken on the part of the physicians. The facility's external medical reviews documented compliance less than 80% with the requirement to provide a rationale for rejection of the recommendations. The scope of assessment of this provision item will be expanded during the next review. The MOSES and DISCUS evaluations were completed by the psychiatrists. In most instances, the forms were adequately completed. Adverse drug reactions were completed by the clinical pharmacists and reported in the Pharmacy and Therapeutics Committee meetings. All of the reporting appeared to be completed by the pharmacy staff. Training for new employees was discontinued and there was no clear plan on how this would proceed with one clinical pharmacist.

	Two DUEs were completed since the last visit. The August 2011 report clearly stated that a new DUE was to be completed each quarter. The risperidone DUE was cited as a follow-up DUE. Moreover, the prescribers of medications reviewed by the DUEs did not participate in the meetings where the information was presented. The medical director was the only medical participant in the Pharmacy and Therapeutics Committee meeting attended by the monitoring team. Medication variances were reported, but the processes at the facility had changed to the extent that dispensing variances were reported as zero. Given the history of dispensing variances, a sudden drop to zero was a clear indication that the facility was not able to provide accurate and reliable data.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	This provision item is related to fundamental components of the medication use system – the prescribing and dispensing of medications. Minimal, if any, progress was noted relative to achieving substantial compliance. Little documentation was available regarding the communication between pharmacists and prescribers. 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. The monitoring team requested copies of all Single Patient Interventions and Notes Extracts completed since the last onsite review. Documents dated from August 2011 through December 2011 were submitted. Summary data are represented in the QDDP below. 2011 Single Patient Intervention Data Number of Interventions August: 48 September: 16 October: 14 November: 24 December: 15 Total: 117 A total of 117 interventions were documented during this period. Forty-one percent of the interventions were documented during August 2011. The interventions addressed numerous issues, such as therapeutic duplication wrong dose, allergies, and wrong drug formulation. The following are examples noted in the SPI documents provided: • 12/2/11 – Called doctor concerning today's order for Keflex and patient allergy to cephalosporin. Doctor said that individual has been on ABX in the hospital with	Noncompliance

#	Provision	Assessment of Status	Compliance
		no problems. • 11/21/11 – Had to delete colon prep orders because the end of the orders did not make sense. Will contact doctor for clarification. • 8/1/11- Spoke with nurse. Order for lactulose written for po. Patient using G-tube currently. Order clarification needed for correct route of med. • 8/2/11 – Notified doctor that only Tylenol 325 mg is available at the pharmacy. Patient is allergic to ASA and doctor will change Naproxen order to Tylenol. • 8/18/11 – Spoke to nurse – said patient is allergic to sulfa and not Bactrim. • 8/18/11 – Spoke to nurse regarding trimethoprim order – patient is allergic to Bactrim. • 8/12/11 - Spoke with doctor about Cipro suspension – not able to put in G-tube. Doctor will select something else. • 9/1/11 – Spoke with nurse, CBC due this week. • 9/2/11 – Follow-up with nurse on repeat CBC/diff. Not done. • 12/12/11 - Called doctor about guaifenesin order. Was written for 10 mg instead of 10 ml. • 12/9/11 – Called to get clarification on Topamax taper. • 11/9/11 – Spoke with doctor about ampicillin allergy with amoxicillin order. Will change to Zithromax. • 10/11 – Verified Augmentin order with doctor. The notes extracts consisted of more than 200 pages of data related to drug interactions and duplicate alerts. Much of this information was not clinically relevant, as the WORX system would note duplicate alerts when two strengths of a medication were combined to achieve a total dose. The monitoring team made the following observations with regards to the SPI documents provided: • Allergy issues, wrong doses, wrong drug formulation, and routes were frequently noted. • The interventions did not adequately document the issues. The exact problem was frequently not documented. • There was a lack of documentation of resolution for many of the interventions documented. • The management of drug interactions based on severity was not clear. Even with the limited amount of SPI data submitted, it was clear that some types of issues were repetitive. This information was not used by the medical director to address provider specific or systemic problems and it should have been. The medical director should track this data, analyze it, and use it to develop corrective actions and training	

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		opportunities for the medical staff. When individuals are prescribed medications to which they are known to have allergies, the matter should be reviewed to determine the existence of human or systemic error. Patterns regarding incomplete, incorrect, and vague orders should be addressed with the medical staff. The monitoring team, along with representatives from state office and the SASSLC clinical pharmacist had the opportunity to visit the State Hospital pharmacy, tour the facility, and review the processes. There was an extensive discussion with the State Hospital assistant pharmacy director. Documentation of the resolution of problems recorded as single patient interventions posed some challenges within the WORx system. A few day prior to the onsite review, a potential solution had been proposed for the problem of documenting communication between pharmacists and prescribers, inclusive of the resolutions. This plan, however, had not been presented to the State Hospital pharmacy director. Over the past year, the State Hospital had implemented several changes that would assist the facility in moving towards substantial compliance with the Settlement Agreement. Most recently, one pharmacist had been assigned to manage the medication orders for SASSLC. Finally, this provision item required "upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about… the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication." The monitoring team discussed this requirement with representatives from state office including Dr. Kenda Pittman who served as the statewide lead for pharmacy issues. Dr. Pittman presented a pilot plan related to meeting the requirements of this component of the provision item. While additional work was required for resolution of this matter, efforts were ongoing.	
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 Quarterly Drug Regimens Reviews were reviewed to determine substantial compliance with this provision item. In accordance with state policy, the QDRRs included reviews of allergies, the appropriateness of medications, rationale for therapy, proper utilization, duplication of therapy, polypharmacy, drug – drug/food/disease interactions, and adverse reaction potential. The facility had adopted the lab matrix as the 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. The pharmacists commented on many clinically relevant issues. Each review contained a table listing pertinent lab values. All values were usually documented. In some instances, the clinical	Substantial compliance

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		pharmacist documented by exception. Normal ranges were included in the table. In addition to lab values, the pharmacists usually 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 also noted in several of the reviews and this was an area of improvement since the August 2011 review. The following are a few examples of clinically relevant information that was noted to be deficient in the QDRRs assessed: Individual #252, 11/15/11 • The monitoring team noted that documentation of renal function for lithium use was missing. Individual #86, 12/2/11 • The QDRR noted that the CBC and CMP were not located in the records. • A recommendation was made to monitor lipids every six months since the LDL>130. Individual #151, 12/30/11 • The recommendation was made to review drug indication for Levetiracetam since the indication was listed as "seizure taper," but no decrease in dose had occurred since 2010. • The MOSES evaluation was not current. The RN case manager was notified. • The recommendation was made to check a vitamin D level due to low bone density. Individual #178, 12/14/11 • The recommendation was made to obtain a vitamin D level due to the long course of treatment with ergocalciferol. • An indication was requested for the use of lisinopril. Individual #226, 11/28/11 • The recommendation was made to obtain an EKG to better monitor the long-term effects of diabetes mellitus and hypertension. The last was dated 2004. • Follow-up lipids and CMP were requested. Fenofibrate was started on 11/21/11. The documentation in the IPN indicated that lipids and a CMP would be obtained in three months, but no order was written. Individual #116, 12/29/11 • A request was made to provide an indication for lactulose.	

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		• The last DEXA scan was documented as 2001. No recommendation was made to obtain a repeat study. This individual was at risk for osteoporosis due to treatment with phenobarbital. Individual #228, 11/27/11 • The QDRR noted that the individual had bilateral breast discharge that was most likely associated with Reglan induced prolactin elevations. The review, however, did not provide any information on the prolactin levels. • Recommendations were made to obtain a phenobarbital level since the last was done 5/09. It was also recommended that a slight calorie reduction occur due to weight gain with enteral meals. Individual #276, 11/29/11 • The recommendation was made to obtain an eye exam due to the use of psychotropics. • The individual had evidence of a mild chronic metabolic acidosis, but no comments or recommendations were made. These reviews had evolved into valuable sources of information for the clinicians. Practitioners were provided information on compliance with performing monitoring, the results of the monitoring (normal or abnormal), and recommendations when appropriate. At the time of the onsite review, the facility employed one clinical pharmacist who would need to complete at least four QDRRs each day to meet the quarterly requirements. Given the numerous responsibilities assigned to the clinical pharmacist, the need to fill the clinical pharmacist vacancy is an urgent one. The requirements for completion of the Quarterly Drug Regimen Reviews were outlined in state policy. Additional guidance was provided in the localized medical services policy. There was no localized policy for pharmacy services or the drug regimen reviews. The facility will need to be cautious with regards to timelines for completion. The current facility medical policy required that the pharmacist conduct reviews and forward as done, and no later than the 7th day of the month following the month in which they were due. Physicians were required to complete and sign the reviews by the 21st day of the month. Providing such timelines did not take into account factors, such as holidays, but could also permit a lapse of a few weeks prior to submitting the reviews to physicians. The facility should develop a separate policy that specifies the process and timelines for completion of the QDRRs. A two week period would be a reasonable timeline from pharmacy completion to physician review and return.	

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N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The use of stat medications/chemical restraints was discussed in the daily clinical meetings as well as the Pharmacy and Therapeutics Committee meeting. A synopsis of each individual's use of chemical restraints was recorded in the minutes. Psychotropic polypharmacy data were presented each month at the Pharmacy and Therapeutics Committee meeting. This review focused on the facility's aggregate data. The facility did not have a Polypharmacy Oversight Committee responsible for reviewing and justifying the use of psychotropic polypharmacy for each individual. Psychotropic polypharmacy, the use of benzodiazepines, and chemical restraints are discussed in Section J. The QDRRs were utilized to monitor for the metabolic and endocrine effects of the new generation antipsychotics. The documents consistently noted the monitoring parameters. The clinical pharmacists usually commented on all of the monitoring parameters. Occasionally, documentation was by exception. The lab matrix should be revised to reflect that assessment for development of metabolic syndrome requires monitoring of blood pressure, FBS, central obesity (weight and abdominal girth), triglycerides, and HDL. Benzodiazepine, anticholinergic burden, and polypharmacy were commented on in each QDRR when appropriate. The MOSES evaluations also assisted in monitoring for effects of anticholinergic use.	Noncompliance
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Medications were filled at the San Antonio State Hospital. The order sheets noting responses were not a part of the active records and the SPI forms did not adequately document follow-up. This is discussed in Section N1. Substantial compliance with this provision was determined based on information related to the Quarterly Drug Regimen Reviews. The clinical pharmacist reported that starting in October 2011, the physicians were provided with an outline that included all of the recommendations provided in the QDRRS. This was intended to improve efficiency of responses since the QDRRs were signed in the offices, but records were located in the living areas. A column was added for QA follow-up to track if recommendations were completed. The forms submitted were largely incomplete and did not document follow-up. The monitoring team reviewed a sample of QDRRs submitted by the facility in addition to the QDRRs included in the record sample. The following was noted for the record sample: • 9 of 10 (90%) records contained QDRRs with multiple recommendations • 8 of 9 (89%) records had evidence that the providers acted on the	Substantial compliance

#	Provision	Assessment of Status	Compliance
		recommendations of the pharmacists • 1 of 9 (11%) records had a QDRR recommendation that failed to be implemented • 3 of 9 (33%) records had QDRRs with recommendations that were made in two consecutive reviews, but were eventually resolved. The recommendations that were repeated mostly pertained to the need for medication indications. This problem may have been partly due to a problem with faxing orders to the State Hospital. That problem was addressed and corrected by the CNE. For the sample of 20 QDRRs reviewed from the documents submitted: • 12 of 20 (60%) QDRRs included recommendations made by the clinical pharmacist • 12 of 12 (100%) QDRRs indicated that the prescriber would consider the recommendations The QDDRs reviewed were consistently signed by the prescribers and all indicated that consideration would be given to the recommendations. Many providers included notes indicating what actions were taken or would be taken to address the recommendations. None of the QDRRs included comments from the clinical pharmacists indicating that recommendations remained outstanding. Nonetheless, rounds two and three of the external medical reviews both documented slightly less than 80% compliance for documentation of a rationale when recommendations were rejected. The assessment of this provision item will be expanded during the next review.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The monitoring team reviewed a sample of the most recent MOSES and DISCUS evaluations in addition to the most recent evaluations included in the active record of the record sample. The findings are summarized below: Thirty-five MOSES tools were reviewed for timeliness and completion: • 35 of 35 (100%) were signed and dated by the physician • 27 of 35 (77%) documented no action necessary • 7 of 35 (20%) documented actions taken, such as drug changes and monitoring • 1 of 35 (3%) documented no prescriber review Thirty-three DISCUS evaluations were reviewed for timelines and completion: • 33 of 33 (100) were signed and dated by physician • 26 of 33 (79%) indicated no TD • 3 of 33 (9%) indicated TD present • 4 of 33 (12%) documented no prescriber conclusion	Substantial compliance

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		The MOSES evaluation was completed every six months while the DISCUS evaluation was required every three months. The psychiatrists were responsible for review of these evaluations and the majority of the evaluations included the final physician review with comments as appropriate. Recent ADR data indicated that some suspected ADRs were actually identified through the completion of these evaluations. This finding served as a reminder of the importance of monitoring for the presence of medication side effects and through completion of these evaluations. Although it was reported in the self-assessment that RN case managers were trained on completion of the MOSES and DISCUS evaluations, there was no documentary evidence for this. The facility must ensure that all new staff receive appropriate training. The clinical significance of the identification of the development or presence of extrapyramidal symptoms and the potentially irreversible tardive dyskinesia requires that staff be vigilant in completing these reviews. This information should be provided to the neurology consultants for review. It is also important that the primary care physicians review this information and consider including it in their annual and quarterly assessments.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility continued to report ADRs. From July 2011 to December 2011, 25 ADRs were reported. The reactions were discussed in the Pharmacy and Therapeutics Committee meetings. The clinical pharmacist tracked and analyzed data in an effort to detect systemic issues. During the onsite review, the monitoring team attended the Pharmacy and Therapeutics Committee meeting and noted that each ADR was discussed. The discussions focused on individual specific data, but also contributed to the overall analysis of aggregate data. The use of aggregate data provided further direction to the facility on matters related to medication safety. For example, valproic acid was implicated in several adverse drug reactions resulting in completion of a DUE on its use. This is discussed further in N7. The forms reviewed were completed appropriately, signed, and dated by the clinical pharmacist. The last section "P&T review and recommendation" did not include the final determination of the committee regarding the occurrence of an adverse drug reaction. It should also include recommendations made by the committee and any follow-up that needs to occur. Notwithstanding continued reporting of ADRs, there were several concerns that need to be addressed to achieve substantial compliance with this provision item: • Appropriate training must be provided to staff. During the August 2011 review, the facility demonstrated progress with regards to staff education. At that time, new employees were receiving training on adverse events associated with the use of psychotropic medications. In March 2011, the clinical pharmacists began	Noncompliance

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		providing inservices to the direct care professionals on psychiatric medication changes and the potential side effects of these medications. Many of these efforts were halted with the resignation of one clinical pharmacist in December 2011. ADR training was on longer provided in NEO. Additionally, it appeared that the use of the adverse reaction warning sheet for serotonin syndrome and NMS, developed in late 2011, was not clearly communicated to direct care professionals and nursing. At the time of the onsite review, there was no overarching plan on how staff would be trained on identification and reporting of adverse drug reactions. • The facility did not have a procedure to outline this process and provide guidance on who should report ADRS and the process for doing so. All of the forms reviewed were completed by the clinical pharmacists. Other clinical staff, such as nursing and physicians should be able to complete this form. As recommended in previous reports, a procedure must be developed for the ADR reporting and monitoring process. A fully implemented ADR reporting and monitoring system mandates that all healthcare professionals and others with extensive contact with the individuals have the ability to recognize and report adverse drug reactions. The facility must ensure that all medical providers, pharmacists, nurses, respiratory therapists, and direct care professionals receive appropriate training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained.	
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.	A Drug Utilization Evaluation policy was implemented in January 2012. The procedure, detailed the process of completing DUEs in accordance with Appendix B of the Health Care Guidelines. One DUE was to be completed each quarter with high use and high risk drugs given priority. The facility maintained a DUE calendar. Since February 2011, DUEs were completed on lithium, topiramate, warfarin, risperidone, and valproic acid. The risperidone DUE was a follow-up DUE. As noted in the August 2011 report, completion of a new DUE was required each quarter. The risperidone and valproic acid DUEs completed since the last review are summarized below. <u>Risperidone</u> This was a follow-up to a 2009 DUE and was intended to reassess dosages of risperidone utilized at the facility and compliance with monitoring parameters. A 25% sample (seven records) was randomly selected for review of drug indications, contraindications, patient monitoring, and dosing. The DUE reported the following results:	Noncompliance

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		• Overall, indications were found to be appropriate. • One individual had a relative contraindication. • Lab monitoring was largely in accordance with recommended criteria. • Three individuals received dosages in excess of recommended maximum dosage. There was no documented justification for the dosage, but psychiatry notes documented a goal for reduction. Recommendations resulting from the DUE included: • Assessment of barriers for evaluation of EPS for weeks following initiation of antipsychotics and after dose change. • Continue quarterly assessment of EPS with DISCUS. • Educate nursing and medical staff concerning importance of questioning about visual disturbances at least annually. • Consider obtaining prolactin levels if MOSES indicates presence of symptoms. • A clinical rationale and risk/benefit ratio must be documented for use dosages above the recommended maximum dosage. <u>Valproic Acid</u> The stated objective of the DUE was: valproic acid was identified as the leading medication associated with adverse drug reactions. These adverse reactions included bruising, increased ammonia, neutropenia, and thrombocytopenia. In addition to assessing laboratory abnormalities in individuals treated with VPA, adherence to the monitoring matrix will be assessed. A 24% sample (15 records) was selected to review for completeness of monitoring parameters. Data were presented on drug use by living area, dosage form, gender, psychiatrist, primary physician, and indication. Adherence to the monitoring parameters, such as CBC, CMP, and drug levels was also presented. The DUE reported the following conclusions: • The majority of individuals were treated with the most expensive DVP-ER product. • Lab monitoring for the most part was appropriate. • Lab abnormalities associated with VPA included neutropenia, anemia and thrombocytopenia. Recommendations from the DUE included: • Consider changing to less expensive formulation. • Ensure standing orders for medication monitoring are written on all who receive the drug. • Ensure follow-up labs are written at the time of medication dose change.	

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		• Consider obtaining free levels biannually. • Consider performing a DUE examining individuals with hyponatremia and correlate with medications. • Ensure follow-up CBC and VPA levels are obtained within two weeks of dose change. The findings and recommendations of the valproic acid DUE were discussed during the February 2012 Pharmacy and Therapeutics Committee meeting. The monitoring team noted that, although the results and recommendations were thoroughly discussed, no action plan was developed during the context of the meeting. The notes of previous meetings did not include corrective action plans for DUEs presented. The meeting minutes listed the recommendations as stated in the DUE report, but did not indicate the committee's decision to accept or reject the recommendations. The monitoring team attended the August 2011 meeting during which the committee discussed the need to explore the necessity of a "Coumadin diet." That recommendation was captured in the notes, but follow-up did not appear in any subsequent meeting notes. During the August 2011 review, the requirement to complete a new DUE each quarter was discussed. As noted in the report, follow-up of the implementation of corrective actions must be ongoing until the problems are resolved. Following resolution, periodic re-assessment should be completed to ensure maintenance of corrective actions. Both of the completed DUEs contained information relevant to practices at the facility. The valproic acid DUE presented information on many aspects of drug use. The nature of the evaluation seemed to expand beyond its initial focus. The monitoring team suggests that the criteria be specifically defined and the evaluation and report focus on the selected criteria. The findings of the report may actually result in another focused or full DUE. One major objective of the DUE process is to educate heath care professionals to promote the use of criteria, guidelines, treatment protocols, and standards of care. Per policy, results were to be disseminated to medical, nursing, and pharmacy staff through the Pharmacy and Therapeutics Committee meeting. When deficiencies were identified, corrective actions were to be implemented and followed. The primary care physicians did not attend this meeting. Notes of the various daily clinical meetings and physician meetings did not reflect any discussion of the content of these evaluations. Moreover, the February 2012 P & T meeting did not have participation by any psychiatry staff who were frequent prescribers of valproic acid. The monitoring team recommends that the medical director play a greater role in this process by ensuring that corrective action plans related to medical issues are	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>implemented and by ensuring that physicians are present for discussion of the findings and development of corrective actions. This is one area where the current reporting structure did not provide the appropriate medical oversight of this required process.</td><td></td></tr>
<tr><td>N8</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.</td><td>The facility continued to report medication variances. Data for total, dispensing, and omission variances are summarized in the table below.

<table>
<tr><th colspan="14">Medication Variances 2010 - 2011</th></tr>
<tr><th></th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>Dispensing</td><td>190</td><td>122</td><td>117</td><td>122</td><td>82</td><td>67</td><td>60</td><td>80</td><td>48</td><td>58</td><td>67</td><td>0</td><td>0</td></tr>
<tr><td>Omissions</td><td>77</td><td>56</td><td>61</td><td>50</td><td>57</td><td>43</td><td>56</td><td>68</td><td>43</td><td>43</td><td>51</td><td>0</td><td>5</td></tr>
<tr><td>Total</td><td>195</td><td>138</td><td>117</td><td>133</td><td>113</td><td>80</td><td>80</td><td>93</td><td>66</td><td>115</td><td>89</td><td>1</td><td>10</td></tr>
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A review of longitudinal data showed that the number of medication errors increased with implementation of the reconciliation process implemented in late 2010. In November 2010, prior to reconciliation of medications, there were a total of 12 variances reported. In January 2011, the number of variances began to decrease. This was attributed to interventions, such as the bagging of medications. Many changes had also occurred at the State Hospital, such as the requirement for a pharmacist to enter orders into WORx and adjustments to the dispensing robot.

A new Medication Variance Review Committee was implemented in October 2011. This Committee was developed to complete a more in depth analysis of medication errors by a multidisciplinary committee. During the first meeting of the committee on 10/26/11, the minutes documented a unanimous decision to discontinue the “medication wrapping.” All members of the committee were in agreement with this decision. One voting member abstained. The decision to stop wrapping medications resulted in the discontinuation of the wrapping, but also resulted in medication reconciliation being terminated. The use of the fill sheets from the State Hospital was also discontinued. Meeting minutes for November 2011, December 2011, and January 2012 reported that one home continued to bag meds in spite of the decision to discontinue this process. It was stated that some nurses “missed” the bagging process. It was also noted that fill sheets were sporadically used.

The monitoring team attended the Medication Variance Review Committee meeting and engaged in an extensive discussion on the medication variance tracking and reporting system. The CNE reported that, bagging of medications was discontinued at the end of October 2011. The use of the State Hospital fill sheet was also discontinued in November 2011. Essentially, there was no reconciliation of meds upon receipt at the facility and no reconciliation prior to returning medications to the State Hospital pharmacy. This</td><td>Noncompliance</td></tr>
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		represented a significant problem given the fact that dispensing errors and omissions were frequently documented in the months prior to discontinuation of these processes. Many of the dispensing errors were attributed to the dispensing robot at the State Hospital. Medication omissions and extra doses were most frequently noted. The medical director was a member of the committee, but due to other duties attended the meeting for a limited period of time. This committee required active participation by all of the discipline heads (pharmacy, medical, and nursing) in addition to the other members. The problem of medication variances was further discussed in the Pharmacy and Therapeutics Committee meeting during which the CNE provided the quarterly report. Information was presented on initiatives taken by nursing to improve the medication administration at the facility: • New fax machines were installed in the nursing areas due to problems with faxes sent to the state hospital. • Phone lines had been upgraded to accommodate the faxing demand. • The ODRN had been charged with the task of completing weekly MAR checks. Notwithstanding these improvements, a decision to terminate medication reconciliation resulted in a system that was incapable of truly assessing the extent of medications variances that occurred within the facility. It would not follow a reasonable course of logic to consider that total errors would have actually decreased from 115 in September 2011 to one in November 2011. Moreover, a decrease of dispensing errors to zero for the months of November 2011, December 2011, and January 2012 should have alerted all parties responsible for review of this data to question such results. Given the decision to cease reconciliation, it was not surprising that other issues, such as the reconciliation of liquid medications remained outstanding. The CNE reported that a meeting to address reconciliation and other issues was scheduled to occur. The failure to have a system that accurately captured dispensing errors and omissions unfortunately negated much of the progress that had been noted over the past year. The monitoring team highly recommends that the facility address the issue of medication reconciliation. A system of checks and balances must be implemented to provide more accurate information on the dispensing and use of medications at the facility. Until this occurs, it is very likely that medication errors are occurring, but simply going unrecognized and unreported. The failure to have an appropriate medication variance system is not consistent with safe medication practices.	

Recommendations:

1. The facility will need to continue to work with the State Hospital to ensure that the appropriate actions occur in a timely manner such that the communication between pharmacists and prescribers is adequately documented. The system implemented must be capable of allowing the pharmacist to follow-up and document resolutions. The monitoring team suggests that the facility director play an active role in monitoring the progression of this important issue (N1).

2. The medical director should review the SPI data and analyze it. Patterns and trends related to physician practice patterns should be addressed. The data should also be reviewed to determine if systemic issues exist, such as appropriate documentation of allergies or availability of the correct formulations of medications for enteral tube use. The medical director should collaborate with the clinical pharmacist in developing educational opportunities for the medical staff based on the findings of the review (N1).

3. The management of drug-drug interactions must be clarified. The actions required for each level of drug interactions as well as the requirements for pharmacy staff and prescribers should be clearly defined in policy and procedure (N1).

4. The facility will need to work with State Office in outlining the requirements for fulfilling the need to complete laboratory monitoring as part of the prospective review (N1).

5. A written procedure for provision N1, the prospective review of medication orders, should be developed (N1).

6. The facility should develop a written procedure for the process of Drug Regimen Reviews. The policy should outline the process, timelines, and requirements for monitoring labs and other pertinent clinical data. The facility's lab matrix should be included as an attachment to this procedure if it continues as the standard for laboratory monitoring (N2).

7. The clinical pharmacist should comment on every medication for which there is a monitoring parameter included in the Lab Matrix. The actual values should be provided. Documentation by exception should not occur (N2).

8. The clinical pharmacists should ensure that all individuals who are on antiepileptic drugs associated with a greater risk of osteoporosis have appropriate evaluations including measurement of vitamin D and bone density testing. This is particularly important since the neurology clinic notes currently do not address these issues (N2).

9. The facility should proceed with the development of a Polypharmacy Oversight Committee to ensure that the use of polypharmacy is appropriately justified (N3).

10. The Lab Matrix should be revised to the specify parameters monitored for metabolic syndrome including blood pressure, fasting blood sugar, central obesity (weight and abdominal girth), HDL, and triglycerides (N3).

11. The clinical pharmacist should track the responses of the physicians to the QDRR recommendations. The medical director should review this information and counsel the medical staff as indicated (N4).

12. The facility must ensure that employees have adequate training on completion of the MOSES and DISCUS evaluations. Documentation of training and attendance should be maintained (N5).

13. The results of the MOSES and DISCUS evaluations should be provided to the neurology consultants. The primary care physicians should also review the data and consider documenting scores and findings in annual and quarterly assessments (N5).

14. The facility must take several actions in advancing the ADR system:
    a. A procedure, consistent with state issued policy, should be developed to guide the process. The procedure should include the responsibilities of the various disciplines, how reporting occurs and who completes the form.
    b. The requirements for use of the probability scale and intense case analysis should also be included.
    c. Data reporting, tracking and analysis requirements should be outlined.
    d. The role of the Pharmacy and Therapeutics Committee should be included.
    e. Training requirements should be documented: All health care professionals (medical providers, pharmacists, nurses, and respiratory therapists) and direct care professionals must receive training on detecting and reporting adverse drug reactions. The training should be appropriate for each discipline (N6).

15. The last section of the ADR form, "P&T review, and recommendation" should include the final determination of the committee regarding the occurrence of an adverse drug reaction. It should also include recommendations made by the committee and any follow-up that needs to occur (N6).

16. The Pharmacy and Therapeutics Committee should record minutes for each meeting. The document should include the discussions of the meeting with data presented, actions steps that need to occur and the persons responsible for those steps. Timelines for completion of the action steps should also be included. Open items should be reviewed at the follow-up meeting (N6).

17. The Pharmacy and Therapeutics Committee should provide a synopsis of the ADR data including the final determination, follow-up, and action steps that need to occur (N6).

18. In accordance with policy, one DUE should be completed each quarter. The DUE should be a new one rather than a follow-up of a previous DUE (N7).

19. A corrective action plan should be developed for any deficiencies noted during the conduct of completing DUEs. The actions should be specific, have timelines, and identify the person(s) responsible for the actions. This should be reflected in the Pharmacy and Therapeutics Committee meeting minutes (N7).

20. The medical director should collaborate with other discipline heads to ensure that all corrective actions related to information in the DUEs are completed. For additional oversight, corrective action plans developed by the Pharmacy and Therapeutics Committee should be forwarded to the QI department (N7)

21. The medical director must ensure that physicians participate in the DUE process (N7).

22. Several actions must occur with regards to the medication variance system:
    a. A reconciliation system must be developed. At a minimum, the facility must know with each med cycle, the number of meds received and returned.
    b. All medication errors, actual and potential must be captured and reported.

c. Each discipline should be responsible for taking corrective actions related to medication variances. A report of those errors should be discussed at the Medication Variance Committee meeting
d. A system for reconciling liquid medications is needed.
e. The medical director, CNE, and clinical pharmacist should all actively participate in this process.
f. The Medication Variance Committee should be codified in policy and procedure (N8).

23. The facility should make effort to fill the pharmacy technician position because reconciliation of medications is needed (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o SASSLC Client List o PNMT Staff list o PNMT member Resumes/CVs o PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Minimum Common Elements of Physical Nutritional Management o Settlement Agreement Section O: PNM Audit forms submitted o OT/PT/SLP Assessment template o PNMT Assessment template o PNMT meeting minutes and sign-in sheets submitted o PNMT action plans and ISPs: • Individual #39, Individual #165, Individual #227, Individual #91, Individual #19) o PNMT Comprehensive assessments • Individual #95 Individual #311 o Tracking log of OT/PT assessments completed o Individuals with PNM Needs o List of hospitalizations/ER visits/Infirmary Admissions o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o Graphs/trending summaries o Dining Plan template o Lists of individuals with PNMP monitoring tools in the last quarter o PNM Maintenance Log o Habilitation Therapy Adaptive Equipment (1/18/12) o PNM and check-offs for NEO o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Modified Diets/Thickened Liquids o Individuals with Texture downgrades o Poor Oral Hygiene o Chronic Respiratory Infections o Pneumonias in the Past Year (1/1/11 to 12/31/11) o Individuals with Fecal Impaction

	o Individuals with Choking Incidents and related documentation: • Individual #8 and Individual #94 o Individuals with MBSS in the last year o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals With Decubitus Ulcer During the Past Year o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Orthopedic Devices and Braces o List of competency-based training in the last six months o Documentation of competency-based staff training submitted o PNMPs submitted o APEN Evaluation • Individual #126 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, 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, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165 o PNMP section in Individual Notebooks for the following: • Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165

	Interviews and Meetings Held: o Margaret Delgado-Gaitan, MA, CCC/SLP, Habilitation Therapies Director o Patricia Delgado, RN o Edward Harris, DPT o Joanna Ramert-VanHoove, OTR o Roberta Washburn, MBA, RD/LD o Allison Block Trammell, MA, CCC/SLP o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas, dining rooms, day programs o PNMT meeting o ISP meeting for Individual #31
	Facility Self-Assessment: SASSLC Habilitation Therapies had made a considerable revision to the Presentation Book, expanding the evidence provided to demonstrate efforts directed toward achieving compliance with section O. The self-assessment, previously called the POI, was essentially the same document and remained separate from the action plans for each provision of the Settlement Agreement. The self-assessment continued to consist of a list of activities completed and, in some cases, these were not the same as those listed in the action plan for this section. Most of these activities and actions, however, described more of what occurred during the last six months rather than a description of activities to conduct a self-assessment of substantial compliance. Moving forward, consideration should be given to the areas reviewed by the monitoring team and presenting evidence of actions and progress in those. The audit tools currently in use, and also others in development, will be key indicators of status toward substantial compliance. An analysis of the findings with a discussion of what was working, what was not, and what was needed in the next phase would assist the facility in the ongoing review of the overall strategic plan and to keep a steady pace toward the achievement of compliance. The development of the overall strategic action plan should link to this self-assessment. The Presentation Books for O, P, and R were extensive and provided a tremendous amount of information related to the actions taken, accomplishments, and work products. Even though continued work was needed, the monitoring team wants to acknowledge the tremendous efforts of the PNMT and Habilitation Therapies toward compliance with this section. This was an excellent effort.

	The facility self-rated itself as not in compliance with each of the provision items of section O. Actions taken were definite steps in the direction of compliance, but the monitoring team concurred with noncompliance for O1 through O8.
	Summary of Monitor's Assessment: There was a fully-constituted PNMT, including a full time nurse. The dietitian was an exceptional addition to the team and will likely provide information and analysis that was, until now, missing from the team and the facility. They had met consistently each weekly. A meeting observed during this review showed some improvement since the last review, and the team did a particularly good job with addressing concerns with a parent who attended. Continued experience with the PNMT process will likely result in further refinement. The PNMT decided to initiate review of all individuals with aspiration pneumonia, but other key clinical indicators should also be examined, including bacterial/non-classified pneumonia or significant or consistent weight loss. Only two comprehensive assessments had been completed and these appeared to be more of an extensive record review rather than an actual assessment of the individuals' current status and issues that led to a need for referral to the PNMT in the first place. The action plans were not well organized and it was difficult to discern actions taken, completed, and assessed for their effectiveness. There was no sense of comprehensive action plan outcomes, timelines, people responsible, and clear intervals of review. Documentation was weak with excessive information that detracted from the real issues that required PNMT attention. These concerns were discussed extensively with the PNMT members. Significant supports must be considered to ensure that the team members become better skilled in their assessment of individuals and in the development of intervention plans. Mealtimes and snacks were observed in a number of homes. Observations in home 670 were disappointing because there were implementation and texture errors. Performance in home 674, however, was exceptional and there were some noted improvement in homes 671 and 668. The key to success in some areas appeared to be related to the quality of the supervisors. The successful supervisors were actively involved, were coaching and monitoring staff, and knew what should be done and how to do it. Positioning overall was improved. Staff did not understand the relationship of individual risks and triggers to their duties and responsibilities. Some staff were better able to answer questions about implementation of the plans and this was noted to be an improvement over previous reviews. The PNMPCs appeared to be more confident though some were active in their roles while others appeared to merely supervise and observe. A system of monitoring based on risk level had been developed and implemented.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	Core PNMT Membership: The current core team members of the PNMT included: Patricia Delgado, RN; Edward Harris, DPT; Joanna Ramert-VanHoove, OTR; Allison Block-Trammell, MA, CCC/SLP; and Roberta Washburn, MBA, RD, LD. With the exception of the PT, each of these team members was a full-time state or contract employee. Only the nurse served full-time on the PNMT. Each of the others had additional responsibilities as IDT therapists. Qualifications of Core Team Members Resumes/CVs were submitted for each of the team members listed. Each of the team members had documented more than three years of experience in their respective fields. Only the dietitian appeared to have experience with individuals with developmental disabilities prior to working at SASSLC. As the newest member, the dietitian appeared to bring great enthusiasm and expertise. This had been a significant need at SASSLC and the monitoring team was pleased with her addition to the PNMT. PNMT Meeting Frequency and Membership Attendance Per the sign-in sheets, there were 25 meetings conducted by the team from 8/4/11 to 1/19/12, approximately once each week. Meeting minutes were not submitted for any, but a few of the most recent, meetings. In most cases, more than one individual was reviewed during the same meeting and various members of their IDTs attended the PNMT meetings (these were not counted as individual meetings by the monitoring team). Meeting attendance varied depending on who was being reviewed by the PNMT, so some IDT members participated only in the part of the meeting pertaining to the individual they specifically served. As of 10/6/11, attendance was limited to core team members only. Attendance by core team members from 8/4/11 to 1/19/12 was as follows, based on review of the attendance sheets submitted: • PNMT RN: 96% • RD: 80% • PT: 92% • OT: 96% • SLP: 76% Consistent attendance by the core team members was generally adequate, with the exceptions of representation by the SLP and RD. There was no evidence of a back-up representative for five meetings not attended by the core team dietitian. In the case of the SLP, there was another SLP in attendance for each of the meetings for which minutes were submitted. These are important team members and regular attendance was critical to the provision of appropriate and adequate services.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	<u>Ancillary PNMT Members</u> Ancillary PNMT members were not included in the PNMT meetings at the time of this review. This had been a practice previously, but was discontinued, evident from the sign-in sheets for meetings held after 10/5/11. The team had made this decision to limit the PNMT meeting to core team members only at that time. After discussion with the monitoring team during the week of this review, the PNMT determined that they should reinstate the practice of having IDT members attend their meetings as well as to attend pertinent IDT meetings pertaining to individuals they reviewed. This is a critical practice to ensure that assessment, review, intervention and monitoring are well integrated into the ISP process, especially for risk assessment, and for action plan development and implementation. IDT members who attended the eight PNMT meetings held prior to 10/6/11 included the following: • RN Case Manager: 88% • QDDP: 100% • PNMP Coordinator: 25% • Psychology: 50% • MD: 50% • Home staff: 50% • Pharm.D.: 23% It was of concern that key clinicians, such as a physician or psychologist, for example, did not participate in critical discussions of the health status of these high risk individuals (e.g., Individual #311, Individual #95, Individual #267). Other key staff should include, at a minimum, the QDDP, nurse case manager and psychology, or any other IDT members who know the individual well and should participate in the development of an effective approach to mitigating risks and conditions that resulted in PNMT referral. <u>Continuing Education</u> Continuing education was documented for the OT, PT, and RN core members of the team at the Annual Habilitation Therapy Conference in October 2011. There was no evidence that the SLP or RD had participated in the state-sponsored PNM education opportunities. The OT had also attended a course related to mobility and assistive technology in classroom settings. No additional continuing education was documented for these or other core team members. This level of continuing education was inadequate given that this team should continue to achieve and maintain the highest possible level of knowledge and expertise in the area of PNM. Consideration of PNM-related continuing education opportunities for all team members and outside of only the state-sponsored conferences and webinars should be a priority.	

#	Provision	Assessment of Status	Compliance
		Attendance by core team members and participation by key IDT members was not consistent. As described below, the experience and competence of each of the team members was improved, but not yet to the level of substantial compliance.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>PNMT Referral Process</u> Minutes for the five most recent PNMT meetings were the only minutes submitted. The PNMT reviewed a total of eight individuals since the previous review: Individual #227, Individual #267, Individual #311, Individual #165, Individual #39, Individual #19, Individual #95, and Individual #91. Only two of these had received a comprehensive assessment (Individual #95 and Individual #311). Full implementation of the core team process to include review of all referrals and full comprehensive assessments as determined via the review process was implemented only as of 12/1/11. The reasons for referral were identified, but it was not clear if the referral was made by the IDT or was a self-referral. By report, IDT referrals were extremely limited. Per the self-assessment, the PNMT was to initiate reviews of all individuals with a diagnosis of aspiration pneumonia also as of 12/1/11. Even so, the monitoring team noted that Individual #219 was being considered for a gastrostomy tube placement, but there was no evidence that the PNMT had assessed him to determine if alternative interventions would be effective. The meeting minutes (for five meetings) reflected that the PNMT discussed a variety of other individuals, including everyone who was hospitalized or sent to the ER for any reason. However there was little to no information reflecting actions taken by the team in the cases of Individual #311 and Individual #95 (see below). In addition, the PNMT nurse attended each clinical rounds meeting and took extensive notes that were reported on during each meeting of the PNMT. Post-hospitalization assessments were also conducted by the PNMT nurse and reviewed by the PNMT. The discussion section of the meeting minutes generally indicated that the IDT would manage the health care for these individuals. It appeared that the PNMT nurse did not adequately screen information that required review by the PNMT. As a result, the RN and the PNMT appeared to spend an extensive amount of time reviewing cases that did not necessitate their supports thereby leaving less time for the individuals who clearly did have those needs. There was reference to reviews of the PNMT referral process, though no specific procedures were submitted to the monitoring team. It was stated in the minutes that the physicians did not want to use the process, but rather just write an order. It was stated that the IDTs needed to provide health risk ratings, action plans, and interventions completed prior to PNMT involvement.	Noncompliance

#	Provision	Assessment of Status	Compliance
		PNMT Assessment and Review As of 7/20/11, the PNMT had developed a list of individuals with high health risk indicators and had begun to conduct assessments for those with the most high risk factors. It was stated also on 12/1/11 that they had initiated full PNMT assessments based on a review process. Only two individuals, however, had been provided Comprehensive PNMT assessments (Individual #311 and Individual #95). Other individuals reviewed by the PNMT had not received assessments, but rather PNMT Action Plans. These were separate plans from the IDT-developed plans and were not integrated. The IDT members did not attend the PNMT meetings when these plans were developed. The plans were lengthy and reflected status from each meeting when the individual was reviewed. As such, this may have been a good record for the PNMT, but was cumbersome for other IDT members to discern what supports had been provided or most importantly, the individual's health status. There was no analysis of findings. The PNMT documentation, when included in the individual record, was redundant and difficult to discern specific findings, actions taken, and recommendations. For example, in the case of Individual #267, a slightly revised version of the PNMT Action Plan was in his individual record nine times, and Individual #165 had 16 Action Plans to reflect that the team had met on him (simple progress notes would have sufficed and would have been far more useful to the IDT). The two individuals who had been provided PNMT assessments did not have action plans. The PNMT assessments were consistent in format with like headings. The assessments were difficult to read, however, because the content prompts were not removed from the body of the report and replaced by the actual content provided by the team. In addition, in the case of Individual #95's assessment, significant content was typed with strike through markings. Furthermore, most of the content in both assessments appeared to be based on record review with very little actual new assessment findings reported. There were a wide variety of domains addressed in the assessment reports, but there was a significant lack of new clinical findings and essentially no analysis of the plethora of information obtained from record reviews. Important aspects of each of these cases were not addressed in the assessments, as described below. As such, these assessments cannot be considered to be comprehensive. Individual #95: • She had a significant weight loss over the last year, from 153 pounds in December 2010 to a low of 94 pounds. Her IDT had not met during that time to update her risk ratings or to develop an appropriate action plan to address this significant weight loss until her annual ISP on 10/19/11. • There was no evidence that the PNMT was involved beyond the assessment dated 9/27/11, despite ongoing weight loss since December 2010.	

#	Provision	Assessment of Status	Compliance
		• PEG tube placement occurred on 10/13/11. The IDT provided a body suit/leotard, abdominal binder, and mitten to prevent her from pulling out the tube. After pulling out her g-tube on at least two occasions, the facility director instructed staff to put knots in the sleeves of her body suit to restrict her hand use, per a progress note dated 11/26/11, per mother's suggestion. There was no evidence of an ISPA meeting to address this concern. Restraints to hands resulted in swelling of her right hand, per a progress note dated 11/30/11. • Analysis by the PNMT was that her problem was behavioral, secondary to her diagnosis of Cornelia de Lange Syndrome, and indicated that this was to be addressed by psychiatry and psychology. There was no evidence that the PNMT reviewed her history of self-injurious behavior, aggression, dental concerns, or vomiting reported in her record or determined if there were any correlations to her meal refusals and subsequent weight loss. There were no recommendations other than to monitor her weight monthly. There was no evidence that the PNMT tracked her weight monthly since that time. The most current PNMP submitted from her individual record was dated 9/26/11, prior to tube placement, and as such, did not reflect appropriate PNM supports. Individual #311: • The evaluation report was dated 2/9/12. The reason for referral was recurrent aspiration pneumonia. PEG tube was placed on 1/21/11. Since that time, he had aspiration pneumonia in May, June, September, and December 2011. It was unclear why he had not been referred to, or self-referred by, the PNMT prior to 12/15/11. The documentation submitted was limited only to the PNMT assessment and a few progress note entries. • On 12/12/11 there was follow-up by the PNMT nurse, post-hospitalization for aspiration pneumonia. It was reported that his PNMP had been changed to ensure that he was tilted back slightly for enteral feedings, though this had been recommended by OT seven months earlier. • On 12/20/11 a Head of Bed evaluation was completed by the OT and the RN. Findings were that he was uncomfortable on his right side, and that oxygen saturation levels dropped, and breath sounds were wet and audible, when positioned on his right side. Recommendations in his HOB evaluation and PNMT action plan were reported by the facility. • His PNMT assessment was quite lengthy, with voluminous data and it included attachments. In all of that information, there was no sense of Individual #311 or his issues, but rather only lists of raw data. Only one issue was identified for analysis by the PNMT and involved the findings from the Head of Bed evaluation conducted approximately six weeks prior to finalizing the report on 2/9/12. Review by PNMT reflected extensive record review only; analysis was extremely	

#	Provision	Assessment of Status	Compliance
		limited. The only recommendation was to bathe him on a bathing table rather than a bath trolley because his head could be maintained more upright. <u>Risk Assessment</u> Health risks were reported in the two PNMT assessments, but there was no evidence of review by the PNMT to determine if these were accurate. For example, Individual #95's last rating had been completed by her IDT a year earlier. At that time she was rated LOW for weight concerns, though this was the reason she was referred to the PNMT. Furthermore, the PNMT did not report the most current rating completed by the IDT on 10/19/11 at the time of her annual ISP meeting. There was no evidence that the PNMT and IDTs collaborated to establish appropriate health risk ratings. Risk assessment ratings for the individuals selected in the sample by the monitoring team were requested. The total number of individuals included in the sample was 11. Risk rating tools were included in the individual records for 7 of the 11 (64%) of the sample. There were a number of inconsistencies in the risk ratings for a number of individuals. Though improved since the previous review, the rationales continued to be weak. • Individual #95 was described with aggression, self-injurious behaviors and others and her severe weight loss over the last year was attributed largely to behavioral issues yet she was considered to be only at MEDIUM risk for challenging behaviors per her risk assessment dated 10/19/11. There was no evidence of an action plan for the areas considered to be HIGH or MEDIUM risk. • Individual #94 was identified at LOW risk for constipation per his risk assessment dated 6/22/11, yet was taking 100 ml of GoLytely on a daily basis to prevent constipation. There was no evidence of an action plan for the areas considered to be HIGH or MEDIUM risk. • Individual #325 was considered to be at low risk in a number of areas, including aspiration. The rationale was that he had no episodes of aspiration, but that did not address his actual risk of aspiration. He was listed at HIGH risk for skin integrity concerns. There did not appear to be any additional actions identified to address this concern beyond standard routine care practices. A notation dated the next day, however, reported that skin breakdown on his buttocks had worsened. An action plan for 24/7 positioning, and check and change every two hours was written. It was not clear why these standard practice actions had not been included in the original plan, but only after his condition had worsened. This was an example of reactionary care as opposed to preventive interventions. • Individual #200's risk rating tool was incomplete as submitted. Only one page of the risk rating form was provided, as well as a one page action plan. The rationale for a LOW risk rating for osteoporosis was that he did not have a diagnosis, yet there was no discussion of his actual risks for developing this condition.	

#	Provision	Assessment of Status	Compliance
		• Individual #311 had a risk rating tool dated 8/26/11 with a review on 12/14/11, rather than the completion of a new assessment tool. The only team members present during the review included the QDDP, a direct support professional, the hospital liaison RN, psychologist, and day program representative. An accurate risk assessment could not be conducted effectively without additional key team members participating. In August 2011, it was stated that no action plan was needed because all interventions had been in place since 1/27/11. Unfortunately, they clearly were not sufficiently effective because he had aspiration pneumonias in May 2911, June 2011, September 2011, and December 2011. The PNMT did not attend skin integrity meetings or meetings of the pneumonia committee. The PNMT nurse attended clinical rounds daily to assist in the identification of individuals with PNM-related issues that may have required review and assessment by the PNMT. <u>PNMT Follow-up and Problem Resolution</u> Though difficult to follow due to the format, redundancy, and complexity of the documentation used by the PNMT, follow-through to resolution appeared to be inconsistent. Some examples included: • Individual #165: His action plan contained an objective for the team to determine why he would not stand. There was no follow-up related to findings from a CT scan (8/4/11) and no follow-up related to PT implementing a standing program for 10 minutes on 7/12/11. Another objective was to implement the dentist's recommendations into a training objective. There was no evidence that the PNMT followed-up to determine if it was effective, addressed the dentist's recommendations, or was implemented correctly. • Individual #39: An objective was to ensure that she received a 2200 caloric intake. From 9/1 to 11/23/11, there were no data available related to this training. There was no evidence that the PNMT followed up or pursued this. There was no analysis of her intake though there was a reported weight gain. There was no evidence that the PNMT reviewed Individual #39's status during any subsequent PNMT meeting through 2/16/12. • Individual #95: She had a gastrostomy tube placed on 10/13/11. There was no evidence that her PNMP had been updated since 9/26/11. At that time, she was eating orally only and did not receive enteral nutrition. • Individual #94: A progress note entry by the PNMT dated 2/12/12 noted that the PNMT had discussed his "rapid neuro decline" and that the IDT would manage his healthcare with no further assessment or supports provided by the PNMT. This was decided despite a significant history of falls with injury and choking incidents in the last year.	

#	Provision	Assessment of Status	Compliance
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>PNMP Format and Content</u> PNMPs were reviewed for the 11 individuals selected by the monitoring team, as well as for 10 others who received enteral nutrition, for a total of 21. These varied in format and content. A new format had been developed by the state to address risks, triggers, and outcomes related to the prescribed interventions and supports. None of the PNMPs reviewed had been converted to this format; this was planned to begin as of 3/1/12. There were approximately 257 individuals, or 93% of the current census, identified with PNM needs and provided with PNMPs. Comments related to the 21 PNMPs reviewed are provided below. Improvements in the format and content are indicated and as also noted below in this report, improvement was also observed in the implementation of the plans. • PNMPs were submitted for 21 of 21 (100%) individuals included in the sample. Photographs were submitted for 81% of the plans reviewed. • PNMPs for 21 of 21 individuals in the sample (100%) were current within the last 12 months, though the photographs were undated. • PNMPs for 0 of 21 individuals in the sample (0%) were in the revised format provided by the state. • In 21 of 21 PNMPs reviewed (100%), positioning was addressed. • In 18 of 18 PNMPs reviewed (100%) for individuals who used a wheelchair as their primary mobility or for transport, some positioning instructions for the wheelchair were included, though generally minimal. Pictures were included for most, and the photos were generally large and clear. However, in approximately 12 of the 18 cases, the individual did not appear in the photo to be in optimal alignment and well supported in the seating device. • In 21 of 21 PNMPs reviewed (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 4 of 21 PNMPs reviewed (19%), the PNMP had a distinct heading for bathing instructions. The information related to bathing in all of the plans was generally limited to the number of staff necessary for bathing. The PNMPs consistently listed the equipment needed. None of the PNMPs reviewed provided toileting instructions, though several indicated that two staff were needed for check and change activities. • In 14 of 14 (100%) of the PNMPs reviewed for individuals who were not described as independent with mobility or repositioning, handling precautions or instructions were included. These instructions varied in detail and, in some cases, were limited to the number of staff needed for activities. • In 21 of 21 PNMPs reviewed (100%), instructions related to mealtime were included. Dining plans were also submitted for individuals included in the sample who received oral intake.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• There were 14 of 21 individuals (67%) who had feeding tubes and 12 individuals were NPO (nothing by mouth). This was not clearly stated in their PNMPs for three individuals (Individual #281, Individual #37, Individual #217). Individual #95 was listed with a tube, but this was not addressed in the PNMP. Individual #335 received pleasure feedings and presentation instructions were included. There was no indication, however, as to when or how these were to occur. • In 15 of 21 PNMPs reviewed (71%), dining position for meals or enteral nutrition was provided. There were four individuals who were to remain upright before and during eating, but where this was to occur was not specified. One individual was to have head of bed elevated for enteral nutrition and at all other times, but it did not indicate whether she could also receive a tube feeding while in her wheelchair. • In 6 of 6 PNMPs reviewed (100%), diet orders for food texture were included for those who ate orally. Assistance techniques for oral intake were not consistently provided in the plans. • In 6 of 6 PNMPs for individuals who received liquids orally (100%), the liquid consistency was clearly identified. As stated above, Individual #95 did not have a current PNMP. • In 6 of the 6 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section. • In 21 of 21 PNMPs reviewed (100%), a heading for medication administration was included in the plan. This was shared with oral hygiene instructions and the content was limited to position only. However, this was not always useful. For example, in the case of Individual #165, the instructions were to "encourage head and upper body positioning," but did not describe the intended position or alignment. Texture, liquid consistency, equipment, or presentation strategies were not addressed in any of the plans reviewed (0%). • In 21 of 21 PNMPs reviewed (100%), a heading for oral hygiene was included in the plan. As stated above, the content was shared with medication administration and instructions were limited to positioning only. There were no specific assistance strategies or precautions outlined in this section (0%). • 20 of 21 PNMPs (95%) reviewed included a heading related to communication. Specifics regarding expressive communication or strategies that staff could use to be an effective communication partner varied somewhat, but were significantly improved. In many cases, staff were referred to the Communication Plan for specific communication strategies. Three of the ISPs in the sample were not current within the last 12 months (Individual #241, Individual #325, Individual #302). The ISP for Individual #311 expired the week of this onsite visit. ISP meeting attendance by team members was as follows for the six	

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		current ISPs included in the sample for whom signature sheets were present in the individual record (also see section F above): • Medical: 1 of 6 (17%) • Psychiatry: 2 of 6 (33%) • Nursing: 6 of 6 (100%) • RD: 1 of 6 (17%) • Physical Therapy: 0 of 6 (0%) • Communication: 5 of 6 (83%) • Occupational Therapy: 4 of 6 (67%) • PNMPC: 2 of 6 (33%) • Psychology: 4 of 6 (67%) It would not be possible to achieve adequate integration given these levels of PNM-related professional participation in the IDT meetings. In addition, it would not be possible to conduct an appropriate discussion of risk assessment and/or to develop effective action plans to address these issues in the absence of key support staff and without comprehensive and timely assessment information. PNMPs could not be reviewed and revised in a comprehensive manner. The Physical Nutritional Management Plan was referenced in six of seven of the ISPs reviewed, though review of the PNMP by the IDT was not evident in any of those (0%). There was no consistency as to the manner or content of how the PNMP was addressed in the ISPs. In some cases, strategies were included. In others, it was mentioned only that the individual had a PNMP. It would be extremely difficult for staff to locate information needed to further understand the PNMP. The PNMP was not well integrated into the individual's ISP as a result. ISPAs were submitted for six of seven individuals and, in some cases, the PNMP was discussed relative to changes required in PNM practices for the individual. There were, however, often insufficient IDT members to address the issues and, in some cases, actions were not recommended to address the identified issue: • Individual #108: An ISPA was held on 8/12/11 to review his risk action plan due to concerns documented on his Aspiration Trigger Sheet regarding coughing. The team indicated that the RN and Home Manager would continue to monitor. There was no Habilitation Therapies staff at this meeting. There was no plan for assessment or to review his PNMP to determine the root cause of the coughing. • Individual #94: An ISPA was held on 9/8/11 to discuss a fall with head/facial laceration that required sutures. These injuries occurred despite his wearing a helmet. The IDT was considering a second opinion from an outside neurologist to evaluate the effectiveness of his current seizure medications. There was no evidence of a follow-up ISPA to address findings.	

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		There was no evidence of consistent review by the IDT in relation to identified risk and the efficacy of the interventions implemented. In some cases, statements from the assessments were included in the ISP, but there was no element that indicated the information was discussed or that the PNMP was reviewed by the full IDT. The QDDPs may require greater guidance as to consistent strategies to incorporate PNMP information into the ISPs and action steps.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with limited input by other IDT members. Efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should ensure that there is improved IDT involvement in the development of the plans. Dining Plans were available in the dining areas. 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 positioning strategies outlined in the plan. Wheelchair positioning instructions were generally not specific in the PNMPs. Limited instructions in the PNMP identified that individuals should remain upright. General practice 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 and in individual-specific training provided by the therapists and PNMPCs. <u>Observations</u> Though there was clear improvement in some homes, as stated above, this was less obvious in others. The homes that were most successful had active supervisors and PNMPCs who provided coaching and modeling for staff. They actively intervened when needed to ensure a self-correcting system. Errors were noted in (a) staff implementation, (b) recommendations outlined in the PNMP and/or Dining Plans, and (c) the preparation of food texture modifications provided from the kitchen. Some examples are presented below in hopes that this detail will be useful to the facility: • Individual #72: No support noted under feet during a meal and her legs and feet were dangling as a result. She was served large spinach leaves though she was on a ground diet. • Individual #9: She was served large pieces of potato. She was observed taking large bites and drinking from the Ensure can rather than a cup. Staff required prompting to address each of these issues. • Individual #8: She was observed taking large bites and staff provided only intermittent verbal directives telling her to slow down after prompts from the monitoring team.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #206: She was observed to take a huge bite of spinach without staff intervention. Her Dining Plan had instructions for her to take small sips, but she was noted to drink quickly without staff intervention. • Individual #241: She was served a burrito that was cut into one and a half to two inch size pieces, though she was on a chopped diet. Staff had to be prompted several times to correct this. • Individual #343: She was presented with food and fluids with her head turned to the right rather than at midline. • Individual #200: He was seated in a wheelchair with a soft seat and back. He leaned to the right and laid on his arm throughout the meal. Staff did not reposition or prompt him to sit more upright. • Individual #22: His legs were extended in his wheelchair and, as such, were not adequately supported. • Individual #23: He was noted to cough multiple times throughout his meal without adequate staff intervention. • Individual #121: He did not appear to be sufficiently back in his wheelchair seat or the seat bottom was too short to properly support his thighs. • Individual #230: Staff was observed providing oral hygiene. She brushed Individual #230's teeth for less than 10 seconds, brushing the front teeth only. When asked why she stopped the activity, staff replied that the individual had moved her head back so she stopped at that time. • Staff were noted to stand to supervise and or assist in individuals in many of the homes observed. • Individual #54: He was observed to walk into the dining area with the assistance of four staff. One staff assisted at his walker, one staff held his gait belt, one staff followed behind with his wheelchair, and the fourth staff turned the dining chair and set it up for the transfer to sitting. These strategies were not outlined in his PNMP. • Individual #65: His gait belt was loosely applied to his trunk. The majority of staff were not able to verbalize the rationale for the strategies included in the plan, though several who did answer the questions did so confidently and accurately. By report, drills were conducted by the PNMPCs, but this had not resulted in significant improvements in this area. In some cases, supervisors present in the dining area were not able to correctly answer specific questions, such as what size pieces were required for a ground diet for example. In some cases, the supervisors were noted not to follow the Dining Plan and did not recognize errors by other staff. <u>Choking/Aspiration Events</u> Two individuals were listed with choking events in the last year. Individual #94 had a	

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		reported incident on 2/28/11, though per the SLP this was not an actual choking event. Individual #8 experienced an event on 2/4/11, when she appeared to eat some chopped lettuce from a container in a dining room cabinet. The Heimlich was performed in each case. There was no evidence of review by the PNMT in either case, though an SLP conducted a mealtime observation following each incident.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>New Employee Orientation</u> The NEO training materials had been revised with a greater focus on implementation of the PNMP as of 11/10/11. The check-off process had been updated since the previous review to refine the competency checks for participants. The list of important skills is worth listing below: • Competency for use of a gait belt • Dining Plan review • PNMP quiz • Positioning in a wheelchair checklist • Positioning in a wheelchair test • Head of bed elevation test • Food and liquid texture competency • Mealtime validation • Mealtime competency • Physical management validation • Physical management competency Some of these were written tests and others involved skills-based performance testing. A number of competencies had previously been tested by PNMPCs, but were recently to be transferred to CTD and home management staff. These included the following: • Providing hygiene care in bed or on changing table • Bathing using a shower chair • Stand pivot transfer • Two person manual lift • Two person mechanical lift • Van transfers Competency training for existing staff had been initiated as of 9/21/11 for DSP IIs, DSP IIIs and DSP IVs and was conducted by the PNMPCs in the areas listed above. Additional retraining with check-offs of DSP Is had been initiated during the week prior to this onsite review. Retrained supervisors who had demonstrated competency were to also conduct training, check-offs, and monitoring. By report, supervisors and PNMPCs had not specifically been competency trained to conduct inservice training and check-offs, but rather only a skills-based check off of their performance of a specific activity. It was of	Noncompliance

#	Provision	Assessment of Status	Compliance
		concern that it was not known how well these staff were equipped to conduct training and to determine the competency of other direct support staff. Annual Refresher Training Annual refresher courses were currently being provided in classroom settings and a new iLearn format related to aspiration and mealtime training for existing direct support staff had been developed. Lifting and transfers refresher training continued to be provided. Additional training was provided as indicated in areas related to adaptive equipment, drawsheets, foot wear and general training related to mealtimes. Individual-Specific PNMP Training Inservice training for changes in the Dining Plans and PNMPs were conducted by both therapists and PNMPCs. A general inservice was completed with check-offs conducted with specific staff. The training sheet described the training content and, in most cases, the PNMP or Dining Plan was attached. There was no evidence that this training was competency-based with return demonstration based on the documentation submitted. There were no written procedural guidelines to describe this process to ensure consistency. Trainer Competencies There was no evidence of a training module for PNMPCs. Training was not consistently effective as evidenced by the implementation errors observed by the monitoring team and described above. In some cases, the PNMPCs were noted to work side by side with staff and provided appropriate coaching and support. In other cases, the PNMPC was noted to move through the area while a holding a clip board with minimal interactions noted. In still other cases, the PNMPC was noted to take the lead with tasks rather than to promote skill development with the direct support staff. Further support and training was indicated. It was also of concern that much of the training was being turned over to non-habilitation therapy staff. It is hoped that this will not result in further decline in implementation compliance for PNMPs and Dining Plans.	
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.	Monitoring Staff Competency and Compliance Monitoring of staff competency and compliance was documented on a Meal Observation Form or Physical Management Observation Form. Frequency of this monitoring, conducted largely by the PNMPCs, was reported to be based on risk levels as established by the IDT as of 9/20/11. The Action Plans, however, were not well developed and did not generally address the frequency of monitoring required. There was an effort to promote greater participation by the home staff to conduct monitoring and they were responsible for completing plans of correction for identified concerns. It was reported that monitoring data were tracked and reviewed monthly, but a database for this was not submitted to the monitoring team. However, graphs that showed a by month compliance	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>percentage for six variables related to mealtimes and for six variables related to physical management were submitted. The data were reported, but there did not appear to be an analysis of these results. For example, an improvement or a decline in compliance was not explained and there was no evidence of an action plan to address these.

Though monitoring analysis was requested, only the Settlement Agreement Audit findings were submitted and included in the Presentation Book for this section. Monitoring forms completed by OTs and PTs for the last month were submitted. Physical management monitoring was completed for 28 individuals and mealtime monitoring was completed for 11 individuals in the month of December 2012. Only Individual #259 and Individual #229 were monitored more than one time during the month. Physical management monitoring was completed primarily by the PT assistant (83%) and mealtime observations were completed by OTs and SLPs.

Monitoring for individuals included in the sample for the last three months was requested. Completed monitoring forms were submitted for 10 of the 11 individuals. None were submitted for Individual #95 despite significant PNM-related concerns over the last six months and an assessment buy the PNMT.</td><td></td></tr>
<tr><td>O7</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.</td><td><u>Individual-Specific Monitoring</u>
As described above, the current monitoring system for implementation compliance and staff competency was based on individual risk levels. It was reported that guidelines for monitoring by professional staff had been developed and a protocol to address identified issues. A schedule was submitted in the Presentation Book that outlined frequency of monitoring. The schedule for individuals included in the sample was as follows:

<table>
<tr><th>Name</th><th>Mealtime</th><th>Physical Management</th><th>Medication Administration</th></tr>
<tr><td>Individual #94</td><td>2x year</td><td>1x year</td><td>0x year</td></tr>
<tr><td>Individual #311</td><td>0x year</td><td>24x year</td><td>0x year</td></tr>
<tr><td>Individual #95</td><td>0x year</td><td>0x year</td><td>0x year</td></tr>
<tr><td>Individual #302</td><td>24x year</td><td>1x year</td><td>0x year</td></tr>
<tr><td>Individual #108</td><td>0x year</td><td>12x year</td><td>0x year</td></tr>
<tr><td>Individual #92</td><td>0x year</td><td>2x year</td><td>0x year</td></tr>
<tr><td>Individual #241s</td><td>1x year</td><td>1x year</td><td>0x year</td></tr>
<tr><td>Individual #267</td><td>2x year</td><td>1x year</td><td>0x year</td></tr>
<tr><td>Individual #165</td><td>12x year</td><td>2x year</td><td>0x year</td></tr>
<tr><td>Individual #200</td><td>12x year</td><td>12x year</td><td>0x year</td></tr>
<tr><td>Individual #325</td><td>4x year</td><td>1x year</td><td>0x year</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

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		Monitoring during oral hygiene was not scheduled for any individual. A number of other individuals were noted to be listed at HIGH risk in one or more PNM-related areas, such as aspiration, choking, respiratory compromise, weight, dental, falls, and osteoporosis. Many of these individuals were scheduled for minimal monitoring over a year's time. Guidelines for determining frequency had been developed in September 2011. The guidelines were as follows: • HIGH risk in PNM category: Therapists could choose from 2x/month, 1x per month or every other month. • MEDIUM risk or HIGH risk for falls due to behavior: Therapists could choose from quarterly, twice a year, or annually. • LOW risk or no PNMP required: Therapists could choose from annually or no formal monitoring at all. A number of individuals, however, were scheduled for monitoring that was not consistent with these guidelines. For example: • Individual #94 was considered to be HIGH risk for aspiration, falls, choking and dental, yet he was scheduled only for biannual mealtime monitoring and annual physical management monitoring. • Individual #7 was considered to be HIGH risk for falls and osteoporosis, yet she was scheduled only for annual mealtime monitoring. • Individual #311 was considered to be HIGH risk for aspiration, respiration and dental, yet he was no scheduled for any mealtime monitoring (enteral nutrition). • Individual #164 was considered to be at HIGH risk for aspiration and had been diagnosed with aspiration pneumonia in the last year. He was not scheduled for mealtime monitoring (enteral nutrition). Additional monitoring was conducted by the PNMPCs on a more frequent basis for most individuals, though it could not be determined how this was scheduled based on the documentation submitted. A protocol was developed in conjunction with the Unit Directors outlining specific actions to be taken when issues were noted, including negative trends in specific areas. This involved plans of correction and was implemented on 1/1/12. Based on monitoring forms submitted, there was often a follow-up monitoring conducted, but this did not always involve the staff who had made the error. PNMPs were revised as needed throughout the ISP year. Review of the plans occurred during annual assessments as of 1/15/12. Changes were not always documented via an ISPA, however. It was reported that reviews by the IDTs were occurring, but it was not reflected in the documentation. The ISP process was again undergoing changes and it is hoped that this will be addressed via implementation of those modifications. The	

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		monitoring team looks forward to seeing improvements with this over next six months. Effectiveness Monitoring As described above, effectiveness monitoring of the PNMPs was limited to annual assessment, with changes in status, or by request. There did not appear to be an elevated level of review of effectiveness of plans for individuals with increased risk beyond the compliance monitoring. There was no proactive system of quarterly reviews, and in most cases, the effectiveness of interventions and supports were not specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. Validation of Monitoring by PNMPCs There did not appear to be validation monitoring of the PNMPCs by professional staff at this time. It is critical that some level of ongoing validation is conducted so as to ensure the quality and consistency of the monitoring conducted by the PNMPCs.	
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.	Individuals Who Received Enteral Nutrition There were 55 individuals listed who received enteral nutrition. Individual #90, Individual #92, Individual #301, Individual #126, Individual #116, Individual #121, and Individual #151 were listed as also receiving oral pleasure feedings. The PNMP for Individual #335 indicated that he received oral pleasure feedings, but he was not on the list submitted. The facility is commended for reviewing the potential for oral intake for individuals who received enteral nutrition. The clinical pathways for return to oral intake was a step-by-step process and, while an individual may not be immediately ready for this, there may steps that could be initiated to move him or her along this continuum. This should be an ongoing consideration via the APEN assessments (see below) and an aspect of the action plans developed by the IDTs and PNMT. There were seven individuals who had tube placements in the last year: Individual #95, Individual #121, Individual #36, Individual #61, Individual #165, Individual #219, and Individual #199. No one listed as recently placed on enteral nutrition was listed with a diet downgrade. Individual #149 was listed with a date of tube placement as "to be announced" (TBA). Only Individual #165 and Individual #95 had been reviewed by the PNMT. Each individual with tube placement or who was at risk for tube placement should, at a minimum, be reviewed by the PNMT, if not provided a full comprehensive assessment. There were five individuals who received enteral nutrition who were also listed with poor oral hygiene (Individual #32, Individual #311, Individual #37, Individual #259, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #61). Both Individual #311 and Individual #259 had multiple incidences of aspiration pneumonia. The list submitted that identified individuals with aspiration pneumonia in the last 12 months included 22 incidences for 17 individuals since 12/12/10. Another list identifying the occurrence of pneumonia in the past year included 32 incidences for 22 individuals. This list reported that there were 19 incidences of aspiration pneumonia for 13 individuals (though three cases were described as hospital acquired). There were nine cases of bacterial pneumonia or non-classified that would not necessarily be ruled out as aspiration. Individual #108, Individual #116, Individual #200, Individual #19, Individual #311, Individual #40, and Individual #91 each had more than one instance of pneumonia. The PNMT determined that they would begin to review/assess each individual who received a diagnosis of aspiration pneumonia. This would be appropriate, though it would also be necessary to review any individual who also had multiple episodes of pneumonia, due to the impact this would have on his or her health status. It is not always possible to accurately classify the type of pneumonia an individual has. Regardless, PNM supports and interventions, as well as potential for preventative strategies, must be considered, necessitating assessment by the PNMT. The correlation between poor oral hygiene and bacterial and aspiration pneumonia should be considered by the team. <u>APEN Assessments</u> A sample of APEN assessments was requested for 10 individuals for whom these were completed since the previous review. Only one was submitted for Individual #126. It was difficult to imagine that with 55 individuals receiving enteral nutrition and the requirement that the APEN was to be completed annually that no others had been completed in the last six months. A measurable outcome was outlined for Individual #126 indicating that he would have three or less episodes of aspiration pneumonia through 8/12/11 (this was likely a typo that should have read 8/12/12). At any rate, that would be an unacceptable outcome for most individuals, but particularly for him because he had not had presented with pneumonia since November 2010. There was no discussion or analysis of the clinical findings of that study other than he had aspirated liquids, consistency not specified. There was no discussion of his potential for even pleasure feedings of liquids in any form or of solids. It was also reported that there was "no benefit to advanced strategies as he is uncooperative for oral hygiene efforts." His oral hygiene status was listed as poor and there was no indication that the IDT had considered any desensitization program or other interventions to address his resistance to oral hygiene care.	

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		Pathway to Return to Oral Intake The facility was to be commended because they had initiated assessments for oral intake for five individuals who received enteral nutrition. One of these individuals had begun pleasure feedings as of 12/22/11 (Individual #335) and continued to be successful with oral intake at the time of this review. PNMPs All individuals who received enteral nutrition in the selected sample had been provided a PNMP that included the same elements as described above.	

Recommendations:

1. Collaborate to design a better system to document the actions taken by the PNMT (O1).

2. Devise a system to access the existing data of risk, and occurrence of key clinical indicators and/or diagnoses to drive better identification of a need for PNMT review. This should effectively impact the referrals from the IDT as well as for self-referral (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 record review and history or a team that polices the IDT. 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. Use caution in the determination as to the need for assessment versus review only (O.2).

4. An action plan should be developed to drive the assessment and recommendations. A continuation of the plan should be integrated with the IDT in order to accurately and collaboratively complete the health risk assessment and action plan (O1 and O2).

5. Assist the PNMT nurse in sorting out what is critical to do and what is not. Improved system of documentation should also assist with this (O1).

6. Re-engage participation by the IDT in the PNMT assessment and action plan process (O1).

7. 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 and O7).

8. Consider a system of drills for modeling and coaching with staff, perhaps a "flavor of the week" approach. Selection of a particular theme with a focus of training, coaching and review would heighten staff awareness of these concerns and would likely yield overall improvements (O3-O6).

9. The IDTs continue to require support regarding risk assessment and real time modeling to effectively complete risk assessments and action plans. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks (O2).

10. The PNMP should include more essential content related to oral hygiene and medication administration beyond positioning that is currently provided. Head alignment, collaboration with dental hygienist to outline specific strategies and other instructions may be necessary for individuals with significant aspiration risk or poor dental hygiene status. Medication administration may need to outline equipment and special preparation related to food textures or liquid consistencies (O3 and O4).

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 Admissions list o Budgeted, Filled, and Unfilled Positions o OT/PT Staff list o OT/PT Continuing Education documentation o Section P Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section P-Physical and Occupational Therapy o Settlement Agreement Section P: OT/PT Audit forms submitted o Individuals receiving direct OT/PT o OT/PT/SLP Assessment template and checklist guidelines o Tracking log of OT/PT assessments completed o Individuals with PNM Needs o List of hospitalizations/ER visits/Infirmary Admissions o PNM Monitoring tool templates o Completed PNMP Monitoring Forms submitted o Lists of individuals with PNMP monitoring tools in the last quarter o PNM Maintenance Log o Habilitation Therapy Adaptive Equipment (1/18/12) o PNM and check-offs for NEO o Graphs/trending summaries o Individuals at Risk for Choking, Falls, Skin Integrity, Aspiration, Fecal Impaction (bowel obstruction/constipation), and Osteoporosis o Poor Oral Hygiene o Chronic Respiratory Infections o Pneumonias in the Past Year (1/1/11 to 12/31/11) o Individuals with Choking Incidents and related documentation • Individual #8 and Individual #94 o Individuals with BMI Less Than 20 o BMI Greater Than 30 o Individuals with Greater Than 10% Weight Loss o Falls o List of individuals with enteral nutrition o Individuals Who Require Mealtime Assistance o Individuals with Skin Breakdown in the last 12 months o Fractures o Individuals who were non-ambulatory or require assisted ambulation

	o Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Wheelchair seating assessments/documentation submitted o Individuals Who Use Ambulation Assistive Devices o Orthopedic Devices and Braces o List of competency-based training in the last six months o PNMPS submitted o OT/PT/SLP Assessments for individuals recently admitted to SASSLC: • Individual #283, Individual #350, Individual #285, Individual #114 o OT/PT Assessments, ISPs, ISPAs, SAPs and other related documentation for the following individuals receiving direct PT • Individual #127, Individual #48, Individual #215, Individual #270, Individual #227, Individual #336, Individual #51 o OT/PT Assessments and ISPs for the following: • Individual #311, Individual #25, Individual #89, Individual #114, Individual #235, Individual #87, Individual #298, Individual #244, Individual #327, Individual #150, Individual #194, Individual #216, Individual #304, Individual #86, Individual #279, Individual #349 o OT/PT/SLP Assessments for the following: • Individual #72, Individual #106, Individual #5, Individual #43, Individual #41, Individual #250 o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, 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, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following: • Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165 o PNMP section in Individual Notebooks for the following: • Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165 o PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following: • Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and

	Individual #165 Interviews and Meetings Held: o Margaret Delgado-Gaitan, MA, CCC/SLP, Habilitation Therapies Director o Edward Harris, DPT o Joanna Ramert-VanHoove, OTR o Cynthia Buckmeyer, PTA o Leesa Cotton, DPT o Kelsey Wallin, DPT o Kristi Tuck, OTR/L o Maureen Quinn, OTR/L o PNMP Coordinators o Various supervisors and direct support staff Observations Conducted: o Living areas, dining rooms, day programs o ISP for Individual #31 o OT/PT/ST consultation in Sensory Skills area
	Facility Self-Assessment: SASSLC Habilitation Therapies had made a considerable revision to the Presentation Book, expanding the evidence provided to demonstrate efforts directed toward achieving compliance with section P. The self-assessment, previously called the POI, was essentially the same document and remained separate from the action plans for each provision item of the Settlement Agreement. The self-assessment continued to consist of a list of activities completed and in some cases were not the same as those listed in the action plan for this section. Most of these activities and actions, however, described more of what occurred during the last six months rather than a description of activities to conduct a self-assessment of substantial compliance. Moving forward, consideration should be given to the areas reviewed by the monitoring team and presenting evidence of actions and progress in those. The audit tools currently in use, and also others in development, will be key indicators of status toward compliance. An analysis of the findings with a discussion of what was working, what was not, and what was needed in the next phase would assist the facility in the ongoing review of the overall strategic plan and to keep a steady pace toward the achievement of compliance. The development of the overall strategic action plan should link to this self-assessment. The Presentation Book for P was extensive and provided a tremendous amount of information related to the actions taken, accomplishments, and work products. Even though continued work was needed, the monitoring team wants to acknowledge the tremendous efforts of the PNMT and Habilitation Therapies toward compliance with this section. This was an excellent effort.

	The facility self-rated itself as not in compliance with each of the provision items of section P. Actions taken were definite steps in the direction of compliance, but the monitoring team concurred with noncompliance for P1 through P4.
	Summary of Monitor's Assessment: The most significant change in this area was the level of staffing, with increases in OT and PT clinicians. The therapists appeared to be knowledgeable and enthusiastic. Though this level was an improvement, the contract therapists were in short term contracts with an option to roll over after three months. There was a great concern for continuity. There was a significant amount of on the job training that had to occur that was time intensive, though apparently quite effective for the clinicians currently on board at SASSLC. There needs to be a clear plan for orientation to ensure consistency of the information passed on to new therapists joining the facility. There was a sound assessment template with guidelines for the comprehensive assessment. The assessments definitely continued to improve. This was discussed extensively with the clinicians with suggestions for improvement provided by the monitoring team. The OT and PT clinicians conducted their annual assessments together and the SLPs had begun to participate in the assessment process, too. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment, such as wheelchairs, and to review other supports and services. In those cases the assessment report was a combined OT/PT/SLP document. The PNMPs continued to be reviewed, with improvements noted in many areas. Positioning, in general, appeared to be improved, though attention to personal body mechanics used by staff continued to need improvement. Review of gait belt use was also indicated. A number of individuals with gait belts did not appear to require them and/or they were not used correctly. Some staff were more confident in their responses to the monitoring team's questions and appeared to have a better understanding of why they were doing what they were doing in relationship to the PNMP. This was likely associated with the skills drills and ongoing coaching with staff related to risks and to the rationale for interventions and supports. Continued implementation of this process 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. There continued to be a limited number of individuals participating in direct PT and there were none receiving direct OT services. The PT interventions were generally well documented, though there were some who had not received a recent assessment. Measurable objectives were noted for each, though the data collected did not always clearly relate. There was inconsistency in the rationales provided to continue or discharge from services.

#	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.	<u>Current Staffing</u> At the time of this onsite review, Margaret Delgado-Gaitan, MS, CCC/SLP continued to serve as the Department director. OT/PT staffing had changed since the previous review. Physical therapists included Edward Harris, DPT and Cynthia Buckmeyer, PTA, both previously employed at SASSLC with additional contract services from Leesa Cotton, DPT and Kelsey Wallin, DPT. Contract OTs included Kristi Tuck, OTR/L, Maureen Quinn, OTR/L and Joanna Ramert VanHoove, OTR/L. Mr. Harris' contract was for 32 hours a week while all others were full time. Only Ms. Buckmeyer was hired as a state employee; each of the others were contract. While these staff numbers were a significant improvement since the previous review, it was likely to be short term. Contracts for four of the staff were short term contracts (three months) and they had extended these at least once. By report, they would not renew again and, as such, their contracts would suspend in April/May 2012. There were plans to attempt to replace these clinicians. It takes a significant amount of time to adequately orient any new employee and this process must be repeated each time there was turnover in clinicians. This will likely impact the department's progress with the elements of this provision on an ongoing basis as a result. At the time of this review, the census at SASSLC was 276 individuals. The reported number of individuals with PNM needs was 257 or 93% of the total census. Ratios based on the current census were approximately 1:92 for OT and PT and approximately 1:85 based on the number of individuals with identified PNM needs. Ms. Buckmeyer was not included in the ratios because she was not licensed to complete assessments and design interventions supports. Her role was critical, however, in that she was able to provide training, supervision of technicians and PNMPCs, assist with data gathering, provide monitoring, and provide direct/indirect supports. These ratios were too high to ensure adequate provision of necessary supports, particularly because both Mr. Harris and Ms. VanHoove also had dual responsibilities on the PNM Team as described in section O. There was one PT technician and one OT technician, plus seven PNMPCs. There were two wheelchair fabricators. These positions had been relatively stable over the last six months. <u>Continuing Education</u> Mr. Harris, Ms. Buckmeyer and Ms. VanHoove had attended the Texas DADS-sponsored continuing education offering, "Issues in Evaluation and Treatment of Individuals with Developmental Disabilities on October 13-14, 2011. Mr. Harris also had attended the 20th Annual Habilitation Therapies Conference and Ms. VanHoove had also attended "Access to	Noncompliance

#	Provision	Assessment of Status	Compliance
		Mobility and AT in Classroom Settings: Applications Workshop. The other clinicians had reportedly not attended any continuing education in the last six months. Although it was recognized by the facility that supporting continuing education may be difficult to justify for the clinicians who fill short term contracts, it would be important that they minimally attend those opportunities provided by the state. It was not clear if the four new contract therapists came to SASSLC after the Conference that the other clinicians attended, but in the future, this should be a requirement for all contract staff. Additionally, it will be important that all clinicians be supported to attend PNM-related continuing education opportunities beyond that offered by the state to ensure that they expand their knowledge and skills. A key area to obtain more training would be related to wheelchair assessment and should be considered a priority for the therapists at SASSLC. <u>New Admissions</u> There were four individuals newly admitted to the facility since the last onsite review. Each had a comprehensive assessment including OT, PT, and speech dated within one month of their admission dates. Unfortunately, the copies submitted to the monitoring team did not show signatures and, as such, it was not known when the assessments became available to the IDT. <u>OT/PT Assessments</u> A new assessment format was used at the facility based on the one developed by the state that included assessment by OT, PT, and SLP. This new outline included medical history and current health issues that would impact the delivery of OT, PT, and speech services. A section of the report addressed the identified risk levels established by the IDTs. The outline also included sections to address the clinicians' analysis of findings, recommendations, measurable outcomes, monitoring schedule, interval for reassessment, and considerations for community placement. The checklist and guidelines were only recently developed and were shared with the monitoring team during the onsite review. Results of these audits will be a focus of the monitoring team's during the next onsite review. The most current assessments for each clinician were requested by the monitoring team for review. Twenty assessments were submitted, including six Habilitation Therapy Comprehensive Assessments OT/PT/SLP that were in this new format and 14 old-style Comprehensive Evaluations (OT/PT). Additional assessments were included for 75% of the sample individuals requested by the monitoring team (i.e., 9 of 12). The assessment for Individual #94 was dated 6/27/01 and was not current. No records were submitted for Individual #234, and there were no OT/PT assessment submitted in the records for	

#	Provision	Assessment of Status	Compliance
		Individual #95. Four of the assessments were Comprehensive OT/PT assessments (Individual #267, Individual #108, Individual #311, and Individual #165), four were Comprehensive OT/PT/SLP assessments (Individual #302, Individual #241, Individual #200, and Individual #325), and one was a PT/PT/SLP Evaluation Update (Individual #92). Assessments for individuals listed as participating in direct OT and/or PT services were also requested for seven individuals, but five were received (assessments for Individual #270 and Individual #48 were not submitted). The assessment for Individual #127 was dated 8/19/10 and was not current within the last 12 months (as would be expected for an individual participating in direct therapy). The remaining assessments included OT/PT Comprehensive Assessments (1), and Habilitation Therapy Comprehensive Assessments OT/PT/SLP (3), each current within the last 12 months. Assessments for four individuals newly admitted to SASSLC included two OT/PT assessments and two OT/PT/SLP assessments. The total number of assessments reviewed was 37. Comments and analysis by the monitoring team of these 37 assessments was as follows: • 95% of the assessments were dated as completed prior to the annual ISP meeting, though some were done less than one week prior. Individual #215's assessment was undated for his ISP on 3/16/11. The assessment for Individual #267 was dated 9/12/11, the same day as his ISP. • 43% of the assessments were completed using the new Habilitation Therapy Comprehensive Assessment OT/PT/SLP format. • 33 of the 37 assessments (89%) were consistent with the outline submitted. Assessments for Individual #215 (undated), Individual #165 (4/4/11), Individual #108 (5/26/11), and Individual #92 (7/13/11) were of a different format. Individual #92's assessment was an OT/PT/SLP Update. • Of these 33 assessments:: o 0% of these identified the date of the previous assessment. o Most of these were copies of the originals, and were unsigned or undated. o 97% of these included a Summary and Analysis section. o 100% of these included a Recommendations section. o 46% of these included suggestions for training objectives for implementation in the home or through OT/PT. o 57% of these included a monitoring schedule. o 89% of these included a reassessment schedule. o 62% of these included opinions whether the individual could be served appropriately in a community setting. Overall, the assessments were improved, though there were no sections of the assessments that identified any personal outcomes, goals, or skills to be taught, such as	

#	Provision	Assessment of Status	Compliance
		what might have been taken from each individual's Personal Focus Assessment, or from the ISP's strengths, challenges, and preferences. The analyses sections were brief, though improved, especially the more recent ones. A number still did not consistently provide a rationale for the recommendations offered. Comments on some of the assessments are below: • Individual #106: Per his assessment dated, 11/21/11, he had a reported risk for choking and aspiration and had Parkinson's disease. It was recommended that his PNMP, Dining Plan, and adaptive equipment be evaluated annually, though another recommendation indicated that he would not be re-evaluated until 2014. • Individual #92: Per his assessment update on 7/13/11, he was at high risk for aspiration and received enteral nutrition. His adaptive equipment (standing frame and wheelchair) was to be reviewed annually and he was to continue lower extremity strengthening and coordination exercise. There was no mention of this in his assessment. It was recommended that an updated comprehensive assessment was not indicated unless there was a change in status. Given his health and functional status, it appeared that an annual assessment would be appropriate to ensure that his supports and services were effective. • Individual #5: Per his assessment dated 9/15/11, he had lost weight, experienced a decline in his self-feeding skills, and had approximately 35 falls in the last year. He had a wheelchair in addition to ability to ambulate and transfer with a gait belt. It was not clear when or how often these were used. PT intervention was not recommended. His PNMP was to be monitored twice a year and his Dining Plan quarterly. Further it was stated that a comprehensive assessment would be completed only in the event of a change in status. This was not consistent with the needs described in this assessment.	
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	<u>OT/PT Interventions</u> The primary intervention provided was the PNMP. These were addressed in detail in section O above. Other interventions via direct PT were provided for only a small number of individuals (Individual #270, Individual #227, Individual #48, Individual #336, Individual #51, Individual #127, and Individual #215). There were no individuals who received direct OT services. Documentation was inconsistent related to these direct services. • Baselines or need for therapy interventions were not well established in an assessment (Individual #51, Individual #48, Individual #270). • Changes were not made to the intervention plans to address lack of progress or when goals were achieved (Individual #51). • Measureable goals for direct OT and PT were not included in the ISP (Individual #51, Individual #227). • There was insufficient justification to continue or discharge individuals from	Noncompliance

#	Provision	Assessment of Status	Compliance
	regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	direct therapy (Individual #336). • Assessments did not adequately describe previously or currently provided therapy services with goals and status of progress (Individual #51, Individual #336). • Therapists did not consistently provide interventions when they were on vacation. There did not appear to be a mechanism to make up or cover for missed sessions (Individual #336, Individual #48). • The introduction of direct therapy was not addressed in the annual ISP or via an ISPA when the need was identified in the interim (Individual #51, Individual #270, Individual #336). • Change in status was not consistently addressed via an assessment and ISPA (Individual #336, Individual #48, Individual #270). • Documentation was inconsistent and did not close the loop regarding the status of direct therapy provided, the individual's progress or status (Individual #270, Individual #48, Individual #227). OTs and PTs did not routinely complete a post-hospitalization assessment for individuals upon return to SASSLC. This was the case for Individual #200, Individual #311, and Individual #108, among others. There was a progress note by OT on 12/17/11 documenting an observation of Individual #311's position during enteral nutrition only. This was not a comprehensive assessment and did not include PT or speech. As described above, findings were often not integrated into the ISP. Recommendations (other than the PNMP) were often not included, and there was no evidence of therapist-designed skill acquisition plans or SAPs related to direct therapy services. A new process had been implemented prior to this onsite visit that involved therapy teams making observations in the day program areas and making recommendations to staff as to how to incorporate therapeutic supports into the activities and programs implemented in these settings. This was an excellent first step and should be an ongoing support to ensure that coaching and modeling are provided to staff.	
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.	Competency-based Training Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in section O above. No evidence of competency-based training for the implementation of OT- or PT-designed programs by therapy technicians or by direct support staff was submitted to the monitoring team.	Noncompliance

#	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.	Monitoring A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at SASSLC and addressed in section O above. Recommended frequency of monitoring had recently been included in the OT/PT assessments and the results of monitoring were to be included in the assessment as well. Consistent evidence of this was not noted in the assessments submitted to the monitoring team. There was no consistent method used to document progress related to OT/PT interventions via SAPs. Although some progress notes, discipline specific assessments, weekly progress notes, datasheets, and monthly summary notes were in the records submitted, these were not consistent across the records reviewed. While there were measureable goals in some cases, the documentation related to these interventions was inadequate in providing sufficient data and comparative analysis of progress from month to month. There was also inconsistent justification to continue or discontinue the interventions. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT were included in the routine monitoring of the PNMPs as described above in section O. There were no routine maintenance checks to assess the working condition of the wheelchairs, gait trainers, and adapted chairs, but responses to requests for repairs were completed in a timely manner. Staff were responsible for cleaning the equipment and this was reviewed by the PNMPCs as well. A log of work orders was generated and tracked for completion and timeliness with orders generated through routine PNMP monitoring, routine random checks, and reports by direct support and home management staff.	Noncompliance

Recommendations:

1. There was a continued need to develop programs to address increasing or expanding functional skills. 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. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. A program of this nature could be especially effective if implemented with the SLPs and/or psychology (P1 and P2).

2. Integrate direct and indirect supports into the ISP through the development of SAPs 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).

3. Implement a quarterly maintenance schedule and log (P4).

4. Continue to conduct assessment audits to ensure continued improvement and consistency (P1).

5. Assessments should identify the previous comprehensive assessment and interim updates. The recommendations should include the required frequency of monitoring and the re-assessment schedule for both comprehensives and updates (P1).

6. The assessments should consistently include a review of the efficacy of existing supports and services with concrete justifications for these and all other recommendations in the analysis section (P1).

7. Clarify what constitutes a valid comprehensive assessment and subsequent updates. Ensure that updates reference a comprehensive assessment (P1).

8. Continue aggressive efforts to recruit OT/PT staff including OT, PT, COTA, PTA, and therapy technicians (P1).

9. Include oral hygiene status in OT/PT assessments not only positioning. Consider strategies to address sensory issues that may negatively impact the effectiveness of oral hygiene care (P1).

10. Conduct post-hospitalization assessments for high risk individuals and other PNM-related concerns (P1).

11. Documentation of direct therapy services should state a clear rationale to continue the service, modify the plan or discharge. Measureable goals should be clearly stated and integrated into the ISP. Data collected should link to the expected outcomes and progress notes should summarize progress. Close the loop (P2).

12. Continued implementation of coaching and skills drills 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 (P3).

13. Conduct routine validation of monitoring and training completed by the PNMPCs and home supervisors (P4).

14. Review of gait belt use is also indicated. A number of individuals with gait belts did not appear to require them or they were not used correctly (P2).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, 8/17/10 o SASSLC Standard Operating Procedure: 200-14A Facility Dental Services, 11/17/11 o Standard Operating Procedure: 300-29A Medical/Dental Restraint, undated o SASSLC Dental Operating and Procedure Manual, 7/29/10, revised 12/28/11 o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Section Q Self- Assessment o Presentation Book, Dental o Restraint Reduction Committee Notes, 12/1/11, 12/13/11, 1/13/11 o Dental records for the individuals listed in Section L o Desensitization plans for the following individuals: • Individual #160, Individual #169, Individual #77 o Emergency Treatment documentation for the following individuals: • Individual #220, Individual #7, Individual #39, Individual #155, Individual #24, Individual #62, Individual #292 o ISP Addendums for the following individuals: • Individual #113, Individual #159, Individual #173, Individual #20, Individual #310, Individual #41, Individual #197, Individual #123, Individual #199, Individual #31 o Dental Risk Action Plans for the following individuals: • Individual #159, Individual #284, Individual #58, Individual #38, Individual #18, Individual #88, Individual #60, Individual #114, Individual #11, Individual #349, Individual #121, Individual #250, Individual #22, Individual 287, Individual #25, Individual #236, Individual #123, Individual #270, Individual #155, Individual #200, Individual #126, Individual #273, Individual #15, Individual #259, Individual #165, Individual #51, Individual #319 o Annual Dental Summaries for the following individuals: • Individual #119, Individual #111, Individual #304, Individual #83, Individual #97, Individual #295, Individual #292, Individual #239, Individual #349, Individual #216, Individual #41, Individual #43, Individual #250, Individual #89, Individual #194, Individual #289, Individual #150, Individual #72, Individual #86, Individual #17, Individual #257, Individual #51, Individual #244, Individual #314, Individual #236, Individual #63, Individual #234, Individual #40 Interviews and Meetings Held: o James P. Fancher, DDS, PhD, Dental Services Director o Russell Redell, DDS, DADS Dental Services Coordinator

	o Carmen Mascarenhas, MD, Medical Director o Amy Weimer, RDH, Dental Hygienist Observations Conducted: o Dental department o Informal observation of oral hygiene regimens in residences o Tour of the new dental clinic under construction
	Facility Self-Assessment: SASSLC submitted its self-assessment, which was updated on 2/1/12. The self-assessment provided a very short list of items that were status updates on the initiatives of the dental program. It noted some accomplishments, but also highlighted many areas where progress was lacking and influencing care. The assessment clearly noted self-ratings of noncompliance based on failure to provide a fully functional clinic and a lack of an effective system to address those individuals who could not or would not cooperate with a dental treatment plan. The monitoring team agreed with the self-ratings of noncompliance for both provision items. While this information was helpful, the monitoring team suggest that for future self-assessments, the dental director read each provision item of this report noting the following: (1) activities the monitoring team described that were used in the assessment of the provision item, (2) the topics that the monitoring team commented on and (3) suggestions and recommendations contained in the body of the report as well as the recommendations section. This approach should assist the dental director in developing a series of "activities" that can be completed in order for SASSLC to conduct a self-assessment. Completion of the self-assessment should provide a reasonable sense of where the provision stands relative to substantial compliance. Thus, the dental director would report a self-rating of substantial compliance or noncompliance and provide an objective rational for that determination.
	Summary of Monitor's Assessment: Continued progress was noted in the provision of dental services. The clinic continued to operate in home 637. The size of the space, however, was not adequate to accommodate the equipment needed to perform work with the use of anesthesia. The new clinic was originally scheduled to open by 2/29/12. That completion date was moved back by approximately six weeks. Nonetheless, the clinic continued to operate efficiently. Records continued to be produced electronically and contained good information that was easily understood and informative for the IDTs. A new document was created that was emailed daily to clinical and residential staff. It summarized the clinic's activities of the day, including missed appointments, who received treatment, sedation used, effectiveness of the sedation, and other relevant information. The hygienist was responsible for submitting this on a daily basis. The medical staff found this to be very helpful information.

	Staffing changes occurred in the clinic since the last review. The part time hygienist resigned leaving one full time hygienist. A dental assistant position was allocated, but remained unfilled. The dental director had submitted his resignation, which was effective the last day of February 2012. Steps had been taken to address this change. This represented a potential setback for the facility given the current dental director's high level of involvement in all activities related to dental services. Individuals were seen in their homes when necessary, but the hygienist was no longer visiting homes to provide instruction to the individuals and staff on toothbrushing and oral care. This was unfortunate because the increased presence of the clinic staff in the homes likely contributed to the significant overall improvement in oral hygiene ratings. One disturbing finding noted during the conduct of this review was the delay in treatment that was caused by a lack of consent for use of sedation and consent for treatment. This appeared to be attributed to issues related to the HRC process as well as some individuals lacking a legally authorized representative. It appeared to have been addressed. The dental director reported that implementation of dental recommendations was poor. He also pointed out that assessments for the appropriateness of desensitization plans was slow. Finally, the monitoring team had the opportunity to tour the clinic that was in the process of being renovated. It was clear that much thought and detailed planning had gone into development of the clinic. The physical space was a generous one and the framework had been established to provide full services including the use of TIVA. Moving forward with this clinic should allow the facility to provide the necessary dental services.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these	The dental clinic staff was comprised of a full time dental director and one full time hygienist. The dental director was scheduled to resign at the end of February 2012. Interviews were being conducted to fill the position. The medical director reported that a locum tenens dentist would provide part-time coverage until a new dental director was hired. The part-time hygienist resigned and a dental assistant position was added, but that position remained unfilled at the time of the review. <u>Provision of Services</u> The dental director reported that the current clinic was a bridge clinic that was capable of providing only basic dental services. 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. Even so, it was reported that these services did not adequately meet the needs of the individuals supported by the facility. Dental treatment was aggressively pursued to the extent	Noncompliance

#	Provision	Assessment of Status	Compliance
	standards.	possible given the current resources. The number of clinic visits is summarized below:	

Dental Clinic Appointments 2011							
	July	Aug	Sep	Oct	Nov	Dec	Total
Preventive	41	75	58	66	47	40	327
Restorative	4	2	3	1	1	2	13
Emergency	0	3	0	2	1	1	7
Total Appointments	71	115	84	121	59	66	516

In addition to the individuals seen in the onsite clinic, seven appointments occurred off campus.

Emergency Care

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. The dental records for the seven individuals who received emergency (unscheduled) dental services were reviewed. Two individuals received appropriate care and did not require any additional procedures. One individual had no dental issues noted during the exam. Four individuals needed treatment that required consent for sedation or for the procedure.

Documentation in the dental treatment notes indicated that definitive treatment was delayed due to the lack of consent for three individuals. While the procedures were delayed, all of the individuals received immediate care, pain relief, and antibiotics as indicated. The records did not contain documentation of resolution for the three individuals. Several examples of issues related to emergency care are noted below.

Individual #220 was first seen on 12/12/11 due to trauma related to a fall. The individual required one extraction and one restoration. On 1/4/12, the individual was seen back in clinic, but treatment was not successful. The individual required anesthesia for treatment and a consult was initiated. The resolution was not documented in the records provided.

Individual #7 was seen on 8/26/11 with a tooth fracture following a seizure. Local oral care was provided. The individual had an outstanding consent from June 2011. Follow-up on 8/30/11 indicated that the individual was healing well.

Individual #39 was seen on 8/3/11 after sustaining trauma. Consent was needed for restoration and was obtained on 8/4/11 when the dentist met with the sister. The restoration was completed on 9/7/11.

#	Provision	Assessment of Status	Compliance
		Individual #155 was seen on 8/29/11 with a tooth fracture. The consent process was initiated. As of 12/29/11, the consent remained outstanding. Individual #24 was seen on 10/18/11 with an uncomplicated enamel fracture. The consent process was initiated. A follow-up exam, using oral sedation was done on 11/3/11. Additional sedation was required to complete restorative work. This required that new consents be obtained. <u>Oral Hygiene</u> In the summer of 2010, the hygienists started visiting the homes two days each week to provide toothbrushing instruction to the individuals and staff. Due to the reduction in staff, these home visits were suspended. The facility tracked oral hygiene ratings on a quarterly basis. Data were represented in graphs and provided to the IDTs. The facility's aggregate hygiene ratings are summarized in the table below:	

Oral Hygiene Ratings 2010 - 2011			
Quarter	Poor %	Fair %	Good %
12/31/10	62	31	7
3/31/11	48	42	10
6/30/11	39	43	18
9/30/11	47	38	15
12/31/11	33	47	20

These data indicated that oral hygiene status for individuals supported by the facility improved. This was a significant accomplishment for the facility.

The dental director indicated that the IDTs were given a great deal of information about the oral health and needs of the individuals. Nonetheless, it was reported that the implementation of recommendations was poor. The IDTs were required to complete action plans based on risk assessment. The monitoring team reviewed several plans which provided training objectives, action steps, monitoring frequency and outcomes. The documents provided did not provide status updates, so a determination about actual implementation was not clear.

Individuals at risk for aspiration were assessed for the additional needs, such as suction toothbrushing and mechanical toothbrushes. There were currently 19 individuals enrolled in the suction toothbrushing program.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td><u>Staff Training</u>
Direct care professionals received training in oral care during new employee orientation. In late January 2012, the facility implemented a requirement for direct care professionals to complete annual training on the provision of oral care. Completion of this training, which was offered through iLearn, was required by March 2012.</td><td></td></tr>
<tr><td>Q2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.</td><td><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 infection control, and radiology safety. The policy was revised in December 2011. The facility dental services policy was implemented in November 2011. This was essentially a localization of state issued policy.

<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.

<table>
<tr><td colspan="7">Annual Assessment Compliance 2011</td></tr>
<tr><td></td><td>July</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td><td>Dec</td></tr>
<tr><td>Exams Completed</td><td>14</td><td>17</td><td>45</td><td>22</td><td>16</td><td>15</td></tr>
<tr><td>Compliant Exams</td><td>8 (57%)</td><td>11 (65%)</td><td>37 (82%)</td><td>21 (95%)</td><td>12 (75%)</td><td>3 (20%)</td></tr>
<tr><td>Noncompliant Exams</td><td>--</td><td>--</td><td>--</td><td>--</td><td>4 (25%)</td><td>12 (80%)</td></tr>
<tr><td>Last Exam Unknown</td><td>6 (43%)</td><td>6 (35%)</td><td>8 (18%)</td><td>1 (5%)</td><td>0</td><td>0</td></tr>
</table>

For the months of July 2011 through September 2011, several individuals were reported to have an unknown last exam date. Compliance for those months was based on the number of exams that were documented to be completed in a timely manner (no later than the anniversary month). Clinic tracking data for the month of December 2011 indicated that clinic did not occur on several days due to mandatory training for the dentist, leave, holidays and a facility lockdown.

The facility will need to address the low compliance with the requirement for completion of annual assessments.

<u>Dental Records</u>
Dental records consisted of initial/annual exams, oral hygiene evaluations, dental progress/treatment records, and entries into the integrated progress notes. The annual dental summary was developed as a tool to share information with the IDTs. This document presented a concise summary for review and included risk assessment, treatment provided, oral hygiene ratings, self-care assessments, present conditions,</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		needs, behavioral assessment, and recommendations. The summaries reviewed contained very detailed information regarding recommendations to the IDTs on the home oral care that was needed. The majority of the individuals had either fair or poor hygiene ratings and the need for better home care was identified in almost every assessment reviewed. 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. <u>Failed Appointments</u> The clinic schedule was usually distributed one week in advance of clinic. Each morning, the nursing staff was reminded of the clinic schedule. Data were collected on failed appointments and distributed each month to the QDDPs, residential staff, and the residential supervisors. The data provided by the facility are summarized in the chart below.	

Missed Appointments 2011						
	July	Aug	Sep	Oct	Nov	Dec
Refused	5	3	4	3	0	2
Other Missed/Failed	4	11	7	5	4	14
Total Missed	9 (13%)	14 (12%)	11(13%)	8 (7%)	4 (7%)	16(24%)
Total	71	115	84	121	59	66

The number of missed appointments in December 2012 was influenced by a campus "lockdown" as well as the days that the dental director was out. He noted that those numbers were not included in calculating the utilization rate which overall for the year was 89%.

The dental director reported that he had frequent communication with various members of the team, particularly the QDDPs, but reported that he rarely received responses to information submitted. The monitoring team requested a list of interventions implemented to address missed appointments. The response included a copy of two email messages. The first was dated 8/4/11 and was sent by the dental director to the home supervisors and QDDPS. It provided information on July's failed appointment data. The email documented concern about the pattern of refusals because four of five refusals involved one home. Additionally, the four missed appointments were a result of individuals not being available due to activities, such as work, outings, and other appointments. The second email, dated 1/2/12, provided data on missed appointments

#	Provision	Assessment of Status	Compliance
		for the year. Also included was a statement that monthly emails were sent with information related to failed appointments. The emails were not available because the system had apparently purged the emails. It was also documented that a request for documentation of interventions was made on 1/9/12 and no response was received. The monitoring team reviewed six ISP addendums that addressed missed appointments. The reasons for the missed appointments included staffing issues, community outings, and double booking of clinics. In each case, the ISP addendum included a reasonable plan of action intended to prevent future occurrences. <u>Dental Restraints</u> The use of sedation and restraints was tracked and monitored by the restraint reduction committee. A summary of pretreatment sedation used on campus and general anesthesia cases done off-campus is provided below.	

Dental Sedation and Anesthesia 2011						
	July	Aug	Sep	Oct	Nov	Dec
Pretreatment Sedation	9	14	17	9	10	12
General Anesthesia	0	1	1	1	1	1

The dentist attempted to treat all patients without the use of restraints. When treatment was not successful, the recommendation was made to use pretreatment oral sedation. A written consult that included input form the primary care physician, the psychiatrist, and clinical pharmacologist was completed. A package including the standard letter, consults from physicians, psychiatrist, and clinical pharmacist were sent to the QDDP in order to obtain consent from the LAR and HRC approval. Each individual was required to have an SAP that incorporated strategies to minimize or eliminate the use of restraints.

The dental director usually attended the Tuesday morning clinical services meetings during which he discussed the sedation cases that were to occur that week. This provided an opportunity for the primary care physicians to discuss any recent changes in the individuals that would impact or perhaps prevent dental treatment.

<u>Informed Consent</u>
The dental director reported and the self-assessment documented that the process for obtaining consent for pretreatment sedation was a limiting factor. Records reviewed indicated there were numerous individuals whose dental treatment was delayed by the consent process.

#	Provision	Assessment of Status	Compliance
		In a sample of Annual Dental Summaries reviewed, the monitoring team identified numerous individuals whose dental treatment including restorations due to decay were delayed by a lack of informed consent. Several of these individual had delays of eight to 10 months documented. The Restraint Reduction Committee Notes indicated that on 12/1/11, the committee was notified that there were 50 outstanding consents. After review by the committee, there appeared to be 22 individuals where consent was needed. <u>Strategies to Overcome Barriers to Dental Treatment</u> The monitoring team requested evidence that the IDTs reviewed, assessed developed an implemented strategies to overcome refusal of treatment. Four ISP addendums were submitted for review. • Individual #310 refused dental treatment. The ISPA indicated that the individual had a psychiatric history and was undergoing medication changes that impacted work and other appointments. The IDT was working with psychiatry to stabilize the individual. • Individual #113 refused to attend dental clinic. The individual had boarded the bus for school and when told about the dental appointment refused to leave the bus. The IDT agreed that appointments would be made prior to the school bus arriving because the individual enjoyed bus rides and going to school. • Individual #159 was late for clinic due to behavioral issues. A PBSP was implemented. • Individual #41 refused dental clinic. Reinforcers were provided and the individual had a training objective to learn about the importance of medical procedures. It was documented that progress was noted. The individual's appointment was rescheduled. <u>Desensitization</u> The psychology coordinator sent an email on 10/28/11 informing staff that the dental director had identified 13 individuals in need of desensitization plans. The staff was instructed that if current plans were successful they should enter those steps into an SAP and submit. Desensitization plans were submitted for two of the individuals on the list. There was no information given on the status of the other 11 individuals regarding assessment for the appropriateness of desensitization plans or implementation of strategies. Three documents were submitted as evidence of desensitization plans implemented since the last review. • Individual #169 refused to attend dental clinic. The ISP addendums were provided. The first was dated 9/1/10 and it discussed the individual's problem and plausible reasons for treatment refusal. The plan provided a series of	

#	Provision	Assessment of Status	Compliance
		progressive steps intended to overcome barriers to treatment. In January 2012, the individual had a successful clinic appointment. • Individual #160 refused to attend clinic. A Dental Desensitization Skill Acquisition Strategy Sheet was submitted. This document did not include an implementation date nor did it discuss the issues related to refusal treatment. It simply stated that the goal was to allow toothbrushing in the dental chair. • Individual #77 refused treatment. A desensitization plan dated 1/12/12 was submitted. It provided information to explain behavioral problems and issues related to oral care needs. The IDT concluded that a formal desensitization plan was not appropriate for the individual. The plan outlined a series of strategies that would be used to help achieve compliance. The plan also specified that progress would be closely monitored. • The monitoring team noted that one individual who appeared on the facility's refusal list several times had documentation of very poor oral health. Individual #83 was not included in the list for assessment for desensitization nor were any strategies or interventions submitted. The Annual Dental Summary dated, 10/11/11, indicated that the individual had "rampant dental decay throughout mouth." This individual had 13 clinic appointments many of which were refused. The dental director provided specific guidance on actions that were needed to assist this individual in receiving treatment and improving oral health. If not already done, the IDT should aggressively address the recommendations. According to dental clinic tracking data, this individual had not received further treatment. During interviews, the dental director reported that the facility was not meeting the needs of individuals in terms of implementing appropriate supports and strategies to increase cooperation and overcome the barriers to treatment. Moreover, it was stated that the desensitization process was essentially non-existent. In order to better meet the needs of the individuals, a new dental restraint procedure was developed and approved in January 2012. This policy required the IDT, with input from the staff psychologist, develop individualized approach to increase cooperation with dental procedures by using a single method or combination of methods including education, behavioral rehearsal, communication training, counseling strategies, relation therapy, self –calming skills, and desensitization. This procedure was applicable for medical and dental restraints. The procedure was thorough, well written, and outlined all steps from consideration of the need to utilize restraints to the process for post monitoring. The medical director and dental director were aware that state office was developing policy related to restraint use and local policy might require revision. Nonetheless, the facility's procedure certainly represented a good start to addressing a complex set of problems identified in this review.	

Recommendations:

1. The facility must move forward with hiring a new dental director (Q1).

2. The dental assistant position should be filled (Q1).

3. The facility should consider hiring a part time hygienist so that home oral hygiene visits may continue (Q1).

4. The facility should explore the availability of additional community resources to serve those individuals whose needs cannot be met by facility provided services (Q1).

5. The facility should ensure that completion of the dental clinic occur as quickly as possible (Q1).

6. 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).

7. The facility should ensure that the IDT implements the recommendations of the dentist unless there is disagreement with those recommendations (Q1).

8. The facility should consider implementing a process to track compliance with the recommendations of the dentist so that the full extent of this problem is clear (Q1).

9. The facility must address and take the necessary steps to ensure that annual assessments are completed on a yearly basis as required by the health care guidelines (Q2).

10. In order to improve attendance at clinic appointments, the facility should ensure that the appropriate processes are in place to provide accurate information to the IDTs and residential services regarding scheduled appointments. (Q2).

11. The appropriate supervisors should determine if facility staff are responding sufficiently to information submitted and requested by the dental department. Corrective action should be implemented as warranted (Q2).

12. The facility must address the consent process currently used due to the substantial delays in treatment that were noted in the records reviewed (Q2).

13. The guidelines set forward in the new restraint procedure should be implemented. There should be extensive collaboration between the medical, dental and psychology departments to ensure that
    a. Individuals who face challenges in receiving dental services are promptly identified
    b. Issues related to the challenges are thoroughly assessed
    c. Strategies and interventions are developed, implemented and monitored for progression
    d. In those cases where a lack of progression is noted, the challenges and barriers are re-evaluated

14. The Restraint Reduction Committee should carefully review the use of dental restraints and ensure that appropriate strategies and interventions have been implemented when chemical restraints have been used (Q2).

15. If not already done, the IDT should review the dental recommendations for Individual #83 and further assess how this individual's oral health is influencing overall health and behavioral issues (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 Admissions list o Budgeted, Filled, and Unfilled Positions o Speech Staff list o SLP Continuing Education documentation o Section R Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section R-Communication Guidelines o Settlement Agreement Section R: Audit forms submitted o Speech Language Communication Assessment template and guidelines o Monitoring Tool templates for Communication and AAC o Individual Communication Monitor audit findings submitted o Completed Communication Monitoring Forms submitted o Communication Objectives Tracking (8/11 to 12/11) o Communication Devices as of 1/11/12 o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o Individuals with PBSPs o List of individuals receiving direct speech services o Communication Master Plan spreadsheet o Screen for Change in Functional Communication template o Tracking Log of Completed Assessments o Communication Plans submitted o Communication Assessments for individuals recently admitted to SASSLC: • Individual #114, Individual 183, Individual #350, and Individual #285 o Communication Assessments, ISPs, ISPAs, SAPs and other related documentation for the following individuals receiving direct speech services: • Individual #112, Individual #335, Individual #31, and Individual #246 o Communication assessments and ISPs for the following: • Individual #348, Individual #95, Individual #152, Individual #219, Individual #180, Individual #240, Individual #194, Individual #127, Individual #55, Individual #119, Individual #41, Individual #40, Individual #234, Individual #106, Individual #77, Individual #72, Individual #101, Individual #317, Individual #236, Individual #289, Individual #32, and Individual #295 o PNMPs submitted o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QDDP, 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, Integrated Progress notes (last 12 months), Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Medication Administration Records (most recent) Habilitation Therapy tab, Nutrition tab and Dental evaluation for the following:

- Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165

- PNMP section in Individual Notebooks for the following:
  - Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165
- PNMP monitoring sheets for last three months, Dining Plans for last 12 months, PNMPs for last 12 months for the following:
  - Individual #94, Individual #326, Individual #311, Individual #200, Individual #108, Individual #92, Individual #241, Individual #267, Individual #302, Individual #95, and Individual #165

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

- Margaret Delgado-Gaitan, MS, CCC/SLP, Habilitation Therapies Director
- Allison Block Trammell, MA, CCC/CLP
- Roland Hoffman, MS, CCC/SLP
- Cynthia Martinez, MS, CCC/SLP
- Bobbie Hook O'Connor, MS, CCC/SLP
- PNMP Coordinators
- Various supervisors and direct support staff

<u>Observations Conducted</u>:

- Living areas, dining rooms, day programs
- ISP meeting for Individual #31
- OT/PT/ST consultation in Sensory Skills area

Facility Self-Assessment:

SASSLC Habilitation Therapies had made a considerable revision to the Presentation Book, expanding the evidence provided to demonstrate efforts directed toward achieving compliance with Section R. The self-assessment, previously called the POI, was essentially the same document and remained separate from the action plans for each provision item of the Settlement Agreement.

The self-assessment continued to consist of a list of activities completed and, in some cases, were not the same as those listed in the action plan for this section. Most of these activities and actions, however,

	described more of what occurred during the last six months rather than a description of activities to conduct a self-assessment of compliance. Moving forward, consideration should be given to the areas reviewed by the monitoring team and presenting evidence of actions and progress in those. The audit tools currently in use, and others in development, will be key indicators of status toward substantial compliance. An analysis of the findings with a discussion of what was working, what was not, and what was needed in the next phase would assist the facility in the ongoing review of the overall strategic plan and to keep a steady pace toward the achievement of substantial compliance. The development of the overall strategic action plan should link to this self-assessment. The Presentation Book for R provided information related to actions taken, accomplishments, and work products. Even though continued work was needed, the monitoring team wants to acknowledge the tremendous efforts of the PNMT and Habilitation Therapies toward compliance with this section. This was an excellent effort. The facility self-rated itself as not in compliance with each of the provision items of section R. Actions taken were definite steps in the direction of compliance, but the monitoring team concurred with noncompliance for R1 through R4.
	Summary of Monitor's Assessment: Staffing levels were improved at the time of this review and it is hoped that these levels can be increased or at least maintained. As always, the SLPs were responsible for communication supports and mealtime supports for the individuals living at SASSLC. These dual roles made the current ratios quite high. In addition, one clinician served as a member of the PNMT, thus reducing her availability for routine caseload responsibilities. Progress with completion of communication assessments per the Master Plan was reasonable. More than half of the individuals had received a comprehensive assessment that was of the current format that was acceptable based on the Settlement Agreement, but a number of those without assessments would not receive these until 2013. The clinicians were including assessments completed in 2010 as comprehensive and those would be questionable in some cases. Communication had been developed and trained for individuals in at least three homes. There was evidence of a concerted effort to establish training objectives related to communication. In some cases, these were directed by the speech therapist as well as collaboration with the home and day program staff. The SLPS are commended for making strides in this area. Consistency of the implementation of AAC and communication plans, however, continued to be problematic. Documentation was absent and there was limited integration in the ISPs. A focus on implementation is needed over the next six months.

	A new training module had been initiated in one home, which was an excellent start in the provision of additional training to existing staff. NEO training had been expanded and the time available was recently increased from one hour to nearly four hours. Each of these was competency-based. While this was a great foundation, these staff would not be able to ensure that communication plans were effectively implemented alone. Clinical staff had limited time for inserting themselves in the environments and daily routines of individuals, however, this will be key to effective assessments, the selection of meaningful and useful communication supports, the development of communication programs, and to provide modeling of how to be an effective communication partner. 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. An effort to this end was the OT/PT/SLP consultation activities initiated in January 2012. Therapy teams were going to day program areas to observe and make recommendations as to how the activities may be enhanced. This was certainly an excellent first step, consideration to expand this, particularly related to communication is critical.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	<u>Staffing</u>: At the time of this review, there were five speech-language pathologists: Allison Block Tramell (full time), Roland Hoffman (full time), Cynthia Martinez (full time), Bobbie Hook (32 hours contract), and Melissa Garcia (32 hours contract). This was a significant increase in staffing since the previous review. The monitoring team is hopeful that this level can be maintained. There was one speech technician. Considering the entire staffing numbers and the current census, the ratio was approximately 1:60 for the full time therapists and 1:48 for the part time therapists. This would be considered a very manageable caseload for communication services only. The speech pathologists, however, had responsibilities for all communication needs and all mealtime needs because all individuals at SASSLC had potential needs in both of these areas. In addition, Ms. Trammell served as the SLP on the PNMT, in addition to her caseload. These factors impacted the operational ratio. <u>Continuing Education</u> Reported continuing education for the SLPs specifically related to communication was as follows Hoffman: 13.5 hours, Garcia: 2 hours, Hook: 6 hours, Martinez: 15.5, and Trammell: 19.25.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The participation in communication-related continuing education during this last review period was very good and the facility is commended for supporting these opportunities. Continued participation is critical to ensure improved clinical assessment and program development skills for AAC and language for individuals with developmental disabilities.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	The Master Plan submitted was dated 1/18/12. Individuals were prioritized based on their needs for AAC as follows: • Priority 1: Nonverbal- good potential for immediate use of AAC (42 individuals) • Priority 2: Nonverbal – likely needs training for use of AAC (112 individuals) • Priority 3: Limited verbal - but may benefit from AAC (41 individuals) • Priority 4: Verbal – no need for AAC (79 individuals) There were a number of individuals who were considered to be Priority 1 who had a previous assessment in 2009 (23) and 2010 (11), that is, 80% of the Priority 1 individuals. Assessments completed during 2009 and 2010 do not meet the standard required by the Settlement Agreement. Only eight individuals who were Priority 1 had assessments (based on the revised communication assessment format) completed in 2011 and 2012; these would be more likely to be considered comprehensive. There were six individuals who had an assessment update since the previous monitoring review (Individual #239, Individual #112, Individual #223, Individual #190, Individual #17, and Individual #123). None, however, had a comprehensive assessment completed after 2010, so the update was based on old style assessments that were not comprehensive. Of these six, Individual #123, Individual #190 and Individual #112 had been provided AAC. Individual #123 and Individual #223 were scheduled for a new comprehensive assessment in 2012. The others would not receive one until 2013. Ten other Priority 1 individuals were listed as scheduled for a new comprehensive assessment during 2012 because their previous assessment was old and did not meet the current standard. Similarly, there were 112 individuals who were considered to be Priority 2. Approximately 51 of these individuals had a communication assessment in 2009 and 2010 and, again, these would not be considered to be comprehensive. While most were scheduled for new assessment prior to the end 2012, at least 20 were not scheduled until 2013. Four individuals had not received an assessment since as long ago as 1990, however, each was scheduled for 2012, per the Master Plan. There were approximately 43 individuals considered to Priority 3. Sixteen had assessments completed in 2011 or in 2012 as of 1/18/12. Ten others had assessments in 2009 and 2010 and 17 had not received a communication assessment since as long ago	Noncompliance

#	Provision	Assessment of Status	Compliance
		as six to 24 years. All but three, however, were scheduled for assessment by the end of 2012. By the end of this year, approximately 193 individuals will have had a communication assessment using the most current comprehensive communication assessment format. Another 84 will receive this by 2013. Although this showed good progress, it was of concern to the monitoring team that nearly half of these were individuals of the highest priority levels and greatest need for AAC or other communication supports. A new Comprehensive Assessment format was in use at SASSLC. Guidelines for content areas had been developed to ensure consistency of these assessments. There were 31 assessments submitted as current since August 2011. Seven of these had been completed since December 2011 and likely represented SASSLC's best implementation of the new content guidelines. None (0%) of these seven assessments included a heading for "behavioral considerations" which had been included as one of the required content areas in the new format. Instead, the PBSP (if there was one) was typically addressed under the heading "general information." The assessments were significantly improved since the previous review by the monitoring team. They were more comprehensive in nature and addressed the individual's current communication status and potential for improvement. Four of the seven assessments made a recommendation for a communication plan to include a communication dictionary and specialized instructions or strategies. Five of the seven assessments included the development of a communication plan that was attached to the assessment. The assessments made a recommendation related to the schedule for a comprehensive assessment, but did not clearly state the need for an interim update for individuals who received communication supports and services. Each of the individuals was to receive a subsequent communication assessment regardless of the need established in the current evaluation. For example, Individual #350 was reported to have no communication needs. She did not have a communication plan or dictionary and did not use AAC. Her assessment was dated 12/5/11 and her next one was to occur in 2014 unless there was a change in status. Likewise, Individual #219's evaluation recommended a subsequent comprehensive assessment in 2014, though communication training objectives were recommended and he had a communication plan that included communication strategies and hearing aids. He would clearly require an interim update on an annual basis with a comprehensive assessment in no more than three years. This was not outlined in his assessment report. Measurable objectives were identified in five of the seven assessments. None of these individuals were listed as participating in direct therapy, though four of the individuals did (Individual #31, Individual #112, Individual #246, and Individual #335). There were	

#	Provision	Assessment of Status	Compliance
		53 individuals listed with communication objectives developed with SLP support or were recommended in the communication assessment. It was reported that 34 of these were not yet included in the ISP or that the current ISP was not yet available at the time of the audit. The others were either included as written, recommended in the ISP, or had been modified by the IDT to some degree. The clinicians are commended for their efforts in this regard to make these recommendations as well as to track the integration into the ISPs. By report, however, actual implementation was not consistent. This was also noted in the documentation reviewed in the individual records on the homes where communication programs were to be completed. There were approximately 131 individuals with Communication Plans in homes 674, 673, and 671. There were approximately 86 individuals who had AAC beyond a communication dictionary and 14 who had some type of environmental control device (though not necessarily communication-related). In addition, there were 37 individuals who used some level of sign language ranging from established use, limited use, or were participating in training related to use of sign language. It did not appear that this training was formalized through training objectives. This was an increase from the previous review, but the clinicians continued to report difficulties with implementation of these devices. An audit system similar to that conducted for OT/PT assessments was being developed for communication assessments to ensure that the content and comprehensiveness was consistent across each of the clinicians. The outline for this was reviewed with the clinicians with suggestions to address functional vision and hearing, to provide functional examples and contexts for expressive and receptive language, and to include skill acquisition data and findings from the monitoring in the evaluation. There was no specific screening or assessment process for those with behavioral concerns and the potential need for AAC, even though the current comprehensive assessment had content areas related to behavior. There was no specific policy related to the identification of behavioral challenges and related communication deficits. It was reported that collaboration did occur with psychology and other IDT members during the ISP and ISPA meetings. Substantial compliance in this area will not be achieved by merely describing the PBSP in 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 to improve and enhance communication skills, is required. In the case of Individual #348 for example, it was stated in his ISP dated 10/4/11, that	

#	Provision	Assessment of Status	Compliance
		the psychologist was working on increasing Individual #348's use of sign language to properly ask for things he wanted. It was reported by the SLP that Individual #348 used sign language inconsistently and that staff should encourage simple signs and gestures for communicating basic needs and wants. A training objective was recommended, but direct speech intervention was not. There was no indication in the communication assessment of the ISP that psychology and speech would collaborate in the development of the training objective, or for the provision of staff training and monitoring. Further work in this area for all individuals with communication-based behavioral needs was indicated. The SLPs had previously participated on the Behavior Support Committee, but this Committee was not functioning well and their time was not well spent there. As the Committee refines its process, the SLPs should become involved again to ensure appropriate collaboration with psychology.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP</u> ISPs, ISPAs, assessments, and documentation were included in the sample records submitted. At least 24 ISPs were reviewed for individuals for whom assessments were submitted and for those participating in direct communication interventions. ISPs were current for 23 of 24 ISPs reviewed. There were: • No descriptions of expressive or receptive communication skills outlined in the ISPs for 42% of the ISPs reviewed. • Limited descriptions of strategies for staff to use were outlined in 41% of the ISPs reviewed. The Habilitation Director reported to have met with the QDDP Director to review the requirement to address how an individual communicates as well as strategies that staff may use to enhance or promote existing communication skills. The only action documented was that the Habilitation Director would remind the QDDPs, but no specific training was provided. <u>AAC Systems</u> The majority of the individual systems provided were intended to be functional and many were portable for use across a variety of settings. Further, there were an increased number of individuals provided with AAC at the time of this review. It was noted, however, that these were not consistently implemented as evidenced by the lack of documentation or data related to these devices in the individual records reviewed onsite with the SLPS. Consistent implementation continued to be a concern and, as such, meaningful and functional use by the individual often did not occur.	Noncompliance

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		Staff Training NEO was expanded and the curriculum was revised. Previously, NEO training related to communication was one hour. It was increased to three to four hours at the time of this review and specific competencies were checked for participants. The class was set up with stations to promote interactive practice during the training class time. Additionally, a three-part training for existing staff related to communication was initiated in December 2011 in home 668 and was taught by speech clinicians. This was to be competency-based and further review of this training will occur in a subsequent review by the monitoring team. By report, all staff had been trained on the individual-specific communication plans in the three homes where they were provided. While the general interactions of staff with the individuals 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. A good first step had been initiated recently. It was to provide consultation by a therapy team (OT, PT, and SLP) in the day program areas (January 2012). Suggestions to enhance existing activities were provided after observations conducted by these teams. It appeared that modeling for these was more limited and was going to occur only in the short term. This would serve as an excellent mechanism to gather assessment data and to determine the effectiveness of communication strategies recommended in the communication assessments and should be implemented on an ongoing basis.	
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	Monitoring System The monitoring system for communication plans and AAC was not consistent at this time. Reviews were scheduled on a quarterly basis by the therapists and monthly by the PNMPCs. A review of the 48 Communication-Hearing Environmental Equipment Observation Forms submitted for January 2012 indicated that 72% of the monitoring conducted had a "no" finding because the equipment was not working, was unavailable, not observed to be in use, or that staff did not provide appropriate prompts. A tracking system was in development to examine trends related to implementation. Observations conducted by the monitoring team also validated these concerns. Some examples included: • Equipment was not available to the individual (Individual #256) • Equipment was not working (Individual #71, Individual #199)	Noncompliance

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	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.	• No SAP in the individual notebook for staff documentation of implementation (Individual #228) • New ISP and SAPs not available to staff (Individual #229) Monitoring of communication programs and systems should be based on level of needs related to communication, though increased monitoring for an individual with changes in risk level would likely warrant monitoring across all areas to assess the impact of health status on functional performance.	

Recommendations:

1. 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 (R1).

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

3. Develop strategies to address deficiencies in the analysis aspect of the communication assessments (R2).

4. Communication strategies appeared to be considered the extent of communication supports, in some cases. While these were often excellent, they generally were a reflection of the individual's current abilities rather than methods to expand skill. Skills training for individuals are a clear need (R2-R3).

5. Current communication abilities, staff strategies, objectives to expand existing skills and a discussion of the effectiveness of communication supports should be addressed consistently in the individual ISPs (R3).

6. Monitoring conducted by the PNMPCs will be functional only, presence of equipment, basic implementation. The system for quarterly reviews by the SLPs is critical and should be a priority. Guidelines and tracking will likely assist with this (R4).

7. Consider resuming participation in the Behavior Support Committee (R2).

8. It is vital that there be a greater collaboration between psychology and speech clinicians throughout assessment, program development, training and monitoring aspects of supports and services (R2).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Individual Support Plans (ISPs) for: • Individual #99, Individual #97, Individual #114, Individual #96, Individual #223, Individual #16, Individual #117, Individual #319, Individual #257, Individual #234, Individual #32, Individual #122, Individual #335, Individual #239, Individual #216, Individual #299, Individual #232 Individual #17 o Skill Acquisition Plans (SAPs) for: • Individual #178, Individual #216, Individual #122, Individual #155, Individual #32, Individual #335, Individual #239, Individual #299, Individual #17 o Quarterly reviews of SAP progress for: • Individual #330, Individual #57, Individual #16, Individual #86, Individual #150, Individual #270, Individual #85, Individual #280, Individual #127, Individual #146 o Dental Desensitization Plan for: • Individual #160 o Section S Work Group Meeting Notes, 10/27/11, 11/22/11 o Skills acquisition observation tool, undated o Section S Presentation Book, undated o SASSLC Self-Assessment, dated 2/1/12 o A summary of community outings per residence/home since the last review o Graphs of engagement data across each home and vocational site for each month of 2011 o A copy of training materials used to teach staff to implement SAPs, 12/5/10 o A list of on-campus and off-campus day and work program sites, undated o A list of individuals who are employed on- and off-campus, undated o Skill acquisition training in the community for August, September, October, November, December 2011 o List of individuals who were under age 22, indicating if each was attending public school and the name of the school (17 individuals) o ISP, ARD/IEP, and recent progress reports for: • Individual #138, Individual #113, Individual #286 Interviews and Meetings Held: o Active Treatment Meeting o Gina Dobberstein, Active Treatment Coordinator o Faculty and staff from San Antonio Independent School District (SAISD) o Mark Boozer, psychologist, SASSLC liaison to SAISD

	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. o Monthly meeting between SASSLC and SAISD, 2/15/12
	Facility Self-Assessment: SASSLC submitted its self-assessment, dated 2/1/12. In the comments/status 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 self-assessment did not, however, describe what activities the facility engaged in to assess whether they were meeting each provision item. The self-assessment should include the activities used in the self-assessment, and indicate how these findings were used to determine the self-rating of each provision item. SASSLC's self-assessment indicated that all items in this provision of the Settlement Agreement were in noncompliance. The monitoring team's review of this provision was congruent with the facilities findings of noncompliance in all areas. The self-assessment established long-term goals for compliance with each item of this provision. Because many of the items of this provision require considerable change to occur throughout the facility, and because it will likely take some time for 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 improvements since the last review. These included: • Development of an interdisciplinary workgroup to identify a plan for achieving compliance with this provision item (S1, S2, and S3). • Initiation of a pilot program to evaluate the effects of the new SAP format, skill acquisition monitoring tool, and the use of an active treatment specialist in two homes (S1). • Establishment of an active treatment meeting to review engagement data, and discuss plans to

	improve engagement in treatment areas that fall below expectations (S1). • Began tracking the implementation of skill acquisition plans in the community (S3). The monitoring team suggests that the facility focus on the following over the next six months: • Expand the new SAP format to all SAPs at the facility (S1). • Begin to graph SAP data to increase the likelihood that the continuation, modification, or discontinuation of SAPs are the result of data based decisions (S3). • Ensure that the SAPs are implemented with integrity (S3). • Increase the implementation of SAPs in the community (S3).

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable 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. Although there had been progress since the last review, as indicated below, more work needed to be done to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance with this provision item. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) 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 skill acquisition plans (SAPs). These were written and monitored by QDDPs (qualified developmental disabilities professionals) and the Active Treatment Coordinator. SAPs were implemented by direct care professionals (DCPs). An important component of effective skill acquisition plans is that they are based on each individual's needs identified in the Individual Support Plan (ISP), adaptive skill or habilitative assessments, psychological assessment, and individual preference. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. As discussed in the last report, the facility recently modified the SAP training sheet/format to include a rationale for the SAP. The purpose of including the rationale on each SAP training sheet was to encourage staff to ensure that the plan was functional and practical for that individual. The monitoring team reviewed 31 SAPs that were in the new format. In 17 of the 31 SAPs reviewed (55%), the rationale appeared to be based on a clear need and/or preference. For example: • The rationale for Individual #155's SAP using signs to communicate was that a speech/language assessment recommended the expansion of his sign language	Noncompliance

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		vocabulary. • The rationale for Individual #122's SAP of using the phone independently was that he enjoyed talking to his mother on the phone, and being able to independently use the phone increased his independence at the facility and in the community. • The rationale for Individual #239's SAP of saying "hi" was that he enjoyed interacting with others, and that saying "hi" was a an appropriate means of his gaining attention from others. In 14 of the 31 SAPs reviewed (45%), however, the rationale was not specific enough for the reader to determine if it was practical and functional for the individual. For example: • The rationale for individual #122's SAP of counting his allowance to staff was "It was determined through the [ISP] discussion that Individual #122 would benefit learning to count back his allowance when receiving it from staff." SASSLC should ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual. Additionally, the monitoring team encountered several skill acquisition plans in the homes that did not appear to be in the new SAP format. It is also recommended that all skill acquisition plans at the facility use the new modified SAP format. Once identified, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • A plan based on a task analysis • Behavioral objectives • Operational definitions of target behaviors • Description of teaching behaviors • Sufficient trials for learning to occur • Relevant discriminative stimuli • Specific instructions • Opportunity for the target behavior to occur • Specific consequences for correct response • Specific consequences for incorrect response • Plan for maintenance and generalization, and • Documentation methodology The new format SAPs contained all of the above components. As discussed in the last	

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		report, however, the maintenance and generalization plans did not consistently reflect the processes of maintenance and generalization. A maintenance plan ensures that the newly acquired behavior occurs following the end of formal training, while a generalization plan ensures that the behavior occurs in all the appropriate situations and circumstances outside of the specific training situation. An example of a good maintenance plan was: • Individual #216's SAP of making a purchase from the vending machine, in which the plan for maintenance was "…after (Individual #216) has mastered the skill and reached criterion he will continue to make purchases in order to maintain this skill." An example of an unacceptable plan for maintenance was: • Individual #239's SAP of allowing staff to brush his teeth, in which the maintenance plan was "(Individual #239) will be taught this skill to increase his oral hygiene skills." Overall, five of the 31 SAPs reviewed (16%) included a maintenance plan that was consistent with the above definition. The plans for generalization were generally more consistent with the above definition. An excellent example of a generalization plan was: • The generalization plan for Individual #17's SAP of purchasing a newspaper read, "The skills involved in making a purchase will be used for all future transactions involving the exchange of money for goods and services." Overall, 13 of the 31 SAPs reviewed (42%) contained generalization plans that were consistent with the above definition. The majority of SAPs reviewed combined the maintenance and generalization plans into one plan. Since maintenance and generalization are different processes, they typically cannot be addressed in the same plan. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. It is also recommended that the facility ensure that all generalization and maintenance plans, be written as plans (i.e., include how maintenance and generalization will be accomplished). Finally, the training methodology for SAPs reviewed consisted of forward chaining and general shaping procedures. The facility was investigating other training methods and was awaiting the development of a new policy in this area.	

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		Desensitization skill acquisition Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures were developed by the psychology department. A list of dental desensitization plans developed indicated that one plan was developed since the last onsite review. It is recommended that the psychology department develop an assessment procedure to determine if refusals to participate in dental exams are primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) would then be developed. It is also recommended that individualized compliance and dental desensitization plans be incorporated into the new SAP format. Outcome data (including the use of sedating medications) from desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail in future site visits. Replacement/Alternative behaviors from PBSPs as skill acquisition As discussed in K9 of this report, SASSLC included replacement/alternative behaviors in each PBSP. The training of replacement behaviors that require the acquisition of a new skill 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 was encouraged to learn that the habilitation department was beginning to assist in the writing of selected SAPs. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs. Service objective programming 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 QDDPs. The monitoring team did not review these plans in this provision of the Settlement Agreement because these were not skill acquisition plans (see section 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 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	

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		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 observed generally positive and caring interactions between staff and individuals at SASSLC. As found in past reviews, the ability to maintain individuals' attention and participation in the activities varied widely across staff and homes. For example, in Home 672 the staff were engaging individuals in a several lively small group activities. On the other hand, in many other homes staff appeared less enthusiastic with the process of active treatment, and the result was poor individual engagement. The average engagement level across the facility was 50%, a decrease from the last two reviews (i.e., 61% and 59%). Interestingly, the engagement data collected and monitored by the facility revealed a substantially higher engagement level. The engagement level of all home and vocational sites for the month of January 2012 (representing a total of 94 observations) averaged 81%. One explanation for the differences between the facility's data and the monitors' could be due to differences in how engagement data were collected. As described above, the monitoring team used a momentary time sample. That is, they observed and recorded as engaged or not engaged based on what they saw at that moment they observed. On the other hand the facility, did a 5-minute time sample. That is, they observed a particular individual for 5 minutes and recorded engagement if that individual was engaged at <u>anytime</u> during the 5-minute observation period. It is generally acknowledged that the facility's method of data collection will yield a higher level of engagement than that used by the monitoring team. The method of data collection does not, however, explain the difference in the trends in engagement observed by the facility and the monitoring team. While the monitoring team noted a decrease in engagement relative to the last review, the facility's engagement reflected relatively stable performance. The differences found in the trend in engagement data could be the result of many variables, such as the number of observations collected (i.e., the facility observes multiple times a month, while the monitoring team only observes once every six months), reactivity (i.e., staff engaging in activities because their supervisors are observing), or observer bias (i.e., the supervisors want to see improvements in engagement), and so forth. It is suggested that the facility consider these, and other possible explanations of differences in the engagement data, and try to better understand differences in the trend of the monitoring team's and the facility's engagement data.	

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		Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
Home 668	1/7	1:7
Home 668	1/7	1:7
Home 674	1/9	2:9
Home 674	0/2	0:2
Home 674	2/10	0:10
Home 672	1/6	2:6
Home 672	3/3	1:3
Home 672	3/4	2:4
Home 766	2/2	1:2
Home 766	1/1	1:1
Home 670	1/7	1:6
Home 670	3/7	2:7
Home 665	1/1	1:1
Vocational classroom	4/7	4:7
Vocational classroom	5 /7	4:7
Vocational classroom	3/8	4:8
Vocational classroom	2/7	3:7
Seniors Program	5/8	3:8
Seniors Program	3/5	1:5
Home 668	2/6	2:6
Vocational Workshop	9/11	3:11
Vocational Workshop	11/14	4:11
Vocational Workshop	6/13	4:13
Home 766	0/3	1:3
Home 665	2/2	1:2
Home 670	5/12	3:12
Home 670	4/10	3:10

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		Educational Services As of the week of the onsite review, 17 individuals were attending public school at three different high schools and one middle school. Mark Boozer, psychologist, and Andrea Blue, QDDP, were the primary liaisons with San Antonio Independent School District (SAISD), however, other psychologists, QDDPs, and related staff were involved as needed, depending upon the particular student. A monthly meeting was held between SASSLC and SAISD on campus at the facility. During the onsite review, the monitoring team observed this meeting. About a half dozen staff from the public school and about a dozen staff from the facility attended. The group talked about every student, one by one. There was good discussion, all related to ongoing education and participation by each student. The monitoring team was impressed with this working relationship. SASSLC continued to incorporate ARD/IEP information into the ISP, maintained good communication with SAISD staff and teachers, advocated for extended school year, and supported individuals in their educational services. The monitoring team had one recommendation for SASSLC. That is, to ensure review of the student's progress report during the regularly scheduled quarterly reviews held by the QDDP and IDT.	
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 beginning the use of the Functional Skills Assessment (FSA) to replace the Positive Adaptive Living Survey (PALS) for the assessment of individual skills, and as part of the method of identifying skills to be trained. The monitoring team looks forward to learning how this new assessment is combined with the results from clinical assessments (e.g., nursing, speech/language pathology) and individual preference, to identify meaningful individualized skill acquisition programs (also see comments regarding the FSA in sections F and T of this report). Finally, while the ISP attempted to identify individual preferences, no evidence of systematic (i.e., experimental) preference and reinforcement assessments (when potent reinforcers or preferences are not apparent) was found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration.	Noncompliance

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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	More work in the areas of the graphing and evaluating of SAP outcome data, and integrity of the implementation of SAPs is needed before this item can be rated as being in substantial compliance. At the time of the onsite review, QDDPs at SASSLC summarized SAP data monthly and presented those data at quarterly meetings. None of the 10 quarterly data summaries reviewed by the monitoring team, however, included graphed data. Additionally, as noted in the last report, reviews of SAP quarterly data typically indicated if progress was maintained or progressing, but did not consistently present actual SAP data. It is recommended that SAP quarterly reviews be reorganized so that SAP data are recorded and graphed, so that QDDPs can readily determine if the SAPs are producing meaningful behavior change. Finally, it is recommended that these graphed data summaries of individual SAP progress be used to make data based decisions concerning the continuation, discontinuation, or modification of skill acquisition plans. Finally, in an effort to evaluate if SAPs were implemented as written, the monitoring team observed a DCP implementing a skill acquisition plan. The following example was observed in a vocational classroom: • Individual #204 was working on her SAP of replenishing work materials. The DCP however, appeared to be prompting Individual #204 to place items in a bin when implementing this SAP. When asked why she was implementing the SAP in this manner, she admitted she was confused by the SAP. She called her supervisor who was familiar with Individual #204's SAP, and clarified the steps. This observation questioned if SAPs at SASSLC were consistently being implemented as written. The only way to ensure that SAPs are conducted as written, however, is to conduct integrity checks. It is recommended that a plan be developed to collect and graph integrity data to ensure that SAPs are conducted as written. The recently developed skills acquisition observation tool did include a method to collect integrity data. At the time of the onsite review, the facility reported that it would begin to pilot the implementation of the skills acquisition observation tool, and the use of an	Noncompliance

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		active treatment specialist in two homes (i.e., 672 and 674). The monitoring team looks forward to learning the effects of this pilot program during 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 in the community. These data suggested considerable variability across homes in SAP training in the community. For example: • No skill acquisition training occurred during the four month tracking period in homes 668, 670, 673, and 674. • Relatively infrequent skill training occurred in homes 665 and 671 (averaging approximately two per month). • Approximately 12 opportunities for training in the community per month were reported for home 766. • Approximately 26 opportunities for training in the community per month were reported for home 672. It is recommended that the facility establish training in the community goals for each home, and ensure that opportunities to implement SAPs in the community are available for all homes. At the time of the review, two individuals at SASSLC worked in the community. Four 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.	Noncompliance

Recommendations:

1. Expand the new format (i.e., SAPs) to all skill acquisition plans at the facility (S1).
2. Ensure that the rationale for the selection of each individual's SAP is specific enough for the reader to determine if the SAP was practical and functional for that individual (S1).
3. It is recommended that all SAPs contain generalization and maintenance plans that are consistent with their definitions (S1).
4. Ensure that all generalization and maintenance plans include how they will be accomplished (S1).

5. The psychology department should develop an assessment procedure to determine if refusals to participate in dental procedures are primarily due to general noncompliance, or due to fear of dental procedures. A treatment plan based on the results of the assessment (i.e., a compliance program or systematic desensitization plan) should then be developed. Additionally, those individualized compliance and dental desensitization plans should be incorporated into the new SAP format (S1).

6. Replacement behaviors that require the acquisition of a new skill should be incorporated into the new SAP format (S1).

7. It is recommended that the facility expand the number of communication SAPs for individuals with communication needs (S1).

8. The facility should begin graphing SAP outcome data to enhance the likelihood of data based decisions regarding the continuation, modification, or discontinuation of SAPs (S3).

9. Collect and graph SAP integrity data to ensure that SAPs are conducted as written (S3).

10. It is recommended that the facility establish training in the community goals for each home, and ensure that opportunities to implement SAPs in the community are available for all homes (S3).

11. Ensure review of the student's progress report during the regularly scheduled quarterly reviews held by the QDDP and IDT (S1).

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 SASSLC facility-specific policy, 300-21A, Facility Most Integrated Setting Practices, 12/1/11 o Organizational chart, undated o SASSLC policy lists, undated o List of typical meetings that occurred at SASSLC, undated o SASSLC Self-Assessment, 2/1/12 o SASSLC Most Integrated Setting Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/13/12 o Transition specialist program description and job description, 2/7/12 o Community Placement Report, last six months, through 1/12/12; resubmitted after the onsite review and dated through 2/29/12 o List of individuals who had been placed since last onsite review (2 individuals) o List of individuals who were referred for placement since the last review (8 individuals) • Documentation (ISP) showing IDT discussion for referral of Individual #63 o List of individuals who were referred and placed since the last review (1 individual) o List of total active referrals (10 individuals) o List of individuals who requested placement, but weren't referred (5 individuals) • Documentation of activities taken for those who did not have an LAR (0 of 4 individuals) • List of individuals who requested placement, but weren't referred solely due to LAR preference, (1 individual) o List of rescinded referrals (4 individuals) and • ISPA notes regarding each rescinding o List of individuals returned to facility after community placement (0 individuals) o List of individuals who experienced serious placement problems, such as being jailed, psychiatrically hospitalized, and/or moved to a different home or to a different provider at some point after placement (0 individuals) o List of individuals who died after moving from the facility to the community since 7/1/09 (0 individuals) o List of individuals discharged from SSLC following determination of ineligible for services (0 individuals) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (1 individual)

	o APC weekly reports, four, 12/9/11 through 12/30/11 • Statewide weekly enrollment report • Detailed referral and placement report for senior management (none) o Spreadsheet of up to three obstacles to referral/placement for 21 individuals o Variety of documents regarding • Provider fair (1) • Community tours (3) • Trainings for facility staff (3) • Volunteer Service Council presentation, 10/1/11 • Meetings with local MRA (nothing new since last review) o CLOIPs completed by local MRA for the past five months (August 2011 through December 2011) o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred) o List of individuals who had a CLDP completed since the last review (2 individuals) o List used by APC regarding submission of assessments for CLDP (within the CLDP) o DADS central office written feedback on CLDPs (1 individual) o Blank section T statewide self-monitoring tools (none completed, none summarized) o State obstacles report and SASSLC addendum, October 2011 o PMM tracking sheet listing post move monitoring dates due and completed (not submitted) o Transition T4 materials for: • Individual #195 o New-style ISPs for: • Individual #254, Individual #229 o ISP assessments for: • Individual #55, Individual #72, Individual #96, Individual #106, Individual #116, Individual #254 o CLDPs for: • Individual #276, Individual #103 o Draft CLDP for: • (none) o In-process CLDPs for: • (none) o Pre-move site review checklists (P) and Post move monitoring checklists (7-, 45-, and/or 90-day reviews) conducted since last onsite review for: • Individual #1: 90 • Individual #269: 90 • Individual #211: 90 • Individual #275: 45, 90 • Individual #276: P, 7, 45 • Individual #103: P, 7

	Interviews and Meetings Held: o Donnie Wilson, DADS central office most integrated setting practices coordinator o Eileen Short, DADS central office supervisor of the new transition specialist program o Audrey Wilson, QDDP Coordinator o Community residential staff at A&M Residential Services, Inc., and D&S Residential Services, Inc. Observations Conducted: o CLDP Meeting for: • (none) o ISP Meeting for: • Individual #240, Individual #31 o Self-advocacy meeting, 1/12/12 o Community residential programs of: • Community provider apartment program, A&M Residential Services, Inc. • Community provider group home, D&S Residential Services, Inc.
	Facility Self-Assessment: SASSLC submitted its self-assessment. It consisted of two parts. One was a list of the activities the admissions and placement department had engaged in related to each of the provision items of this section along with a self-rating for each. Although it was helpful to read this list, a self-assessment should instead describe what it is that the department did to conduct the self-assessment of the provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. In other words, it should describe what activities they engaged in to assess whether they were meeting each provision item, not only activities they engaged in to meet the provision item. This is a fine and sometimes difficult distinction to make. The second part was a listing of the actions the APC and her department planned to take towards meeting the requirements of the Settlement Agreement. Overall, this 13-page document provided a lot of good direction to the APC. The monitoring team recommends that the new APC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. Doing so will help him or her to begin to conduct an adequate self-assessment and to develop action steps and plans that will be in line with the monitoring team. The understanding of the monitoring team was that SASSLC will implement the new style self-assessment that is being used at other SSLCs by the time of the next onsite review. The facility self-rated itself as being in noncompliance with four provision items: T1c2, T1c3, T1h, and T2a.

	The monitoring team agreed with three of these, but rated T2a as being in noncompliance. The monitoring team rated T4 as being in substantial compliance; the facility had self-rated itself as being in noncompliance. No rationale, however, was provided for the noncompliance rating.
	Summary of Monitor's Assessment Any progress SASSLC had made or was making towards substantial compliance with the items of this provision was, for the most part, halted due to staff turnover in the admissions and placement department. To that end, state office was planning to soon hire a new APC and PMM. In addition, three new transition specialists were being assigned to SASSLC. Thus, there will be five new staff working at the facility towards community referral and placement activities. The monitoring team highly recommends that the facility director take a strong role in providing orientation and direction to this group of new staff. The specific numbers of individuals who were placed was at annual rate of less than 2 percent (2 placements in six months, census of 276). Further, less than 4% of the individuals at the facility were on the active referral list. Two individuals were placed in the community since the last onsite review. Of note, however, was that both individuals placed were highly involved in their own transitions and had complicated behavioral issues. Ten individuals were on the active referral list. This was the largest number of individuals on the active referral list since the initiation of the Settlement Agreement. The new APC should also do a more detailed report and periodic (e.g., weekly, monthly) verbal presentation to senior management, keeping them updated on the details about individuals who are in the referral and placement process. Some, but not all, ISP assessments included the professional's determination and opinion regarding referral to a more integrated setting. Review of written ISPs, and observation of an ISP meeting, indicated that the professionals' determinations were discussed during the annual ISP meetings. Progress was made in improving the provider fair. No progress was made in improving the system of tours of community providers. IDT members were very involved in the placement activities of the individuals who were placed. CLDPs specified actions to be taken and showed involvement of the individuals and their LARs. There was a CLDP for each of the individuals who was placed, however, initiation of the CLDP document at the time of referral was not yet occurring. The CLDPs identified the need for training for community provider staff, but very little detail was provided regarding this training. Some transition assessments were dated within 45 days of the transition, however, the content was copied and pasted into the CLDP with a new date, even though the content appeared to not be updated. The assessments did not comment on the individual soon moving to the community and did not appear to tailor their comments to the upcoming move. SASSLC made some progress in identifying essential and nonessential (ENE) supports: more ENE supports

	were included that related to individual's overall preferences as well as the needs of the individuals, and there were ENE supports that were individualized. Much improvement, however, was still needed as detailed in T1e below. For instance, the supports did not adequately address the individuals' complicated behavioral and psychiatric histories, psychiatric diagnoses, and various psychotropic medications. Further, there was little planning for problems that might arise after the newness of the transition had worn off, especially given the psychiatric histories and diagnoses of both individuals (e.g., BPD) and the monitoring team's observations that the housemates in both homes were much less capable, independent, verbal, and mobile than these two individuals. Self-monitoring tools for quality assurance were not being implemented. The statewide report on obstacles to referral and placement was issued. The addendum for SASSLC, however, did not contain adequate data and did not contain a comprehensive assessment of the challenges faced at SASSLC. SASSLC did not maintain substantial compliance with provision T2a. This was due to the absence of a thoroughness of post move monitoring as evidenced in the reports, lack of follow-up in cases where the PMM indicated that further monitoring was needed, and due to the absence of post move monitoring IDT meetings for six of the eight post move monitoring visits. This was due, in part, to the resignation of the PMM and the retirement of the APC. The state office stepped in, however, to ensure that all post move monitoring was completed by the required timelines. The monitoring team visited the two individuals who had moved since the last onsite review. Even though it was not a visit during which post move monitoring was conducted, the monitoring team observed that both individuals were happy in their new homes.

#	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	Any progress SASSLC had made or was making towards substantial compliance with the items of this provision was, for the most part, halted due to staff turnover in the admissions and placement department. The Admissions and Placement Coordinator (APC) retired in January 2012 and the Post Move Monitor (PMM) resigned in December 2011. Neither position was filled at the time of this onsite review, however, the DADS statewide coordinator reported that strong candidates had been interviewed and he expected both positions to be filled sometime in the next month. During the months prior to her retirement, the APC continued to work on referral and placement activities and state office provided assistance for some activities, such as post move monitoring. Coincidentally, DADS was recently awarded a federal grant to hire transition specialists for each facility. DADS planned to assign three of these transition specialists to SASSLC. Thus, there will be five new staff working at the facility towards community referral and	Noncompliance

	transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	placement activities. The monitoring team highly recommends that the facility director take a strong role in providing orientation and direction to this group of new staff. In the last report, the monitoring team recommended the development of a performance improvement team to address referral and placement. This was not done, however, now that there will be a new set of staff, the need for this PIT should instead be evaluated at a later time. The specific numbers of individuals who were placed was at annual rate of less than 2 percent (2 placements in six months, census of 276). Further, less than 4% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 2 individuals were placed in the community since the last onsite review. This compared with 5, 1, 3, and 5 individuals who had been placed during the periods preceding the previous four reviews. o The placement numbers remained low at SASSLC. Of note, however, was that both individuals placed were highly involved in their own transitions and had complicated behavioral issues. • 8 individuals were referred for placement since the last onsite review. o 0 of these, 1 individual was both referred and placed since the last onsite review. • 10 individuals were on the active referral list. This compared with 9, 4, and 3 individuals at the time of the previous four reviews. o This was the largest number of individuals on the active referral list since the initiation of the Settlement Agreement. o Individuals came off of the referral list either via placement or via the rescinding of the referral. • 5 individuals were described as having requested placement, but were not referred. This compared with 7 individuals at the time of the previous review. o 1 was not referred due to LAR preference, 2 were not referred due to medical reasons, and 2 were not referred due to the MRA not being present at their ISP meeting. o The facility should immediately address the 2 individuals for whom the MRA was not present. o For the other 2 individuals, some sort of placement review or placement appeals process needs to occur. • The list of individuals not being referred solely due to LAR preference contained 1 name. o This was not an accurate count and needs to be completed correctly by the facility. This list should include all individuals, not only those individuals who themselves expressed a preference.	

		• The referrals of 4 individuals were rescinded since the last review. This compared to 2 individuals and 3 individuals at the time of the previous two reviews, respectively. o Each individual's IDT met and an ISPA report was issued that provided information indicating that the decision to rescind was reasonable. Two were rescinded due to the individual changing his decision, one was due to the IDT wanting to do additional planning with the family, and one was because the individual was instead going to transfer to another SSLC to be closer to his family and from there referral to the community would occur. o Other than the IDT meeting, there was no additional review of these rescindings. The new APC should do a detailed review (i.e., root cause analysis) of each of these rescinded cases to determine if anything different could have been done during the time the individual was an active referral, in other words, to assess the overall referral and placement processes. This appeared to be especially relevant in the cases of the two individuals who changed their decision to move. Perhaps something that occurred during the transition process could have been done differently. • 0 individuals were returned to the facility after community placement. This compared with 1 at the time of the previous review. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, or who had run away from their community placements were not available. A detailed review/root cause analysis should be conducted for any of these or similar types of significant post-move events. • 0 individuals had died since being placed. • 1 individual was discharged under alternate discharge procedures (see section T4 below). Each of the above bullets should be graphed separately, as recommended in the previous report. SASSLC had not yet begun to do this. These data should be submitted and included as part of the facility's QA program (see sections E above and T1f below). <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 ISP assessment process, during the annual ISP meeting, and be documented in the written ISP. As indicated below, SASSLC had made some progress via a revised and updated ISP/IDT statewide process. The new process was only very recently implemented at SASSLC. It required that professionals state their determination in their annual assessments. These	

		determinations of the professionals were to then be discussed at the annual ISP meeting and documented in the finalized ISP document. At the time of this review, all QDDPs had completed their training. Only two new-style ISP documents, however, were available for review by the monitoring team (for Individual #254 and Individual #229). Both were conducted in early January 2012 and were done by two different QDDPs. In assessments for annual ISPs, statements regarding the professional's determination about the appropriateness of community referral and placement need to be explicitly made and included. Assessments were not submitted along with the two new style ISPs, so a request made subsequent to the onsite review. A set of assessments for one of the two new ISPs and for five other individuals were submitted. Across this set of assessments, some, but not all, included the professional's determination and opinion regarding referral to a more integrated setting. The set of assessments that contained this information varied across individuals, and no one set of assessments included these opinions for all of the professionals on the IDT. For example, for Individual #106, three professionals gave their opinion (nursing, habilitation, skills training) whereas for Individual #254, only nursing included this opinion. The new style written ISPs and one of the ISP meetings that was observed indicated that the professionals' determinations were discussed during the meetings. Both of the written ISPs listed the members of the IDT who said that, in their opinions, the individual could be supported in a community setting. Moreover, there were no professionals who said the individual could not be supported in a community setting. For Individual #254, the IDT talked about his legal status being a barrier to referral as well as his apparent preference for SASSLC. For Individual #229, the ISP stated that the LAR preferred her to remain at SASSLC, but agreed to receive more information from the MRA. Based on this, the IDT determined that the individual should continue to reside at SASSLC because of the family's lack of knowledge regarding community living. It would be better for the IDT to make a more explicit statement about the opinion of the IDT's professionals, along with their ultimate decision, in this section of the ISP. In the annual ISP meeting for Individual #240 (observed by the monitoring team), the QDDP led the IDT through discussion of community referral at a number of points during the meeting. For instance, it came up as a topic as each IDT member presented his or her update and recommendations. Then, towards the end of the meeting, the QDDP raised the topic of referral and the IDT's opinion. No one had any reason to not refer him and no obstacles were identified, and so, the QDDP planned to talk more with the individual's brother and his LAR (he was not at the meeting). In a way, it appeared that the decision to pursue referral was made because there was no reason to not do so. This is, in part, why the new ISP process and the Settlement Agreement require that IDT members give	

		their individual opinions and that they discuss obstacles. Without these requirements, it is unlikely that the IDT would have considered referral for Individual #240 as much as they did. In the other ISP meeting observed by the monitoring team (for Individual #31), the QDDP began the meeting with the risk review. The risk review lasted more than 90 minutes and the monitoring team was, thereby, unable to observe any discussion of living options, referral, and community living in this ISP meeting. <u>Preferences of individuals</u> SASSLC appeared to work to honor the preferences of individuals. This was seen during ISP meetings, self-advocacy activities, and in the actions of the rights officer. In the previous two monitoring reports, the monitoring team noted a number of concerns with the way in which the facility assessed and supported individuals' preferences. In some instances, it seemed that the facility's efforts were counter-therapeutic the achieving the most beneficial outcome for some individuals. The facility had taken no actions in this regard since the last onsite review. The monitoring team recommends that the new APC review these previous reports and determine if any actions are necessary. <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. <u>Senior management</u> The APC continued to complete a statewide weekly enrollment report. As recommended in previous monitoring reports, a more detailed report and periodic (e.g., weekly, monthly) verbal presentation to senior management should be done, keeping them updated on the details about individuals who are in the referral and placement process.	
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. A revision was being developed over the past months and was expected to be disseminated soon. Part of the reason for the delay may have been due to changes that were occurring to the ISP process. SASSLC had approved and implemented a facility-specific policy on 12/1/11. This policy, however, was a repetition of the state policy with some insertions indicating the specific practice and procedure at SASSLC. This will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated.	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.	To briefly summarize, there was a brand new ISP meeting format, and a brand new ISP written document format. The new ISP was designed to address the many items that were required by the Settlement Agreement, ICFMR regulations, and DADS central office. Further, the new ISP included items that had been missing from previous ISP formats, such as professional's opinions, and the identification of obstacles. <u>Protections, Services, and Supports</u> Given that this major process change was just underway regarding both the ISP meeting and the ISP document, the monitoring team reviewed only two new-style ISP documents (the only two that were available from the facility) and attended ISP meetings during the onsite review. Some comments are provided below. Other comments regarding the facility's ISPs are provided in many other sections of this monitoring report, particularly in sections F and S. • The two ISPs varied slightly in format. The monitoring team learned that a finalized template was scheduled to be issued in mid-March 2012. Further, some typographical errors (e.g., "his" in an ISP for a woman, including the wrong name) made it appear that some paragraphs were merely copied from other ISPs. • The meetings were too long (three hours). • QDDPs tried to discuss action plans throughout the course of the meeting. This was good and in line with the new process. • There was good participation by team members in one meeting, and poor participation in the other meeting. This might be due to the latter meeting beginning with a 90-minute review of the risk categories instead of following the new ISP format as designed. • It did not appear that all of the protections, services, and supports for safety and adequate habilitation were included and detailed. o There were problems in assessments, including the listing of recommendations, from various disciplines (as noted throughout this report). • It did not seem that the ISPs included adequate information from each individual's various plans (e.g., PBSPs, PNMTs, Dining Plans, HMPs, psychiatric treatment plans). • The Functional Skills Assessment (FSA) did not appear to be used at all in the preparation of the ISP. The ISPs made no reference to the FSA, such as whether and how the FSA might have been used to determine progress or identify skills for training. <u>Obstacles to Movement</u> This aspect of this provision item (the identification and addressing of obstacles for each individual) continued to be inadequately addressed at SASSLC, though some progress was seen. For instance, the two new-style ISPs noted some obstacles (e.g., family	Noncompliance

		knowledge, legal status), but the standardized format from the blank ISP template was not included. Perhaps it was deleted from these two ISPs. Even so, these two ISPs included actions to address the obstacles that were identified via an action plan service objective (e.g., provide family with more information, explore ways to solve the legal issue). In the ISP meeting observed by the monitoring team, when asked about whether there were any obstacles, the IDT members responded that they could not think of any. A spreadsheet was given to the monitoring team that listed one or more obstacles for 21 individuals. It appeared to be the beginning of a project that was initiated by the retired APC. The new APC should also see section F1e of this report for additional information relevant to this provision item.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Progress continued to be made, especially for the provider fair. The monitoring teams, DADS central office, and DOJ recently agreed on the specific criteria for this provision item. The monitoring team expects that DADS will soon provide more specific direction to the APC and the facility regarding the expectations for achieving substantial compliance. SASSLC was already engaging in some, but not yet all, of these activities towards educating individuals and their family members and LARs. Below are the agreed-upon activities (the bullets) followed by SASSLC's status for each. <u>Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered o Includes the individual's LAR and family, as appropriate o Indicates if the previous year's individualized plan was completed. <u>SASSLC status</u>: Progress had been made, but this activity was not yet occurring at the required criterion. Some ISPs described what the individual had done, whereas others described what the individual might do during the upcoming year. The new ISP format provided more guidance to the IDT and QDDP in addressing the education of each individual and LAR, however, the QDDPs will need to ensure that they address each of the three bullets listed immediately above. <u>Provider fair</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers)	Noncompliance

		○ Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs SASSLC status: The facility had made good progress regarding the provider fair. A workgroup was formed to focus on improving the fair and determining/assessing outcomes. Thirty-six providers attended this fair in October 2011. Individuals were better prepared for the fair; they were taught questions to ask of providers. The work group created a contest for each home to have as many discussions with as many providers as possible. Data were collected on individual and provider participation (not only on their attendance). The data on individual participation should be shared with the QDDPs for use during the ISP meeting. In addition, there were plans to hold two provider fairs each year. Local MRA/LA • Regular SSLC meeting with local MRA/LA SASSLC status: The retired APC appeared to have a good working relationship with the local authority. She met quarterly and reviewed relevant topics. SASSLC was engaged in this activity at the required criterion. Education about community options • Outcomes/measures are determined and data collected on: ○ Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. ○ Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities SASSLC status: SASSLC had not yet started to address this activity. The new APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the MRA/LA CLOIP workers. Tours of community providers • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. SASSLC status: There was not much progress in this activity since the last onsite review. Only three visits to homes had occurred (one in September 2011 and two on the same day in October 2011). A more organized way of exposing individuals to community living via visits to homes and day programs should be put into place. This was noted as a need in previous monitoring reports for SASSLC.	

		Visit friends who live in the community SASSLC status: SASSLC was not yet implementing this activity. Education may be provided at • Self-advocacy meetings • House meetings for the individuals • Family association meetings or • Other locations as determined appropriate SASSLC status: The rights officer regularly included community living topics in the self-advocacy meeting. In addition, a presentation to the Volunteer Services Council board included information about referrals and placements. There were no house meetings for individuals. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals SASSLC status: The retired APC conducted a training session for QDDPs. There was no other indication of teaching employees, at all levels, about community options during the previous six months. Individuals and families who are reluctant have opportunities to learn about success stories • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition SASSLC status: The APC was not yet implementing this activity.	
	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	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the living options discussion at the annual ISP meeting, or at any other time if requested by the individual, LAR, or IDT member. In addition, a listing was given to the monitoring team showing every individual and whether the IDT referred the individual for placement. The column indicating reason for no referral was blank for most individuals on this list. The monitoring teams have been discussing this provision item at length with DADS and DOJ. To meet substantial compliance with this provision item, the facility will need to show that:	Noncompliance

	remaining individuals for placement pursuant to such policies, procedures, and practices.	• Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments (this was not yet occurring for all professionals). • The determinations of professionals were discussed at the annual ISP meeting, including a verbal statement by each professional member of the IDT during the meeting (this was somewhat evident in the ISP meetings observed) • Living options for the individual were thoroughly discussed during the annual ISP meeting (this was somewhat evident). • Documentation in the written ISP regarding the joint recommendation of the professionals on the team regarding the most integrated setting for the individual, as well as the decision regarding referral of the entire team, including the individual and LAR (this was not yet occurring). As the facility and state move forward on this provision item, they may want to consider ways of prioritizing referrals and/or an interim process to referral for some individuals.	
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. Two CLDPs were reviewed by the monitoring team. This was 100% of the CLDPs developed since the last onsite review. <u>Timeliness</u>: The CLDP for Individual #276 was developed in a timely manner. The CLDP for Individual #103 was not developed in a timely manner. <u>Initiation of the CLDP</u>: 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 initiation of the CLDP document at the time of referral was not yet occurring at SASSLC. It might also be helpful for the cover page of the CLDP to include the date of creation of the CLDP document and then dates of subsequent modification and updates. It would also be helpful if the cover page included the date of the official referral of the individual for placement by the IDT. <u>IDT member participation</u>: IDT members were very involved in the placement activities of the individuals who were placed. They helped choose possible providers, set up and attend visits to residences and day programs, and actively participated in supporting the individual to make the best possible choice of providers. As a result, the process of choosing and determining a provider was individualized. In both of these cases, the individuals actively participated in selecting providers and both had already identified the desired provider and specific home prior to the official referral for placement.	Noncompliance

		CLDP meeting prior to move: The APC held a CLDP meeting prior to each individual's move. None were scheduled during the week of the onsite review and, therefore, the conduct of a CLDP meeting at SASSLC could not be observed. Post post-move monitoring IDT meetings: IDT meetings were not occurring after every post move monitoring visit. Please see T2a below.	
	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.	Two 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. Implementation of the new CLDP policy and facility QA processes will likely bring the facility closer to substantial compliance with this provision item. Some comments regarding the actions in the CLDP are presented below. • The CLDPs identified the need for training for community provider staff. o Very little detail was provided regarding this training. The CLDPs did not include any detail regarding what should be trained, which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff). o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, showing competency in actually implementing a plan, such as a PBSP or nursing care plans. o Training should have a competency demonstration component. If a competency component is not required, a rationale should be provided. • The CLDP contained a somewhat standardized list of items and actions to occur on the day of the move. The content of this list was appropriate, however, it did not identify who was responsible for these actions, and how their completion was to be monitored and ensured. • Actual implementation of ENE supports by staff should be required in the essential and nonessential support sections, not only inservicing. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. o This was especially important for these two individuals, given their complicated behavioral and psychiatric histories. • Also see comments in T1e below. DADS central office conducted reviews of one of the CDLPs (Individual #276). The monitoring team reviewed these comments. The reviewers noted a number of problems with the CLDP, including the absence of many important supports and considerations for	Noncompliance

		this complicated individual. Unfortunately, these concerns were not incorporated into the CLDP. The monitoring team was in agreement with the reviewers' comments (and as noted in T1e below, found other considerations that were missing from the CLDP). The facility should be certain to make use of this resource. • As noted in previous reports, 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 and the timelines for these actions. This included the day of move activities, ENE supports, and other pre- and post-move 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 and LAR review. These two individuals were very involved in the entire referral and placement process.	Substantial Compliance
T1d	Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving.	In preparation for the CLDP meeting, assessments were to be updated and summarized. Therefore, the CLDP document was to contain these updated/summarized assessments, rather than full assessments. This appeared to be an adequate process. The retired APC reported that she used the summary template located within the body of the CLDP to keep track of the summaries submitted and the 45-day time limit. In practice, however, this turned out to not be adequate at SASSLC. The list in the CLDP indicated the due date of the assessment rather than the actual date of completion of the assessment. Therefore, the monitoring team was unable to easily determine the actual completion date of the assessment. Further, some assessments were completed more than 45 days prior to the move, but copied and pasted into the CLDP with a new date, even though the content appeared to not be updated. A second type of assessment tracking sheet used by the retired APC was also submitted for one, but not both, of the CLDPs (Individual #103). It had relevant information and could be a useful way for the new APC to track and document the provision of assessments as required by this provision item. In addition, the assessments, for the most part, did not comment on the individual soon moving to the community and, therefore, did not appear to tailor their comments to the upcoming move.	Noncompliance

		The quality and content of the assessments, however, needed improvement as detailed in section F1c.	
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 made some progress in identifying essential and nonessential (ENE) supports, however, much improvement was still needed. The two CLDPs were reviewed along with their attachments, typically assessments, ISPA meetings, and ISPs. Some progress was seen in that more ENE supports were included that related to individual's overall preferences as well as the needs of the individuals, and there were ENE supports that were individualized. Much more work, however, needs to be done regarding the identification of the full set of ENE supports for each individual. The new APC should make this a priority area when he or she begins to develop CLDPs. The new APC should also review the contents of section T1e in previous SASSLC monitoring reports for more detail, examples, and direction. Moreover, most of the comments in T1e regarding ENE supports made in the previous monitoring report continued to apply. The two individuals who's CLDPs were reviewed for this report had a number of similar challenges and needs. Therefore, the following comments applied to both CLDPs. • The individuals had complicated behavioral and psychiatric histories that included multiple failed placements and serious problem behaviors, such as physical aggression, suicidal actions, delusional thinking, sexually inappropriate actions, property destruction, running away, and making false allegations. The ENE supports did not adequately address these histories. • The individuals had very challenging psychiatric diagnoses, including those that are some of the most difficult to treat, such as borderline personality disorder. The ENE supports did not thoroughly address these. • Similarly, both individuals were receiving various psychotropic medications. Even though that is the responsibility of the psychiatrist, it seemed to the monitoring team that more discussion should have occurred regarding the type, dosage, and number of psychotropic medications. • It was clearly noted in the CLDPs that both individuals had worked hard to improve their behavior so that community placement could occur. This was great to see and both had maintained stability for many months. Eventually, however, the newness and the excitement of moving to the community will wear off. The monitoring team was concerned that there was no discussion or planning for this, especially given the psychiatric histories and diagnoses of both individuals (e.g., BPD). Add to this, the monitoring team's observations that the housemates in both homes were much less capable, independent, verbal, and mobile than Individual #103 and Individual #276. A recent unfortunate and perhaps not totally surprising incident underscored the need for this kind of	Noncompliance

		planning: after only a few weeks in her new home, Individual #276 had numerous problems with one of her new housemates. Fortunately, the community provider was able to make an assignment change and found a new alternative home for this housemate. • The recommendation for the individual's BSP to be developed and managed by a BCBA did not make it into the list of ENE supports. • Keeping busy was extremely important to both individuals, but it was not focused on in the ENE supports other than an ENE support to have opportunities to participate in activities. • Although more individualized items and activities were included in the ENE supports compared to the last monitoring review, many of these individuals' favorite things were absent from the list. A reading of the CLDP and assessments indicated that these individuals had many interests that could have been included in the list of ENE supports, such as self-advocacy, bike riding, voting, learning to make decisions, and caring for animals. • Many of the ENE supports were not measureable and/or had no criterion. • There were few ENE supports about staff training, staff implementation of the training tasks, and provider monitoring of this implementation. The number of ENE supports regarding training seemed to have reversed from the time of the previous monitoring report (at that time, there were too many inservice ENE supports). Perhaps this was an overreaction to the recommendation in the previous report. • Any ENE support that calls for an inservice should have a corresponding ENE support for <u>implementation</u> of what was inserviced. A rationale should be provided for any ENE inservice support that does not have a corresponding ENE support for implementation. • For ENEs requiring implementation, the support description needs to provide detail about what it was that was supposed to implemented, such as the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. • There should also be a requirement for staff to document this implementation every day. This is reasonable for the IDT to request of a provider, and providers have been receptive, if not desirous, of having this guidance and expectation. Further, it not only makes the expectations clear to provider staff, it allows the PMM to more efficiently monitor this aspect of implementation. • There were no specific references to the use of positive reinforcement, incentives, and/or other motivating components to an individual's success, even though these were indicated as being important to these individuals. • There were only two essential supports in each CLDP. That was surprising to see. The monitoring team would be interested in understanding the reason for	

		there being so few essential supports. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. For each of the individuals, the pre-move site review was conducted by the PMM and indicated that each essential support was in place, albeit, there were only two essential supports for each individual. • Each of the nonessential supports should have an implementation date. All of them did.	
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 ISP meeting, the CLDP document, and the post move monitoring documents. The monitoring team recommends that the new APC take a close look at all three self-monitoring tools to ensure they contain the proper content, that the instructions for completion of self-monitoring are adequate, and that the criterion for scoring is valid. These were not implemented since the last onsite review. Once this is implemented, the APC should graph data related to the department's activities as per this provision item as well as what is noted in T1a above.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to	Activities at the facility and state levels demonstrated some progress at the state level, and very little progress at the facility level, towards substantial compliance with this provision item. At the facility level: • Data for five fiscal years, 2007 through 2011, were reported in the annual report. Data included number of placements. • The remainder of the data, however, was incomplete. Data were presented for only nine individuals. This was acknowledged in the report and the facility indicated that this would be fixed for next year's report. • The APC had another spreadsheet with information on obstacles for 21 other individuals (also see T1a above). The new APC will need to assess this data set and determine whether this is a useful way to collect information or if a different way would be more useful to him or her and the facility's senior management. • The data system needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement. • Assistance from QA and state office might be helpful in analyzing data once it is	Noncompliance

	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.	collected. The document did not contain a comprehensive assessment of obstacles at SASSLC. At the state level, DADS created a report summarizing obstacles across the state and included the facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
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	The monitoring team was given a document titled "Community Placement Report." It had some errors and an updated and corrected version was submitted after the onsite review. It was dated for the previous six months, through 2/29/12. 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 IDT 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

	purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living 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	SASSLC did not maintain substantial compliance with this provision item. This was due to the absence of a thoroughness of post move monitoring as evidenced in the reports, lack of follow-up in cases where the PMM indicated that further monitoring was needed, and due to the absence of post move monitoring IDT meetings for six of the eight post move monitoring visits. <u>Timeliness of Visits</u>: Due to the resignation of the post move monitor (PMM) in December 2011, the retired APC and a staff member from DADS central office completed three of the eight post move monitoring visits. Eight post move monitorings were called for and all eight (100%) occurred. Of these eight, eight (100%) occurred with the required timelines of 7-, 45-, and 90-day intervals. The person conducting the review visited both the day and residential sites. One of the eight was the documentation for the visit attended by the monitoring team during the last review (Individual #275, 45-day visit). The monitoring team acknowledges the efforts of the facility and state office to ensure that these post move monitorings occurred.	Noncompliance

	best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Content of Review Tool: Of the eight post move monitorings, the completed review tools for all eight (100%) were reviewed by the monitoring team. Only one of the eight tools was completed on what was now the new format. The new format had many improvements over the previous version. These are worth pointing out here: • Explicit yes/no indication regarding the presence of each ENE support • Indication of what evidence the CLDP required be reviewed and what evidence the PMM actually did review • Eight sets of additional standardized relevant questions • Report of the LAR/family member's satisfaction • Report of the individual's satisfaction The new format, however, was missing, but should include, a subjective paragraph at the end of the report that gives the PMM's overall impression of the placement (day and residential). The absence of this narrative made it difficult to determine the PMM's overall opinion of the placement, any major issues that were occurring, the provider's response, and the PMM's opinion of likely outcome. This would have been good to have for all of the visits, but especially for those who had serious incidents, hospitalizations, housemate problems, and so forth. For instance, Individual #1 was hospitalized for psychiatric and behavioral reasons twice in the time between the 45- and 90-day reviews. Moreover, the provider was planning for him to move to a new home in a different part of town. Individual #276 had serious problems with her housemate that were not mentioned at all in her 45-day review. Individual #275 continued to express ambivalence, if not dissatisfaction, with his home. The PMM checked for whether the staff had a full and appropriate understanding of the psychiatric and behavioral needs of the individuals. It was good to see these scored as "yes," however, this was insufficient and the post move monitor should provide some detail in the narrative for that section (e.g., how did he or she determine staff's knowledge, how did staff respond). This seemed important for those individuals with more serious behavioral and psychiatric problems. Use of Best Efforts to Ensure Supports Are Implemented: IDTs, the APC, and the PMM put a lot of effort into these placements. As a result, three of the six placements appeared to be very successful. On the other hand, there were some problems with two of the placements, and one placement had many problems. For two individuals, the post move monitoring report indicated that additional follow-up was necessary following the 90-day review. There was no evidence, however, that any further follow-up occurred (Individual #275, Individual #269).	

		IDT meetings were held following only two of the eight post move monitoring visits.	
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.	There were no post move monitoring visits scheduled during the week of the onsite tour and, therefore, this provision item could not be rated. Even so, the monitoring team visited two homes. The first was for Individual #103. He had moved in only about three weeks prior to this visit. He and his mother had chosen this home. Overall, the individual was happy with his new home and day program. The second was for Individual #276. She lived in a very nice apartment in an apartment complex. She had moved in only about six weeks prior and was very happy living in her new home, too. It was good to see both individuals doing well. As noted above in section T1e, however, the monitoring team found concerns in some of the planning for their success, especially after the first few months of their transitions have occurred. Nevertheless, the monitoring team commends the efforts of the facility to place these two individuals, both of whom had histories of serious challenging behaviors, psychiatric disorders, and failed placements.	Not rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	This item does not receive a rating.	

T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	One individual was reported to have been discharged under this T4 provision. It was done so properly as per the requirements of this provision item as evidenced by documents submitted to the monitoring team. The individual and the reason for discharge are below: • Individual #195: discharged to another SSLC based upon request of her guardian due to serious behavior problems that were occurring with another individual at SASSLC.	Substantial Compliance

Recommendations:

1. The facility director should take a strong role in providing orientation and direction to the group of new admissions and placement department staff and the new transition specialists (T1a).

2. 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). The facility should immediately address the two individuals in this group for whom the MRA was not present. (T1a).

3. 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 IDTs would otherwise have referred. Add this list to the Community Placement Report (T1a, T1h).

4. The new APC should do a detailed review (i.e., root cause analysis) of each the rescinded cases and any other post move serious incidents, such as hospitalizations, psychiatric admissions, housemate changes, or moves to different homes or apartments, to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a).

5. Each of the data sets listed in T1a should be graphed separately, and included in the facility's QA program (T1a, T1f).

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

7. The new APC should review previous monitoring reports regarding monitoring team concerns about the way individual's preferences were assessed at SASSLC (T1a).

8. The APC should complete a more detailed report and periodic (e.g., weekly, monthly) verbal presentations to senior management, keeping them updated on the details about individuals who are in the referral and placement process (T1a, T1b2).

9. Facility-specific policy will need to be revised or perhaps totally re-written once the new state policy is finalized and disseminated (T1b).

10. ISP meetings were three hours long. Consider if this can be reduced (T1b1).

11. The two new-style ISPs noted some obstacles (e.g., family knowledge, legal status), but the standardized format from the blank ISP template was not included (T1b1).

12. Attend to the detail provided in T1b2, including (T1b2):
    a. The need for an individualized plan, included in the ISP.
    b. Provider fair data on individual participation should be shared with the QDDPs for use during the ISP meeting.
    c. There was little progress in organizing the system of tours of community providers.

13. Consider ways of prioritizing referrals and/or an interim process to referral for some individuals (T1b3).

14. Initiate the CLDP document at the time of referral. Consider adding the date of creation and subsequent dates of updates to the cover page of the CLDP. It would also be helpful if the cover page included the date of the official referral of the individual for placement by the IDT (T1c).

15. More detail needs to be provided in the CLDP regarding training for provider staff (T1c1).

16. The list of items in the day of move activities needs to specify who was responsible for these actions, and how their completion was to be monitored and ensured (T1c1).

17. The facility should make use of the information in the DADS reviews of its CLDPs (T1c1).

18. Ensure that the tracking list of assessments and assessment updates is easy to understand. Ensure that assessments are actually updated within 45 days of the day the individual moves to the community (T1d).

19. Assessments and updates prior to the move should comment on the individual soon moving to the community and, therefore, comments should be tailored to the upcoming move (T1d).

20. Much more work needs to be done regarding the identification of the full set of ENE supports for each individual. Also see the detail provided in previous monitoring reports (T1e).

21. QA activities need to be implemented and included in the facility's QA program (T1f).

22. Conduct the comprehensive assessment of obstacles at SASSLC (T1g).

23. Include a subjective paragraph at end of the PMM's reports (T2a).

24. Provide detail in the post move monitoring report on serious events and situations that occurred in the individual's life since he or she transitioned (T2a).

25. The PMM needs to follow-up on concerns and problems, when indicated, even if after 90 days (T2a).

26. More detail is needed in the post move monitoring report on how the PMM determined that the staff were knowledgeable about psychiatric and behavioral issues (T2a).

27. Conduct a IDT meeting following each post move monitoring visit (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC Plan of Improvement o SASSLC Section U Presentation Book o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o Determination of Need of Guardian/Priority Tool o SASSLC List of Adults without Guardians o Individual Support Plan and Rights Assessment: • Individual #83, Individual #160, Individual #55, Individual #72, Individual #96, Individual #106, Individual #150, Individual #194, Individual #232, Individual #127, Individual #32, and Individual #86. Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Michelle Enderle-Rodriguez, Quality Assurance Director o Daisy Ellison, Psychology Coordinator o Audrey Wilson, QDDP Coordinator o Gevona Hicks, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Daily Unit Meeting 2/14/12 o Incident Management Review Team Meeting 2/14/12 and 2/15/12 o Human Rights Committee Meeting 2/16/12 o Annual IDT meeting for Individual #311 on 2/10/12 o Quarterly IDT meeting for Individual #111 on 2/15/12 o QDDP meeting on 2/15/12
	Facility Self-Assessment: SASSLC submitted its self-assessment. In addition, during the onsite review, the HRO reviewed the presentation book for this provision. The self-assessment 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 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 self-assessment how SASSLC came to this self-rating, though it did indicate that progress had not been made. The monitoring team was in agreement with these self-ratings.
	Summary of Monitor's Assessment: Little progress had been made on addressing the requirements of Provision U. Some steps that the facility had taken in regards to consent and guardianship issues included: • The facility had established a committee to o develop an action plan to address Section U; o develop a process for integration of consent discussion within the ISP process; o establish a Guardianship Committee; and o develop a process of identifying and prioritizing a list of individuals that need guardianship at the facility. • The Human Rights Committee continued to meet and review all restrictions of rights. • The facility had a self-advocacy group comprised of individuals residing at the facility. • The facility had completed a trial using the statewide Provision U monitoring tool. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. IDTs were not adequately addressing the need for a LAR or advocate. • Provision item U2 was determined to be in noncompliance. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a prerequisite. The facility had a Human Rights Committee (HRC) in place to review restrictions requested by the IDT. At the HRC meeting observed, committee members engaged in limited discussion regarding the need for the proposed restrictions prior to giving approval. The HRC did not address individual's ability to give informed consent in regards for the need for guardianship when reviewing rights assessments.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision	The facility indicated that SASSLC was not yet in compliance with the requirements of UI. The facility had a list of 164 individuals at the facility who did not have an LAR. None of the individuals on the list had been prioritized in terms of need for guardianship. A sample of 12 ISPs was reviewed for evidence that the team had discussed the need for guardianship. Seven (58%) individuals in the sample did not have guardians. There was	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	evidence in two (29%) of the seven ISPs reviewed that teams were discussing the need for guardianship. This discussion, however, was not adequate in either case. • The ISP for Individual #72 included a brief discussion regarding guardianship. It was noted that her brother and sister-in-law served as advocates and primary correspondents to assist her in providing informed consent. Her family did not wish to pursue guardianship. According to her rights assessment, she did not have the ability to give informed consent in the areas of medical, programmatic, and financial decisions. The discussion for the need for guardianship was not adequate. • The ISP for Individual #96 noted that his guardian resigned in 2007. The judge did not sign the order for termination because there was no successor guardian, therefore, the guardian was considered noncompliant. There was no indication that the team had pursued guardianship over the past four years. Individual #96 had significant medical needs and restrictions in place. The ISP stated that it was not known what he understands because he is not able to respond, even nonverbally. • The rights assessment for Individual #150 stated that he had limited abilities based on observations, assessments, and court commitment to advocate independently. A referral was recommended for an advocate. The ISP did not indicate that the team had discussed a need for guardianship. IDTs need to hold thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. Priority for guardianship should be based on this discussion. The facility was not in substantial 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	The Human Rights Officer also provided information to community agencies on advocacy and volunteer opportunities at the facility. The facility did have some rights protections in place, including an 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

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	LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.		

Recommendations:

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

2. 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. Teach individuals to problem-solve, make decisions, and advocate for themselves (U1, U2).

4. 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 Two SASSLC recordkeeping-related policies o Organizational chart, undated o SASSLC policy lists, undated o List of typical meetings that occurred at SASSLC, undated o SASSLC Self-Assessment, 2/1/12 o SASSLC Recordkeeping Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 2/13/12 o List of all staff responsible for management of unified records o Tables of contents for the active records and individual notebooks, updated February 2011, and master records, updated March 2011 o Green card placed in each individual notebook titled Guidelines for Documenting, undated o Laminated card created by nursing department to assist nurses in proper documentation, undated o Documentation of training on documentation and recordkeeping processes and expectations for Home 665, psychology department, unit directors and home managers, nurses, and medical department staff, September 2011 through February 2012 o A spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, undated but probably January 2012 o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Blank tools used by the URC: table of contents form, statewide self-monitoring tool, and v4 questionnaire o Description of the recordkeeping department's quality assurance audit procedures, undated o List of individuals chosen for recordkeeping audits, four months September 2011 to December 2011, 20 individuals o 10 completed audits of active records, individual notebooks, and master records, November 2011 and December 2011 (five each month), included the statewide self-assessment form and the facility's table of contents/guidelines form o Email notification of relevant staff of the results of each of these audits, September 2011 to December 2011 o 20 completed audits showing follow-up to errors, September 2011 to December 2011 o Graph presentations of the data from the self-assessment tools, presented in the QA report o Documents related to auditing medical consultations o Description of how the facility implements and assess the utilization of records (review of IPNs, V4 interview tool) o Results of 3 V4 interviews following ISP meetings, October 2011 through December 2011, total of

	three individuals, one interview per individual. o Review of active records and/or individual notebooks of: • Individual #270, Individual #267, Individual #289, Individual #285, Individual #314, Individual #80, Individual #240 o Review of master records of: • Individual #203, Individual #284, Individual #8 <u>Interviews and Meetings Held</u>: o Noemi Cardenas, Unified Records Coordinator o Janet Prince-Page, RHIT, Coordinator of Medical Records o Home records clerks (eight) <u>Observations Conducted</u>: o Records storage areas in residences o Master records storage area
	Facility Self-Assessment: SASSLC submitted its self-assessment. In it, the Coordinator of Medical Records (CMR) and the Unified Records Coordinator (URC) listed relevant activities that they conducted towards each of the provision items. They should instead describe what activities they engaged in to <u>assess</u> whether they were meeting each provision item. That is, it should not only include activities they engaged in to <u>meet</u> the provision item. This is a fine and sometimes difficult distinction to make. To take this process forward, the monitoring team recommends that the CMC and URC review, in detail, for each provision item, the activities engaged in by the monitoring team, the topics that the monitoring team commented upon both positively and negatively, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This should lead them to a listing of "activities engaged in to conduct the self-assessment." Then, they can report the findings of their self-assessment, their self-rating, and a rationale for the self-rating. The facility self-rated itself as being in noncompliance with all four of the provision items of section V. The monitoring team agreed, however, much progress was noted as detailed below.
	Summary of Monitor's Assessment: There were continued improvements in recordkeeping activities and records management. The failure to obtain substantial compliance, and the long list of recommendations, should not be taken as an indication of lack of progress. In fact, the facility was very close to substantial compliance in V1 and V3. The URC and CMR should update their facility-specific policy, which had not been revised in almost two years.

	Overall, the active records were organized and well maintained. Although improved since the last review, there continued to be problems in all current documents being in the record, legibility of entries, and proper signatures. Some steps had been taken (e.g., green card in the individual notebook, yellow card for nurses, training for staff and clinicians). The IPNs had entries other than only handwritten notes, such as emails and typed notes. In general, the standard is to not allow emails, memos, and so forth to be included in the IPNs. The facility should examine this and create an acceptable and agreed upon standard for SASSLC. Overall, the individual notebooks were well organized and available. The record clerks maintained the individual notebooks each day, ensuring they were put together correctly. A master record was in place for every individual. They were put together nicely and in a consistent manner. There was still no satisfactory resolution as to what to do when items could not be located. Not all state policies were yet in place, though continued progress was evident. SASSLC had a four-page spreadsheet that indicated the status of state policies, related facility-specific policies, and all other facility. This appeared to be a reasonable way to track state and facility policies. The spreadsheet should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12. Also, SASSLC needs to document training of relevant staff on both the state policies and the facility-specific policies. The URC continued to conduct five thorough quality assurance audits each month of all three components of the unified record. She used a table of contents tool and the statewide self-monitoring tool. She held a high and appropriate standard for physicians' orders, IPN entries, and observation notes. The URC developed a system to ensure that she was aware of what medical consultations had occurred so that she could look for each one in the corresponding section of the active record. The URC sent out a color-coded report of the table of contents audit results to all of the facility's department heads. Each department was designated a color, thus, making it easy for each department head to see the errors that he or she was responsible for addressing. This seemed like a reasonable and easy system. Problems in legibility, signatures, and so forth were the primary reasons for the statewide self-monitoring tools scores being approximately 80% rather than closer to 100%. Facility management, however, was likely to assume that recordkeeping was meeting the Settlement Agreement requirements due to these high scores, when in actuality, there were ongoing problems with the legibility, signatures, etc. The URC should create a set of graphs as described in V3, and that these graphs should be included in the facility's QA program.

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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 substantial compliance in all four provision items of section V. There were continued improvements in recordkeeping activities and records management. Recordkeeping practices continued to be managed by Noemi Cardenas, the Unified Records Coordinator (URC) and Janet Prince-Page, the Coordinator of Medical Records (CMR). The URC and the CMR were again responsive to the recommendations made in the previous monitoring report. This responsiveness will play a large role in their achieving substantial compliance. The DADS statewide policy remained in effect. Regarding facility-specific policy, nothing new or updated was submitted by the facility. Given that a number of changes and improvements had been made in recordkeeping practices over the past year, the URC and CMR should update their facility-specific policy #300-10, which had not been revised in almost two years. The table of contents and maintenance guidelines were updated in February 2011 for the active record and individual notebook and in March 2011 for the master record; they had not changed at the time of this review. <u>Active records</u> Overall, the active records were organized and well maintained. Although improved from the last onsite review, there continued to be a need for further improvement in all current documents being in the record, legibility of entries, and proper signatures, as required by Appendix D. The URC was not yet trending these important areas (see V3). The need for these improvements related to Appendix D were identified in the facility's own auditing of the active records and in the monitoring team's review of a sample of active records. As such, this was not a new issue for the facility and some steps had been taken. First, the URC created a green 8- x 11-inch card that was placed in front of the observation notes section of the individual notebook to increase the likelihood of correct entries by direct support professionals. Second, the nursing department created its own yellow laminated card with instructions on how to properly make nursing entries into the IPNs. The URC worked with the nursing department because many of the errors were made by nurses. Third, the URC provided training for direct support professionals in homes in which active record entries were most problematic based upon the URC's monthly audits (e.g., Home 665). Approximately 60 staff at this home were trained across two sessions. She also held training sessions for unit directors and residential managers (18 attendees),	Noncompliance

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		psychology department staff (18 attendees), nurses (26 attendees), and medical staff, PCPs, and psychiatrists) (7 attendees). Below are additional points regarding the active records: • An FSA and/or PALS was in each individual's active record. These were large documents, more than 50 pages long, and, as far as the monitoring team could tell, were never used after completion. The active records were large, heavy, and multi-volume. Consideration should be given to documents, such as these, that might not need to be in there. • The monitoring team met with the record clerks. They were knowledgeable and quite experienced with the minutiae of the active records. One topic discussed was possible ways to reduce the size of the active records. The monitoring team recommends the facility solicit their opinions. For example, the clerks questioned whether two full years of psychiatric clinic notes and two full years of seizure logs were needed to be kept in the active record, and they had ideas for possible ways in which the nursing section could be either reduced in size or subdivided to make the binder easier to manage. • The IPNs had entries other than only handwritten notes. Examples included emails printed and inserted and typed notes that were inserted. In general, the standard is to not allow emails, memos, and so forth to be included in the integrated progress notes. The facility should examine this and create an acceptable and agreed upon standard for SASSLC. <u>Individual notebooks</u> Overall, the individual notebooks were well organized and available; though see comments in V4 below. The record clerks maintained the individual notebooks each day, ensuring they were put together correctly. Some of the individual notebooks had lots of blank observation note forms. This added to the weight and bulk of the notebooks. Each of the notebooks had the new green sheet of observation note instructions described above. This was good to see and the URC reported that she felt it had helped. The monitoring team recommends that this green sheet be updated regularly, such as every three months, with new information and perhaps on a new color sheet. Otherwise, staff, over time, will stop attending to the green sheet and it will become another non-used page that clutters the individual notebook. In response to a recommendation in the previous report, the CMR and URC reviewed the contents of the individual notebooks to determine if everything that was required to be there really needed to be there. They determined that the content was as lean as it could be, that is, that there was nothing that could be removed.	

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		<u>Master records</u> A master record was in place for every individual. They were put together nicely and in a consistent manner. The CMR reported that the master records were sometimes useful to other staff, that is, the staff sometimes came to her for a document and it was now easier to locate than it had been in the past, such as guardianship papers. The CMR reported that once the master records were created, she did not need to devote a lot of time to them (e.g., she reported that she had spent only about 12 hours total on them since the last onsite review). There was still no satisfactory resolution as to what the CMR and URC were to do when items that should be in the master record could not be located. They reported that they were directed to continue with their current practice and to move forward when creating master records for any new admissions. To address this, the monitoring team recommends that there be some sort of procedure, rubric, flow chart, or guideline that the CMR and URC can follow that would indicate how to obtain those missing items and how to document their actions to show their efforts even if the document cannot be located. <u>Overflow files</u> Overflow files were managed in the same satisfactory manner as during the previous onsite review.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	SASSLC had a four-page spreadsheet that indicated the status of state policies for each provision of the Settlement Agreement, the facility-specific policy or policies that related to each of these state policies, and all other facility policies (i.e., those that were not in direct reference to a state policy). All of these included the date of the most recent revision. This appeared to be a reasonable way to track state and facility policies. This spreadsheet, however, should be dated because it is likely to be updated regularly. Not all state policies were yet in place, though continued progress was evident. The spreadsheet, however, should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12, such as, at a minimum, whether or not the facility-specific policy was reviewed by state office. To show implementation and training of relevant staff on both the state policies and the facility-specific policies, the facility should develop a policy and system that: • Incorporates mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy, including the list of job	Noncompliance

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		categories to whom training should be provided. • Defines, for each policy, who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and what documentation will be necessary to confirm that such training has occurred. Some of this responsibility may be with the Competency Training Department, but often others would have responsibility. • Includes timeframes for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). • Includes a system to track which staff completed which training.	
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 URC continued to conduct five thorough quality assurance audits each month. She looked at all three components of the unified record. She used two forms, one was the statewide self-monitoring tool; the other was a review using the table of contents for each of the three unified record components. The latter form was completed while reviewing the unified record, and her findings were used to help her complete the statewide form. The URC made many comments and notes while doing the review. She also conducted a brief interview with one IDT member to address section V4. The URC held a high and appropriate standard for physicians' orders, IPN entries, and observation notes. She noted if there were problems, such as the use of red ink, legibility of entries, legibility and completeness of signatures, and appropriateness of content. The URC addressed a recommendation from the previous report to develop a system to ensure that she was aware of what medical consultations had occurred so that she could look for each one in the corresponding section of the active record. To that end, the URC obtained information from the medical department and she made one spreadsheet that showed the appointments for the previous month and another spreadsheet that showed whether or not she found the corresponding information in the active record. The monitoring team suggests that the URC work with the medical compliance nurse to facilitate this process, so that it can be done in a way that is most efficient and that perhaps meets the needs of the medical department, too. • This spreadsheet, however, needs to include medical consultations for about a year, not only for the previous month. Therefore, the spreadsheet should really have all consultations for all individuals for a rolling 12-month period. • Even so, this was a very good start. Further, for the 10 reviews, according to the URC's tracking sheet, all consultations that occurred had corresponding documentation in the active record. If the appointment was cancelled, she found	Noncompliance

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		a corresponding note in the IPN. For the master record portion of the audit, the URC had a check sheet to indicate whether the item was or was not present. Many of the items, however, were optional and did not apply to many individuals. Therefore, an item scored "no" did not indicate whether this was an item that did not need to be there (i.e., not applicable) or whether it should have been there, but wasn't. Therefore, the URC should revise this form to have three columns: yes (i.e., present), no (i.e., should be in the master record, but wasn't), and NA (i.e., not applicable, not needed). At the end of the table of contents audit tool, the URC made additional comments, usually to provide more detail about the items that were scored as no. The URC also completed a questionnaire about the facility's use of the unified record as required by V4 (see V4 below). After completing the audit and the questionnaire, she then completed the statewide self-monitoring tool. The URC then sent out a report to all of the facility's department heads. The report was her completed table of contents audit tool with each error color-coded. Each department was designated a color, thus, making it easy for each department head to see the errors that he or she was responsible for addressing. This seemed like a reasonable and easy system. The URC reported that she had received positive feedback from department heads and staff. The monitoring team did not hear anything to the contrary. To follow-up on the needed corrections, she allowed about 10 days and then went out to see if the corrections were made. She noted on her own copy of the color-coded table of contents audit tool whether each error was corrected or not corrected. She checked a few more times over the subsequent months, cutting off the re-checks about a month before each onsite monitoring review (i.e., every six months). The monitoring team recommends that a consistent amount of time be allowed for follow-up for each review, such as two months. Errors that were about legibility, signatures, pen color, credentials, and so forth were not noted as errors in the URC's error correction system for the table of contents audits. She did, however, rate these areas in the statewide self-monitoring tool because there were specific items in the tool related to these topics. This was different than the way other facilities were calculating their error data. The URC reported and graphed data for the statewide self-monitoring tool (but not for the table of contents audit tool). These were submitted to the QA department and were included in the QA report. For example, in the January 2012 QA report, the	

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		recordkeeping section included a graph of the current month's five scores (though they were incorrectly presented as a line graph instead of as a bar graph) and a second graph showing the average score for each of the past five months. The average score each month was relatively high (more than 75%). The problems in legibility, signatures, and so forth were the primary reasons for the statewide self-monitoring tools scores being less than 100%. Consider, however, that facility management was likely to assume that recordkeeping was meeting the Settlement Agreement requirements due to these high scores, when in actuality, there were ongoing problems with the legibility, signatures, etc. Thus, the tool was not providing a valid measure of the facility's performance (also see E2 above). Based on the above, the monitoring team recommends that the URC create a set of graphs as follows, and that these graphs are included in the QA program: • Number of reviews done per month • Average score on the statewide self-monitoring tool (this was already being done) • Average score on the statewide self-monitoring tool only including those items that have been problematic (i.e., the items regarding legibility, signatures, etc.). • The average number of errors per table of contents review • The average number of errors that were not corrected as of the cut off date (e.g., two months).	
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 recordkeeping staff. Recently, the monitoring teams, DADS, and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item that was submitted by the monitoring teams would be used by the facilities for the next onsite review. Even though SASSLC did not yet have this list, the items are presented below. It is also likely that the DADS state office coordinator for recordkeeping will provide additional direction and guidance to the MRC and URC. <u>Records are accessible to staff, clinicians, and others</u> SASSLC was not yet self-assessing this. The monitoring team, however, observed that: • Active records were usually available on the units and kept in central locations, which permitted ready access. There were some variations in this practice, but it appeared limited to the occasions when records were in use by physicians, RN case managers, and/or other clinical professionals. • Records were available during psychiatry clinic and staff referred to them and reviewed documentation. • Across the 21 sample individuals whose records were selected for in-depth review, important sections of the records of more than half of the individuals	Noncompliance

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		were missing one or more important documents, such as current ISPs, current comprehensive nursing assessments, health care plans, IPNs, etc. • Current ISPs were not available in all records reviewed in the home, thus DSPs did not have information needed to carrying out each individual's support plan. • The individual books did not appear to always be consistently accessible to staff. In many homes the individual notebooks were locked in an office. • Habilitation therapy clinicians reported difficulty in accessing the record at times to ensure timely documentation. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> SASSLC was not yet self-assessing this. The monitoring team, however, observed that: • None of the PBSP datasheets reviewed during observations across the facility were completed in a timely manner. • Data sheets for PT interventions were noted for the few individuals who received this service. The data collected, however, were not always specifically related to the established goals. • Late entries entered by all disciplines were found in the record sample. Late entries that were written on an IPN page then later placed in the record resulted in IPN entries not being sequential and made record use difficult. • Data, such as weekly weights, fluid intake, vital signs, etc. were not consistently documented, as ordered by their physicians. These oversights were significant because the health status data, which were missing, were to be used by the individuals' clinical professionals to monitor the individuals' response to and effectiveness of treatment interventions, monitor medication side effects, etc. (see detail in M1). • A sample of quarterly reviews did not confirm that data were available for teams to consider when determining if a plan was adequate. As noted in section F, some quarterly reviews noted that data were not available for review by the IDT. <u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> SASSLC was not yet self-assessing this. The monitoring team, however, observed that: • It appeared that the physicians utilized the records and reviewed documentation from other disciplines. • Physicians' notes indicated their use of the active record in making care/treatment decisions. For example, the physicians noted their reviews of blood tests, diagnostic procedures, hospitalization records, etc. • Nurses' notes, on the other hand, did not. Nurses typically documented by exception, that is, they only documented episodic events, findings, etc. that were, in their opinion, abnormal. This type of documentation, which was focused on	

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		detecting, assessing, and analyzing variances, heavily relied upon the experience, knowledge, education and training, and ability of clinical professionals to differentiate normal versus abnormal findings. Thus, this documentation, as implemented by SASSLC nurses, had many problems, and across the vast majority of the records reviewed, there was little evidence that nurses used the active record in making care and treatment decisions. o The only exception to this finding occurred when nurses documented their review of the individuals' bowel logs, noted that individual(s) failed to move their bowels in three or more days, and administered PRN doses of laxatives. • At the risk discussion meeting on 12/14/12, the QDDP coordinator indicated that each discipline reviewed data collected prior to the annual risk review meeting and brought that information to the meeting in terms of recommendations made at annual IDT meetings. Findings for section I, however, did not confirm that information from assessments and data collected by each discipline was used in determining risk levels. • Progress notes for direct therapies, wheelchair clinic, and some other limited actions taken by therapists were noted. Actions by the PNMT were merely reported with a reference to the PNMT action plan. These plans were excessively long, redundant, difficult to read and essentially not useful to other team members as a result. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC conducted a brief, but informative, interview with one IDT member each month for one of the individuals who was audited. The IDT members reported good use of the active record and individual notebook. The URC, based on this interview scored a yes for the question regarding this that was in the statewide self-monitoring tool. • Physicians reported that they used the records and, in fact, needed the records to make decisions about care. Not having easy access to the records resulted in some physicians starting shadow charts of key information. • It was reported that consults and other information could sometimes not be located, but it was not clear if this was a filing issue or due to the consult not returning to the facility. • Nurses reported that they used the ACPs filed in the individuals to guide and direct their care/treatment decisions. Although this was a reasonable process, there was insufficient evidence across the individuals' records that supported this report. For example, during the period of 9/1/11 – 2/13/12, the majority of the 21 individuals' reviewed (section M) suffered one or more acute health problems. Most of these individuals' records failed to have individualized acute	

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		care plans with adequate interventions to guide and direct caregivers implement delegated health care duties to ensure the individuals' health and safety. • The record was clearly used for extensive review in the completion of OT/PT/SLP and PNMT assessments. <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item</u> SASSLC was not yet assessing this, however, the monitoring team found the following: • During the ISP meeting for Individual #240, the RN case manager looked through his active record when no one at the meeting could remember some aspect of his medical history. • During the ISP meeting for Individual #31, the individual's record was brought to the meeting and used during the meeting to make care and treatment decisions, especially with regard to the assignment of levels of health risk. • The integrated records were maintained in the living areas. Physicians had access to them as they conducted clinical rounds. Documentation for acute issues occurred at the time the individual was seen. • In spite of access in the home areas, the use of records presented problems. Physicians were required to review many documents, most of which were routed to their offices. When an IPN entry or order was needed, the physician needed to go to the home to make the entry. Even more problematic was the fact that physicians did not have access to the records at the time of document review. Completing the documentation during sick call was challenging due to the many issues that needed to be addressed in the morning. Most physicians reported coming in early or staying late to move about the homes and make entries into the records. • In the case of QDRRs, the clinical pharmacists began creating a log of recommendations that the physicians could use as a reminder of which records needed review and/or documentation. The medical director reported that this would probably not continue due to limitations with pharmacy staff. • The PNMT meeting was conducted without the availability of the record to check current status or for other reference during the meeting. • Data were not appropriately graphed. Data presented during psychiatry clinic was in tabular form and difficult to interpret. In order for psychiatrists to make data driven decisions, this information must be graphed with the inclusion of time lines and medication change information.	

Recommendations:

1. Update the facility-specific policy (V1).
2. Address legibility, signatures, entries, etc. because the facility's efforts have not yet led to a satisfactory outcome, even though progress had been made (V1).
3. Consideration should be given to documents that might not need to be in the active record (e.g., FSA) (V1).
4. Solicit suggestions from the record clerks (V1).
5. Address the insertion of various forms, cut and pastes, etc. into the IPNs (V1).
6. Update the green individual notebook direction sheets periodically, such as once per quarter, perhaps even changing the color at that time (V1).
7. Determine how to proceed regarding items missing from the master record (V1).
8. Put a date on the policy spreadsheet (V2).
9. Expand the spreadsheet to include relevant information from the assistant commissioner's email on 2/15/12 (V2).
10. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
11. Work with the medical compliance nurse to make the medical consultation spreadsheet list as efficient as possible, and to include consultations for a rolling 12-month period (V3).
12. Add a column to the audit tool for the master record (V3).
13. Allow a consistent amount of time following each unified record audit for corrections to be made (e.g., two months) (V3).
14. Consider whether/how to include legibility, signatures, etc. in the error and correction system (V3).
15. Create a set of five graphs as listed in V3 (V3).
16. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the five areas highlighted with underlined headings in section V4 (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
ABX	Antibiotics
ACE	Angiotensin Converting Enzyme
ACLS	Advanced Cardiac Life Support
ACOG	American College of Obstetrics and Gynecology
ACP	Acute Care Plan
ACS	American Cancer Society
ADA	American Dental Association
ADA	American Diabetes 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
AMS	Annual Medical Summary
ANC	Absolute Neutrophil Count
ANE	Abuse, Neglect, Exploitation
AOD	Administrator On Duty
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
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
AV	Alleged Victim
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
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BTC	Behavior Therapy Committee
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CAL	Calcium
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
CIN	Cervical Intraepithelial Neoplasia
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
CPT	Certified Psychiatric Technician
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	Development Center
DC	Discontinue
DCP	Direct Care Professional
DCS	Direct Care Staff
DD	Developmental Disabilities
DDS	Doctor of Dental Surgery

DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRR	Drug Regimen Review
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
ECG	Electrocardiogram
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
ENE	Essential Nonessential
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
FLACC	Face, Legs, Activity, Cry, Console-ability
FNP	Family Nurse Practitioner
FNP-BC	Family Nurse Practitioner-Board Certified
FOB	Fecal Occult Blood
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicators
FTE	Full Time Equivalent
FTF	Face to Face
FU	Follow-up
FX	Fracture
FY	Fiscal Year
G-tube	Gastrostomy Tube
GAD	Generalized Anxiety Disorder
GB	Gall Bladder
GED	Graduate Equivalent Degree
GERD	Gastroesophageal reflux disease
GFR	Glomerular filtration rate
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
HMO	Health Maintenance Organization
HMP	Health Maintenance Plan
HOB	Head of Bed
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer

HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
IAR	Integrated Active Record
IC	Infection Control
ICA	Intense Care Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ID	Intellectually Disabled
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
IPE	Initial Psychiatric Evaluation
IPN	Integrated Progress Note
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KUB	Kidney, Ureter, Bladder
L	Left
L	Liter
LA	Local Authority
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LDL	Low Density Lipoprotein
LFT	Liver Function Test
LISD	Lufkin Independent School District
LOC	Level of Consciousness

LOD	Living Options Discussion
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
LVN	Licensed Vocational Nurse
MA	Masters of Arts
MAP	Multi-sensory Adaptive Program
MAR	Medication Administration Record
MBA	Masters Business Administration
MBD	Mineral Bone Density
MBS	Modified Barium Swallow
MBSS	Modified Barium Swallow Study
MCG	Microgram
MCP	Medical Care Provider
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
MHA	Masters, Healthcare Administration
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
MOT	Masters, Occupational Therapy
MOU	Memorandum of Understanding
MR	Mental Retardation
MRA	Mental Retardation Associate
MRA	Mental Retardation Authority
MRC	Medical Records Coordinator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphyloccus aureus
MS	Master of Science

MSN	Master of Science, Nursing
MPT	Masters, Physical Therapy
MSPT	Master of Science, Physical Therapy
MSSLC	Mexia State Supported Living Center
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
NIELM	Negative for Intraepithelial Lesion or Malignancy
NL	Nutritional
NMC	Nutritional Management Committee
NMES	Neuromuscular Electrical Stimulation
NMS	Neuroleptic Malignant Syndrome
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NPO	Nil Per Os (nothing by mouth)
NPR	Nursing Peer Review
O2SAT	Oxygen Saturation
OBS	Occupational Therapy, Behavior, Speech
OC	Obsessive Compulsive
OCD	Obsessive Compulsive Disorder
OCP	Oral Contraceptive Pill
ODD	Oppositional Defiant Disorder
ODRN	On Duty Registered Nurse
OIG	Office of Inspector General
OT	Occupational Therapy
OTD	Occupational Therapist, Doctorate
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P	Pulse
P&T	Pharmacy and Therapeutics
PAD	Peripheral Artery Disease
PALS	Positive Adaptive Living Survey

PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
PDD	Pervasive Developmental Disorder
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
QDDP	Qualified Developmental Disabilities Professional
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QHS	quaque hora somni (at bedtime)
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
ROM	Range of Motion
RPH	Registered Pharmacist
RPO	Review of Physician Orders
RR	Respiratory Rate
RT	Respiration Therapist
RTA	Rehabilitation Therapy Assessment
RTC	Return to clinic
RX	Prescription
SAC	Settlement Agreement Coordinator
SAISD	San Antonio Independent School District
SAM	Self-Administration of Medication
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools

SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
S/P	Status Post
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
TAC	Texas Administrative Code
TAR	Treatment Administration Record
TB	Tuberculosis
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
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
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
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
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old