United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: August 20 – August 24, 2012

Date of Report: October 16, 2012

Submitted By:	Alan Harchik, Ph.D., BCBA-D Monitor
Monitoring Team:	Helen Badie, M.D., M.P.H, M.S. Carly Crawford, M.S., OTR/L Daphne Glindmeyer, M.D. Gary Pace, Ph.D., BCBA-D Natalie Russo, R.N., M.A. Teri Towe, B.S.

Table of Contents

Background

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

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while onsite. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

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

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

Organization of Report

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

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the Settlement Agreement, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility 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 from the parties to protect the confidentiality of each individual.

Substantial Compliance Ratings and Progress

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

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

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

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

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

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

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

Executive Summary

First, the monitoring team wishes to again acknowledge and thank the individuals, staff, clinicians, managers, and administrators at SASSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The facility director, Ralph Henry, set the tone for the week and was supportive of the monitoring team's activities. The Settlement Agreement Coordinator, Andy Rodriguez, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed. He was readily available and very responsive.

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

Third, below, are comments on a few general topics regarding services and supports at the facility.

- Engagement and activities: The facility renewed its focused on the engagement of individuals in activities. As management staff move forward in addressing this important aspect of support, the monitoring team encourages them to ensure they are taking into consideration the many responsibilities of staff, such as implementation of PNMPs, SAPs, PBSPs, dining plans, and general health and safety. To that end, the newly formed Active Treatment Coaching Guide PIT might be broadened to be an Active Treatment PIT in which senior management works together with middle managers and AT staff to make this work in a way that is manageable and doable, and something that everyone can work on together.

- Risks and incidents: As the facility moves forward in responding to medical crises, incidents, allegations, and risks for each individual and by following proper documentation processes, the monitoring team wants to ensure that facility management understands that properly addressing these areas requires a facility-wide approach, especially when developing new activities and systems so that crises and incidents are less likely to happen in the first place.

- Dental services: As detailed in section Q, turnover in the leadership in the dental department resulted in poor outcomes for many individuals.

- New ISP process: The ISP process was again updated. It may take some time for it to be fully implemented across the facility.

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

- There was good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents. DADS updated its restraint policy as of 4/10/12. SASSLC had begun implementation, including providing training to all staff on the new policy.
- There were 48 restraints used for crisis intervention between 2/1/12 and 7/31/12. This was a considerable decrease in the number of restraints reported compared to the previous six month reporting period (131).
- From 2/1/12 through 6/30/12, the facility reported 29 incidents of restraint used for medical treatment. This list included pretreatment sedation prior to medical and dental appointments.
- The facility had recently begun to address protective mechanical restraints to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans had been developed for five individuals who were wearing protective restraints due to self-injurious behaviors. These restraints were now reviewed by IDTs and reported in terms of restraints at the facility.
- Restraints were now being reviewed in the daily unit meeting and incident management meeting.

Abuse, Neglect, and Incident Management

- Between 12/1/11 and 5/31/12, there were three confirmed cases of physical abuse and eight confirmed cases of neglect. DFPS conducted investigations of 149 allegations at the facility of 94 allegations of abuse, 9 allegations of exploitation, and 46 allegations of neglect. An additional 16 other serious incidents were investigated by the facility.
- There were 946 injuries reported between 2/1/12 and 6/30/12. These included 10 serious injuries resulting in fractures or sutures. This was a slight decrease from the previous five months.
- Some positive steps taken to address the provision items of section D included:
    - A poster inventory checklist was created to ensure ANE information posters were in place in all buildings.

    - Reminders were now being sent to department heads when employees were delinquent with training requirements.
    - QDDPs were trained on documenting when ANE information was shared with individuals and their families.
    - The facility was sufficiently documenting follow-up to recommendations and concerns in individual investigation files.
- A Performance Improvement Team had recently been appointed to review trends and data in regards to ANE and develop a plan of improvement.

Quality Assurance

- SASSLC continued to make progress towards substantial compliance with provision E. A set of important key relevant indicators/data need to be added to the QA matrix and QA report for each of the Settlement Agreement provisions. SASSLC had begun to revise or create some new self-monitoring tools, such as sections S, U, and some of the 12 M tools.
- A number of QA-type activities were occurring at SASSLC. The QA director should incorporate these into his overall QA program. Examples were in medical, nursing, and habilitation.
- The QA director made very good progress in developing satisfaction measures. The next steps are data collection, summary and analysis of findings, and creation and implementation of any required actions.
- The self-advocacy committee had improved since the last review. The group met very often. The rights officer made sure there were regular relevant topics. Overall, she helped the individuals who participated (about a dozen) to know that their voices were heard.
- The QA report continued to improve. Each month, edits, changes, and additions were made to make it more complete, readable, and logical. The QA director was still developing a system to meet the CAP requirements.
- The QAQI Council meeting observed by the monitoring team was more engaging and on topic than the one observed during the previous monitoring review. There was, however, little discussion or participation by attendees. It may be that they did not know in what ways they could participate.

Integrated Protections, Services, Treatment, and Support

- At SASSLC, training had recently been provided on the ISP process and risk identification by DADS consultants.
- The monitoring team observed one ISP meeting in the new format. It was the first time this newest iteration of the ISP process had been implemented at SASSLC. The IDT was not yet competent at developing an integrated plan that included all needed supports and services based on preferences and needs of each individual. It was apparent that the IDT was attempting to follow the format of the new ISP process and include all required information in the plan.

- A major part of the meeting, however, was devoted to the risk identification process. Although this was very important (see section I), the QDDP failed to keep the risk discussion moving along, resulting in a very lengthy meeting where very little long range planning occurred and minimal focus was placed on the individual's preferences, how he might like to spend his day, and other important supports and services.
- The facility audit indicated that assessments were not being submitted prior to the annual IDT meeting. Without an adequate assessment process and participation by all team members in planning, IDTs could not develop plans to address individual's preferences and needs.
- DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. The new ISP process had not been completed for any individuals at SASSLC.

Integrated Clinical Services

- The facility continued to make good progress. A number of actions were taken to address several issues that would promote the integration of services. The clinical integration policy was implemented in early 2012 and facility staff were working to ensure that the activities included in that policy occurred as required.
- The integration policy listed a series of committees that were important in directing activities critical to integration. The facility's primary activity in assessing this provision was conducting audits of participation of core committee members. The medical director and medical compliance nurse also provided examples of activities that occurred in an integrated manner.
- 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.

Minimum Common Elements of Clinical Care

- There was some, but not much progress, in this area. The facility specific policy remained in draft form and most of the efforts were targeted at provision H1. The management of assessments needed attention because many key assessments were not completed in a timely manner. Moreover, the facility did not provide any evidence that the quality of these assessments was consistently monitored.
- Much of the work that needed to be done for this provision will hinge on the development of a robust set of indicators that can be utilized across the continuum of treatment and evaluation of treatment.

At-Risk Individuals

- Progress had been made through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks.
- All plans, however, were not in place to address all risks identified. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review.
- Assessments were not being consistently completed prior to ISP meetings. 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.
- Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs.

Psychiatric Care and Services

- The facility designated a lead psychiatrist who had implemented policy and procedure geared toward meeting generally accepted professional standards of care in psychiatry.
- There remained challenges with respect to this enhanced psychiatric 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). The department will need the ongoing support of facility administration and the leadership of related disciplines.
- Observations of psychiatric clinic revealed continued 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 facility clinical staff had 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.

Psychological Care and Services

- There was considerable progress accomplished in the last six months. Improvements included hiring of a qualified director of psychology, and the initiation of external peer review monthly, the collection of data reliability, and the collection of interobserver agreement (IOA) data. Simplified graphs and evidence of data graphed in intervals necessary to make data-based decisions were created and there was an increase in the percentage of individuals with PBSPs that have functional assessments. Functional assessments and the quality of annual assessments improved. Most notably, there were improvements in the quality of PBSPs.
- Continued improvements were needed to ensure that all psychologists that write PBSPs had completed or are enrolled in training to obtain their certification as applied behavior analysts. There was a need to simplify the system for collecting both target and replacement data, modify the procedures for the collection of IOA, and establish and achieve IOA and data collection reliability. Data need to be used to make treatment decisions, graphing of replacement behaviors needs to be initiated, and treatment integrity established.

Medical Care

- The medical department made progress in the provision of health care services. Process changes, databases, and development of oversight committees were successfully implemented. There were improvements noted in preventive care services, follow-up of individuals, and documentation.
- The medical compliance nurse became an invaluable member of the medical department. She worked closely with many facility staff on a number of issues. She maintained data on the clinical indicators and tracked medical consultations, assessments, and preventive care for the individuals.
- One noteworthy area of improvement was the development of a medical quality program. A committee was developed to review medical quality based on selected indicators. The program was in its developmental stage, but the model implemented should provide good information for the facility.
- Follow-up of acute medical problems also improved. There was increased documentation of physician evaluations when individuals developed acute problems. Documentation of post-hospital assessments, labs, and consultations were all improved.
- Much work, however, remained. Problems related to the management of pneumonia were addressed with several changes and aspiration guidelines were revised. Unfortunately, the change in policy did not translate into any real change in how individuals were managed. Implementation of the osteoporosis protocols did not seem to take hold because many individuals were not treated in accordance with the guidelines.
- Record audits also identified individuals who experienced a change in status, but notification of a physician was not prompt. There were also instances in which physicians ordered treatment, but did not follow-up with evaluation of the individual. Several of these individuals were acutely ill and ultimately hospitalized for conditions, such as ruptured appendix, volvulus, and pneumonia.

- The provision of neurological care continued to be a cause for concern. The number of neurology clinic hours was inadequate to meet the needs of the individuals. Individuals were identified who had no neurology follow-up in several years in spite of receiving several AEDs.
- External and internal audits were completed, but problems related to same size and scheduling made the reliability and validity of the audits questionable. Mortality management remained problematic at SASSLC.

Nursing Care

- Under the leadership of the CNE, the Nursing Department made progress across all provisions of section M. There were significant improvements in nurses' time and attendance at work, increased accountability, and decreased unscheduled absences. This positively affected nursing care and morale among colleagues.
- There were also improvements in the timeliness of nursing assessments. Systems were developed and implemented, and performance improved to 100% compliance. Other specific areas of nursing care, which were deficient in the prior review, were re-established with expectations for quality, such as skin integrity.
- The Nursing Department continued to maintain good working relationships with other departments, most notably the quality assurance and pharmacy departments. This had been, and continued to be, a very positive finding.
- The results of the facility's self-assessments, audits, monitoring tools, etc., however, continued to reveal problems across the provisions of section M. These findings were consistent with the findings of the monitoring team.

Pharmacy Services and Safe Medication Practices

- Over the past two years, there was progress, however, since the last review, additional progress in some areas was overshadowed by no progress in some areas and regression in others. The supervision of the pharmacy department was moved to the facility director. The medical director continued to have very little involvement
- The pharmacist at the State Hospital increased documentation of communication with SASSLC staff, but the communication occurred largely with the nursing staff. Documentation revealed several interactions that should have been discussed with the physicians, but were not.
- While the overall quality of the Quarterly Drug Regimen Reviews was adequate, the facility did not complete them in a timely manner. A Polypharmacy Oversight Committee was formed just prior to the onsite review.
- Physicians responded to the recommendations of the clinical pharmacist with appropriate actions and orders. Psychiatrists continued to complete the MOSES and DISCUS evaluations in a timely manner and scores were being reported on the neurology consults.
- SASSLC did not have an adequate system for detecting, reporting, and monitoring adverse drug reactions. This resulted in a series of failures that had the potential to adversely affect the care provided to individuals.

- Two Drug Utilizations Evaluations were completed. Both were done in a timely manner and presented to the Pharmacy and Therapeutics Committee.
- Progress was noted in the medication variance system based on the re-institution of minimal reconciliation. Continued work was needed to further define the etiologies of the returned medications.

Physical and Nutritional Management

- There was a progress since the previous review. There was a fully constituted PNMT, including a full time nurse. The PNMT generally met weekly and attendance, with alternates, was good. Documentation had been reviewed and revised to be more concise and streamlined. During the meeting observed, the discussions conducted were thorough. The PNMT had recently reinitiated IDT member participation in their meetings.
- There continued to be some concerns related to mealtimes and position and alignment, though both areas were improved. Some ongoing issues were noted and included food textures, liquid consistencies.
- Positioning and alignment in wheelchairs and alternates, such as recliners continued to be problematic. Other options to these should be considered. Evaluation was needed for the blue geri-chairs.
- Observation of one aspect of NEO training, conducted by the PNMPCs, was observed and noted to be excellent. The implementation of true competency-based training continued to be lacking. Follow-up monitoring of staff should be considered at a specified interval(s) to ensure that continued competency is ongoing and that compliance is consistent.

Physical and Occupational Therapy

- Considerable progress continued to be made. The level of staffing for OT and PT clinicians remained consistent, though low for the number of individuals with identified needs. The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services.
- Assessments were reviewed, and consistency for content was found to be improved since the last review. The audit system was thorough and was conducted in a manner to establish competence, but there did not appear to be a plan to ensure continued competence. P1 was very close to substantial compliance.
- Only a few individuals were listed with direct OT and/or PT, though there were no SAPs. Documentation, however, was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process.

Dental Services

- The dental clinic saw no progress. The number of appointments decreased, compliance with annual assessments remained poor, and missed appointments were not sufficiently addressed. The decreased provision of services and compliance deficiencies may have been due, in part, to the clinic relocation.
- Problems were identified with the provision of emergency care. Home oral care was often noted by the dentists to be poor. Informed consent continued to present challenges and the dentists noted repeatedly that care was delayed due to the processing of consents.
- In many instances, there was evidence of gross inaccuracy of the information submitted.
- The facility did not have a dental director at the time of the review and was planning to conduct interviews to fill the position. Stability of the clinic staff will be vital in evaluating and resolving the many issues identified in this report.

Communication

- The monitoring team observed progress and was very encouraged by the current strategies and infrastructure for staff training and monitoring in place to address communication supports.
- There continued to be individuals who were considered to have priority needs related to communication who had not yet received the new comprehensive assessment. Progress in the completion of assessments was slow and, per the current schedule, would not be complete until June 2013. The current ratio for caseloads continued to be high. Consideration for a Speech Assistant position should occur.
- The completion of assessment is but a step in the continuum of the provision of communication services. The therapists are encouraged to step up their efforts to immerse themselves into the routines of the individuals they support to capitalize on the teachable moments with staff so that they may learn to capture teachable moments with individuals.
- Staff tend to see these systems as an exercise or a single activity rather than as a way to interact with others. This cannot actually be taught or trained in an inservice class, but rather modeled and coached in the moment. Integration of communication strategies and AAC systems should not be the sole responsibility of direct support and day program staff.

Habilitation, Training, Education, and Skill Acquisition Programs

- There was progress and several improvements since the last review. These included training across the facility on the implementation of SAPs. Moreover, the facility began collecting interobserver agreement (IOA) for engagement measure, assessing the integrity of SAP implementation, graphing SAP outcomes, and establishing community-training goals per home. Moreover, the staff developed a plan to implement a pilot program to address the items in provision S.

- Further work will be needed to ensure that the rationale for each SAP clearly states how acquiring this skill is related to the individual's needs/preference, and that each SAP has a plan for maintenance and generalization that is consistent with the definitions in the report below. The facility will also need to initiate an interdisciplinary team to address the use of general compliance plans, dental desensitization plans, document how the results of individualized assessments of impacted the selection of skill acquisition plans, expand the graphing of SAP data to increase the likelihood decisions regarding SAPs are the result of data based decisions, expand the collection of treatment integrity data to all SAPs, and increase the implementation of SAPs in the community.

Most Integrated Setting Practices

- SASSLC made progress since the last onsite review regarding many aspects of provision T. A new Admissions and Placement Coordinator (APC) led a department with five new staff.
- The numbers of individual who were placed remained very low, at a rate of less than 1% of the census (1 individual). The number of individuals on the active referral list was also low, at 5% of the census (15 individuals), however, this was the highest since monitoring began at the facility.
- SASSLC was transitioning to the newest iteration of the ISP process. In the ISP meeting observed during the week of the onsite review, community living was discussed at various times during the meeting. Professionals were not, however, asked to give their opinions.
- The APC made progress regarding the provider fair and in arranging tours and having individuals and staff participate. The rights officer regularly included community living topics in the self-advocacy meeting.
- Assessments were not all completed within 45 days prior to the individual leaving the facility, and in many cases, the monitoring team could not determine if assessments were completed at all (e.g., psychiatry). Further, the assessments need to focus more upon the individual moving to a new residential and day setting.
- The lists of ENE supports in the two CLDPs were inadequate. Important supports were missing, the supports that were included were not written in measurable terms, and the descriptions of what evidence the provider needed to show were not defined in a sufficient manner.
- Three post move monitorings for three individuals were completed. All occurred within the required timelines and were documented in the proper format. The PMM did a good job of following up when there were problems. She must, however conduct post move monitoring in a more assertive, detailed, and thorough manner.

Guardianship and Consent

- The Human Rights Officer had developed a tool to assess individual's ability to give informed consent. The Human Rights Officer had developed an audit system to assess discussions taking place at IDT meetings regarding each individual's functional capacity to make decisions. There had been an increased focus on providing training and opportunities for self-advocacy for individuals at the facility.
- Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need.

Recordkeeping Practices

- SASSLC demonstrated continued progress. A new URC was recently appointed, but had not yet started. The coordinator of medical records will need to ensure that his transition, training and orientation, and completion of duties are all done thoroughly and correctly.
- The active records continued to be in good shape, due in large part, to the work of the record clerks. Even so, there continued to be a need for further improvement regarding documents missing from the active record, legibility of written entries, and the content of the IPNs. To address these needed improvements, the CMR instituted a number of actions.
- Staff appeared comfortable and knowledgeable about the individual notebooks. The individual notebooks, however, were not always readily available to staff. The CMR initiated a new master record table of contents in May 2012, based upon suggestions from state office. The CMR had not resolved what to do about items that should be in the master record, but were not.
- Five quality assurance audit reviews were not conducted each month, as required. The reviews that were conducted, however, were done in a consistent manner. The number of errors found was around four to 10.
- The same procedures were implemented for provision item V4, that is, short interviews of staff following ISP meetings and a review of IPNs. No action was taken to explicitly address the six aspects of V4 that were reviewed during the last monitoring review (and reviewed again during this onsite review).

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 looks forward to continuing to work with DADS, DOJ, and SASSLC. Thank you for the opportunity to present this report.

II. Status of Compliance with the Settlement Agreement

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

<u>Documents Reviewed</u>:
o DADS Policy: Use of Restraints 001.1 dated 4/10/12
o SASSLC Self-Assessment
o SASSLC Provision Action Information Log
o SASSLC Section C Presentation Book
o FY12 Restraint Trend Analysis Report
o Sample of IMT Minutes
o SASSLC QAQI Council Quality Assurance Report
o List of all restraint by Individual 1/21/12 through 6/30/12
o List of all chemical restraint used for the past six months
o List of all medical restraints used for the past six months
o List of all restraints used for crisis intervention for the past six months
o List of all mechanical restraints for the past six months
o SASSLC “Do Not Restrain” list
o List of individuals with desensitization plans
o Dental Support/Desensitization plans for Individual #77.
o Restraint Reduction Committee meeting minutes for past six months
o Training transcripts for 24 SASSLC employees
o Documentation for medical restraints and ISP for:
• Individual #273, Individual #127, Individual #345, Individual #193, Individual #289, Individual #67, Individual #34, Individual #6, Individual #110, and Individual #284.
o ISPs, PBSPs, and ISPAs for:
• Individual #111, Individual #191, Individual #225, Individual #148, Individual #184, Individual #168, and Individual #232.
o ISPA documenting discussion of protective mechanical restraints for
• Individual #317, Individual #227, Individual #167, Individual #164, Individual #255, Individual #314, Individual #96, Individual #77, and Individual #349.
o Crisis Intervention Plans for:
• Individual #168 and Individual #232
o A sample of restraint documentation for crisis intervention including:

<table>
<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#232</td><td>5/15/12</td><td>Physical</td></tr>
<tr><td>#232</td><td>5/8/12@4:52 pm</td><td>Physical</td></tr>
<tr><td>#232</td><td>5/8/12 @2:57 pm</td><td>Chemical</td></tr>
</table>
</td></tr>
</table>

#232	5/8/12 @2:48pm	Physical
#168	8/20/12	Physical
#168	8/19/12	Physical
#225	6/6/12	Physical
#148	3/18/12	Physical
#184	2/23/12	Chemical
#184	2/1012	Chemical
#191	5/10/12	Chemical
#111	2/3/12	Chemical

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Gevona Hicks, Human Rights Officer
- Charlotte Fisher, Director of Behavioral Services

Observations Conducted:

- Observations at residences and day programs
- Unit Morning Meeting for Unit 1 and Unit 3
- Incident Management Team Meeting
- Annual ISP meeting for Individual #281
- Human Rights Committee Meeting
- Restraint Reduction Committee Meeting

Facility Self-Assessment:

SASSLC submitted its self-assessment. It was updated on 8/7/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale.

The facility conducted a number of activities to assess compliance for each provision item. Activities were similar to the activities engaged in by the monitoring team to assess compliance. The self-assessment noted that many of the activities regarding restraint monitoring and review, as well as the audit system, were newly implemented, so it was too early to determine if these activities would result in compliance with section C requirements.

The facility self-assessment commented on the overall compliance rating for each provision item based on restraint documentation audited, as well as commenting on processes in place to address compliance with each item. The facility assigned a rating of substantial compliance to C2 and C3. The facility had met substantial compliance with C2. C3 was not found to be in substantial compliance due to the number of

staff who failed to complete training annually. The self-assessment should look at timeliness of training to ensure training is not just current at the time of audit, but completed annually, so always current. The facility rated the other provisions in C as noncompliant. The monitoring team agreed with the facility's self-assessment. Even so, there had been considerable progress made in developing an adequate self-assessment process.

Summary of Monitor's Assessment:

DADS updated its restraint policy as of 4/10/12. The policy included new definitions for each type of restraint and set new guidelines for restraint debriefing and monitoring. The facility had reviewed the new policies and had begun implementation, including providing training to all staff on the new policy.

Based on information provided by the facility, there were 48 restraints used for crisis intervention between 2/1/12 and 7/31/12. This was a considerable decrease in the number of restraints reported compared to the previous six month reporting period. The SASSLC FY 2012 Trend Analysis indicated restraint totals fluctuated from August 2011 to July 2012, remaining relatively low, except for spikes in September 2011, October 2011, and May 2012. These spikes were attributed to specific individuals at the facility.

Month	Total Restraints	Month	Total Restraints
August 2011	4	February 2012	7
September 2011	64	March 2012	7
October 2011	42	April 2012	5
November 2011	10	May 2012	21
December 2011	5	June 2012	2
January 2012	7	July 2012	6

From 2/1/12 through 6/30/12, the facility reported 29 incidents of restraint used for medical treatment. This list included pretreatment sedation prior to medical and dental appointments.

The facility had recently begun to address protective mechanical restraints to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans had been developed for five individuals who were wearing protective restraints due to self-injurious behaviors. These restraints were now reviewed by IDTs and reported in terms of restraints at the facility.

Action taken by the facility to address compliance with section C since the last monitoring visit included:

- The facility had appointed a new Director of Behavioral Services.
- The new statewide restraint policy was adopted by the facility.
- Training had been provided to all staff on the new statewide restraint policy.
- New crisis intervention plans had been developed for some individuals to offer staff clearer instructions regarding restraint application and documentation.
- Restraints were now being reviewed in the daily unit meeting and incident management meeting.

	The facility had made good progress towards meeting compliance with requirements for documenting and reviewing restraint incidents. The facility was in substantial compliance with one of the eight provision items.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The facility provided a list of all restraints used for crisis intervention between 2/1/12 and 6/30/12 (five month period): • 42 restraints occurred. • 10 individuals were the subject of restraints. • Four (40%) of 10 individuals only had one restraint during the reporting period. • Three individuals accounted for 30 restraints (71%). • 29 were personal hold restraints, • 28 of 29 physical restraints were horizontal restraints, and • 13 were chemical restraints. This was a considerable reduction from the 131 crisis intervention restraints reported at the last monitoring visit. Two of the three individuals with the greatest number of restraints during the last reporting period were no longer at the facility. Overall, the month to month numbers showed little variation other than spikes for September 2011, October 2011, and May 2012 due to an increase in restraints for one or two individuals. There were 29 instances of dental/medical pretreatment sedation reported by the facility since 1/1/12. Nine were for medical treatment and 20 were for dental treatment. The facility had recently begun to address protective mechanical restraints to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans (PMRPs) had been developed for five individuals who were wearing protective restraints due to self-injurious behaviors. PMRPs were reviewed for Individual #77, Individual #349, and Individual #96. PMRPs were individualized and addressed level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. This was a very positive step forward. PMRPs had not yet been developed for all individuals wearing protective medical restraints. Documentation did not support that all IDTs were engaging in adequate discussions that resulted in determination that the restraint was the least restrictive restraint necessary and set specific guidelines for applying and monitoring the restraint. For example, • The IDT for Individual #167 met to discuss a medical order for soft wrist ties "to prevent tracheostomy being pulled out while in wheelchair and when in bed."	Noncompliance

#	Provision	Assessment of Status	Compliance
		The team did not discuss reducing his time in restraint or consider other options, such as mittens that might allow for movement and be less restrictive than keeping his hand tied down. The team did not discuss a schedule for release or monitoring the restraint. The facility needs to continue to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. This includes looking at the use of gait belts, helmets, body suits, and some supports provided on wheelchairs. For example, instances were noted where poor support and alignment in seating systems resulted in the addition of chest and leg straps rather than further assessment of the seating system. <u>Prone Restraint</u> Based on the state and 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 list provided by the facility of all restraints for the past six months, 0 (0%) showed use of prone restraint. A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises. Sample #C.1 was a sample of 12 restraints for seven individuals, representing 29% of restraint records over the last five-month period. The sample included seven physical restraints and five chemical restraints. Three of the individuals in the sample had the greatest number of restraints. Two others had only one restraint. The individuals in this sample were Individual #232, Individual #168, Individual #225, Individual #148, Individual #111, Individual #191, and Individual #184. • Individual #232 had 20 restraints, accounting for 48% of the 42 restraints for crisis intervention between 1/1/12 and 6/30/12. The new statewide restraint policy required that: • Restraints were not used unless necessary to prevent imminent physical harm in a behavioral crisis, to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior that has not yet been reduced by intensive supervision or treatment. • The least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior was used.	

#	Provision	Assessment of Status	Compliance
		• Restraints were not used as punishment, as part of a positive behavior support plan, for staff convenience, or in the absence of or as an alternative to treatment. • Prone and supine restraints were prohibited. <u>Other Restraint Requirements</u> The facility policies stated that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others, after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner, for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included documentation for 12 restraints. The following are the results of this review: • In 12 of the 12 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • In nine of 12 (75%) restraints, staff documented events leading to the behavior that resulted in restraints. Exceptions included restraint checklists for: o The area to describe events leading to the behavior that resulted in restraint was left blank on the restraint checklist for Individual #184 dated 2/23/12. o The restraint checklists for Individual #191 and Individual #111 described the behavior that led to restraint, but not the events leading up to the behavior. • In 12 of 12 records (100%), staff documented that restraint was used only after other interventions had been attempted. • None of the restraints appeared to be used as punishment or for staff convenience. It was not evident that the least restrictive effective restraint necessary to prevent imminent physical harm in a behavioral crisis, or to safely and effectively implement medical or dental procedures, or to prevent or mitigate the documented danger of self-injurious behavior was used in all cases. Of the 42 instances of restraint over the past six months, 28 were horizontal holds (the most restrictive type of physical hold), one was a baskethold, and 13 were chemical restraints. There was no indication that a less restrictive restraint was attempted on any of the restraint checklists in the sample. State policies identified a list of approved restraints techniques. Based on the review of documentation for 12 restraints, 12 (100%) were documented as approved restraints techniques.	

#	Provision	Assessment of Status	Compliance
		Dental/Medical Restraint The facility provided a list of pretreatment sedation and medical restraints to promote healing between 1/1/12 and 6/29/12: this included • Nine instances of pretreatment sedation for medical appointments and 20 instance of dental pretreatment sedation. A list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that there was one desensitization plans in place. The facility reported that the dental department had recently begun working with the psychology department to develop both formal and informal desensitization strategies. The facility was not yet in compliance with provision C1. To do so: • Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, including whether or not the individual was engaged in activities. • Restraint used for intervention should be the least restrictive restraint necessary. • The long-term use of protective mechanical restraints should be reviewed by the IDT as per the new state regulations and strategies should be developed to reduce the amount of time in restraint, eliminate the restraint when necessary. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm. • Desensitization strategies should be considered by the IDT for all individuals requiring the use of pretreatment sedation for routine medical appointments. • IDTs for should focus on developing ISPs that support meaningful engagement throughout each individual's day.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The new statewide restraint policy required that any individual who is restrained as a result of a behavioral crisis must be released from restraint as soon as he or she no longer poses an imminent risk of physical harm to self or others. It further required that if a Crisis Intervention Plan is in place, the plan must describe the behaviors that signal there is no longer an imminent risk of physical harm to self or others. Crisis Intervention Plans had been developed for six individuals to comply with requirements of the new policy. Four of those individuals were in the sample reviewed. The Sample #C.1 restraint documentation for seven 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. • Four of seven (57%) restraints reviewed indicated that the individual was	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		released immediately when no longer a danger. For the other three, restraint could not be safely maintained, as follows: o The restraint checklist for Individual #225 indicated that she was released when she rolled over into a prone position after two minutes. o The restraint checklist for Individual #232 dated 5/8/12 at 2:48 pm noted that he broke free from the restraint after two minutes. o The restraint checklist for Individual #232 dated 5/15/12 indicated that he was released due to injury or physical distress after nine minutes, though the nursing assessment indicated no injury or distress. • The longest physical restraint in the sample was 15 minutes for Individual #232 on 5/8/12. Three (43%) of the physical restraints in the sample lasted two minutes or less. The facility was in substantial compliance with C2	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	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 restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 23 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 23 of 23 (100%) had current training in RES0105 Restraint Prevention and Rules. • 14 of the 19 (74%) employees with current training who had been employed over one year completed the RES0105 refresher training within 12 months of the previous training. • 22 of 23 (96%) had completed PMAB training within the past 12 months. o It was particularly concerning that the Incident Management Coordinator and Assistant Unit Coordinator did not have current PMAB training considering both were at some point responsible for determining when restraints were administered correctly. • 11 of the 19 (58%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. The facility had trained all staff on the new statewide restraint policy. Training for all staff was not completed within the required timeframes based upon the	Noncompliance

#	Provision	Assessment of Status	Compliance
		sample of training records used to assess compliance. The facility was still not ensuring that training was completed annually as required by state policy.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 12 restraint records (Sample #C.1), documentation in 12 (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, protection from self-injurious behaviors, or to complete medical/dental procedures. The facility reported 29 incidents of pretreatment sedation used for medical and/or dental treatment in the past six months. According to a list provided to the monitoring team, a written desensitization program had been developed for one individual since 1/1/12 that needed pretreatment sedation or restraint to have routine medical or dental care completed. The facility had not developed treatment strategies for all individuals who required the use of restraint for routine medical or dental treatment. The one dental desensitization plan, written for Individual #77, included individualized strategies to try to reduce the need for pretreatment sedation. The facility had created a "Do Not Restrain" list. There were 94 individuals at the facility 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. Individual #181 was on the "Do Not Restrain List." The restraint list indicated that wrist ties had been used on 1/11/12 to complete a dental procedure. As noted in C1, the facility had begun to address the review requirements for all protective mechanical restraints. The facility should ensure that these protective restraints are documented, monitored, and reviewed. Teams should review all uses of protective mechanical restraints and document attempts at reducing the use of these restraints and ensuring that the least restrictive restraint necessary is being used. The facility had recently begun to document the use protective mechanical restraints used for self- injurious behavior to comply with the new statewide restraint policy. Protective Mechanical Restraint Plans had been developed for five individuals who were wearing protective restraints due to self-injurious behaviors. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual should include treatments or strategies to minimize or eliminate the need for restraint. The facility was not yet in compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 12 restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 12 out of 12 incidents of restraint (100%), there was assessment by a restraint monitor. • In the 12 instances of restraint in the sample, 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 12 (100%) out of 12 instances. An assessment was documented for each restraint incident in the sample, however, restraint monitors were not adequately reviewing the restraint incident and noting errors in documentation or process. For example, • The restraint monitor completed a Face-to Face, Debriefing and Review for Crisis Intervention form for Individual #191 dated 5/10/12. She indicated that the individual was assessed for injury by a nurse following the restraint. This assessment was not documented on the restraint checklist. • The restraint monitor for a restraint incident involving Individual #168 on 8/20/12 did not note that the nursing assessment was completed late. • The restraint monitor for a restraint incident involving Individual #184 on 2/23/12 indicated that the restraint checklist was completed correctly. Staff did not complete the events leading to restraint section or document the interventions attempted prior to restraint. Based on a review of seven physical and five chemical restraints used for crisis intervention 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 (75%) of the instances of restraint. The exceptions were the following restraint checklists: o Individual #168 dated 8/20/12 o Individual #232 dated 5/15/12 o Individual #225 dated 6/6/12 A sample of restraints used for medical pretreatment sedation was reviewed for compliance with monitoring requirements. Four of 10 (40%) documented monitoring by a licensed health care professional at least every 30 minutes from the initiation of the	Noncompliance

#	Provision	Assessment of Status	Compliance
		restraint. The exceptions were: • Individual #110 dated 6/13/12 • Individual #6 dated 4/6/12 • Individual #34 dated 6/8/12 • Individual #67 dated 4/26/12 • Individual #193 dated 6/8/12 • Individual #127 dated 4/7/12 The facility remained out of compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy. Restraint monitors should document any errors in documentation or procedure for restraint incidents.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample of 12 Restraint Checklists for individuals in crisis restraint was selected for review for required elements in C6. The following compliance rates were identified for each of the required elements: • In 12 (100%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. • In 12 (100%), the date and time restraint was begun were indicated. • In 12 (100%), the location of the restraint was indicated. • In nine of 12 (75%) restraints, staff documented events leading to the behavior that resulted in restraints (see C1). • In 10 (83%), the specific reasons for the use of the restraint were indicated. Exceptions were for Individual #111 dated 2/3/12 and Individual #184 dated 2/23/12. • In 12 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 12 (100%), the names of staff who applied/administered the restraint was recorded. • In 12 (100%) of seven observations of the individual and actions taken by staff while the individual was in restraint for physical restraints were recorded. • In seven (100%) of six physical restraint incidents, the date and time the individual was released from restraint were indicated. • In 11 (92%) of 12 restraints, 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 exception was for Individual #191 dated 5/10/12. • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 15 minutes in duration.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In a sample of 12 records (Sample #C.1), restraint debriefing forms had been completed for 12 (100%). A sample of 10 restraint checklists for individuals receiving medical restraint was requested to ensure enhanced supervision was provided. Documentation of adequate supervision was only documented in four incidents (40%). Exceptions included: • Individual #110 dated 6/13/12 • Individual #6 dated 4/6/12 • Individual #34 dated 6/8/12 • Individual #67 dated 4/26/12 • Individual #193 dated 6/8/12 • Individual #127 dated 4/7/12 The facility had made considerable progress in adequately documenting restraint incidents, however, remained out of compliance with the documentation requirements of C6.	
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, three individuals were placed in restraint more than three times in a rolling 30-day period. This represented a decrease from the six individuals placed in restraint more than three times in a rolling 30-day period reported during the last review. All three of these individuals (i.e., Individual #168, Individual #232, and Individual #184) were reviewed (100%) by the monitoring team to determine if the C7 requirements of the Settlement Agreement were met. PBSPs, crisis intervention plans, and individual support plan addendum (ISPA) meeting minutes that occurred as a result of more than three restraints in a rolling 30-day period were requested for each individual. The facility indicated that no ISPA meetings occurred for any of the individuals following more than three restraints in a 30-day period. Additionally, a crisis intervention plan was not available for Individual #184. The results of this review are discussed below with regard to Sections C7a through C7g of the Settlement Agreement. This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. In order to achieve compliance	Noncompliance

#	Provision	Assessment of Status	Compliance
		with this provision item, the ISPA should reflect a discussion of each individual's adaptive skills and biological, medical, and psychosocial factors. Additionally, if any of these factors are hypothesized to potentially affect dangerous behavior, suggestions for modifying them to prevent the future probability of restraint.	
	(b) review possibly contributing environmental conditions;	This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. In order to achieve compliance with this provision item the ISPA should reflect a discussion of possible contributing environmental factors (e.g., noisy environments), 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 was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. This item is concerned with a review of potential antecedents to the behavior that provokes restraint. Examples of issues that could be discussed here would be the role of antecedent conditions such as the presence of demands or novel staff on the behavior that provoke restraint. This discussion should also include how relevant antecedent conditions would be removed or reduced (e.g., the elimination or reduction of demands placed) to decrease the future probability of the dangerous behavior.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated as being in noncompliance because no ISPA meeting following more than three restraints in a rolling 30-day period occurred. This item is concerned with review of the variable or variables that may be maintaining the behavior provoking restraints. In order to achieve compliance with this provision item, the ISPA should reflect a discussion of the variables maintaining the dangerous behavior (e.g., staff attention) that provokes restraint. The ISPA minutes should also reflect an action (e.g., increase staff attention for appropriate behaviors, etc.) to address this potential source of motivation for the target behavior that provokes restraint.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to	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, • Three (100%) of the PBSPs reviewed specified the objectively defined behavior to be treated that led to the use of the restraint (see K9 for a discussion of operational definitions of target behaviors), • One (33%) of the three PBSPs reviewed (i.e., Individual #184) specified the alternative, positive, and functional (when possible and practical) adaptive	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	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. One of the three PBSPs reviewed (33%) that had procedures to weaken or reduce the behaviors that provoked restraint, however, was determined to be incomplete (i.e., Individual #168) because it did not contain clear, precise interventions based on a functional assessment (see K9). The two available crisis intervention plans of the individuals in the sample were reviewed. The following represents the results: • In both crisis intervention plans reviewed (100%), the type of restraint authorized was delineated, • In both (100%) crisis intervention plans reviewed, the maximum duration of restraint authorized was specified, • In both plans reviewed (100%), the designated approved restraint situation was specified, and • In both crisis intervention 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%) was integrity data available demonstrating that the PBSP was implemented with a high level of treatment integrity (see 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 days of the start of each instance of	According to policy, each incident of restraint was to be reviewed at the daily Unit Meeting and the daily Incident Management Team meeting, within three business days. During the onsite monitoring visit, Unit Meetings and Incident Management Team meetings were observed and, during this timeframe, discussion of restraint was evident on the day after the episode. Follow-up to restraint episodes was noted as being tracked more thoroughly and consistently. However, the restraint checklists examined for Sample #C.1 documented that:	Noncompliance

#	Provision	Assessment of Status	Compliance
	restraint, other than medical restraint. ISPs shall be revised, as appropriate.	• The review form had an area for signature indicating review by the Unit Director and IMT. Two restraints in the sample (17%) were signed by the Unit Director within three days. This included the restraint for Individual #168 dated 8/19/12 and 8/20/12. None were signed by a representative of the IMT. • The Restraint Monitor completed debriefing forms, as required, in 12 out of 12 (100 %) of the incidents. As noted in provision C5, problems noted with documentation and monitoring were not addressed during this review. The Restraint Reduction Committee had recently been revamped under the Director of Behavioral Services. The Restraint Review Committee would now be reviewing restraint trends for the facility. To gain compliance with C8, the facility will need to document a review of all restraints within three business days.	

Recommendations:

1. Restraint documentation needs to clearly indicate what was occurring prior to the behavior that led to restraint, including whether or not the individual was engaged in activities (C1).

2. The facility needs to continue to focus on protective mechanical restraints including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. This includes looking at the use of gait belts, helmets, body suits, and some supports provided on wheelchairs (C1).

3. Restraint used for crisis intervention should be the least restrictive restraint necessary (C1).

4. Desensitization strategies should be considered by the IDT for all individuals requiring the use of pretreatment sedation for routine medical appointments (C1, C4).

5. IDTs for should focus on developing ISPs that support meaningful engagement throughout each individual's day (C1).

6. The long-term use of protective 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 (C1, C2, C4).

7. Monitoring by a nurse should be conducted and documented as required by state policy (C5).

8. Restraint monitors should document any errors in documentation or procedure for restraint incidents (C5).

9. All restraints should be documented consistent with Appendix A (C6).

10. Each individual's ISPA meeting minutes following more than three restraints in 30 days should reflect a discussion of each of the issues presented in C7a-d, and a plan to address factors that are hypothesized to affect the use of restraints. Additionally, there should be evidence that each individual's PBSP has been implemented with integrity, and that PBSPs have been revised when necessary (i.e., data-based decisions are apparent) (C7).

11. All restraints should be reviewed within three working days (C8).

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 Section D Self-Assessment 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 Preventing Abuse, Neglect, Exploitation training curriculum dated April 2012 o Information used to educate individuals/LARs on identifying and 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 Training transcripts for 23 randomly selected employees o Acknowledgement to report abuse for 23 randomly selected employees 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 Trend Reports FY12 o Injury Trend Reports FY12 o List of incidence for which the reporter was known to be the individual or their LAR 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 23 current employees o ISPs for: • Individual #208, Individual #13, Individual #198, Individual #199, Individual #220, Individual #256, Individual #195, Individual #226, Individual #47, and Individual #191 o Injury reports for three most recent incidents of peer-to-peer aggression incidents o ISP, PBSP, and ISPA related to the last three incidents of peer-to-peer aggression o List of all serious injuries for the past six months o List of all injuries for the past six months o Analysis of ANE Performance Improvement Team minutes o List of all ANE allegations since 2/1/12 including case disposition o List of all investigations completed by the facility since 2/1/12 o List of employees reassigned due to ANE allegations o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect.

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

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#4232440	Physical Abuse	Unconfirmed	6/11/12 4:26 pm	6/13/12 6:30 pm	6/28/12
#42238993	Physical Abuse	Unconfirmed	6/1/12 8:59 am	6/4/12 11:00 am	6/9/12
#42240152	Physical Abuse (2)	Unconfirmed (2)	6/1/12 9:59 am	6/4/12 10:09 am	6/10/12
#42137432	Physical Abuse	Confirmed	5/21/12 5:02 am	5/24/12 3:40 pm	6/6/12
#42083412	Emotional/Verbal Abuse (2) Physical Abuse (2) Neglect (2)	Unconfirmed (2) Unconfirmed (2) Other (2)	5/14/12 9:21 am	5/17/12 5:30 pm	5/29/12
#42074473	Neglect (9) Physical Abuse (2)	Confirmed (7) Unconfirmed (2) Confirmed (2)	5/14/12 12:35 pm	5/15/12 11:15 am	5/30/12
#42080435	Physical Abuse (3)	Unconfirmed (3)	5/14/12 6:38 pm	5/16/12 5:38 pm	5/24/12
#42060132	Physical Abuse (3)	Unconfirmed (3)	5/11/12 2:58 pm	5/14/12 5:01 pm	5/23/12
#42148612	Emotional Verbal Abuse Physical Abuse	Unconfirmed Unconfirmed	5/22/12 8:08 am	5/24/12 3:37 pm	6/1/12
#41994898	Neglect (2)	Confirmed (2)	5/6/12 2:48 pm	5/8/12 3:26 pm	5/23/12
#41838823	Emotional Verbal Abuse	Unconfirmed (2)	4/18/12 10:12 pm	4/20/12 2:47 pm	4/28/12
#41762713	Neglect Sexual Abuse	Unconfirmed Unconfirmed	4/11/12 12:42pm	4/11/12 2:25 pm	4/20/12

Sample D.2	Type of Incident	DFPS Disposition	Date of DFPS Referral	DFPS Completed Investigation	Facility Completed Investigation
#42355957	Neglect	Referred Back – Other	6/28/12	7/3/12	7/5/12
#42217009	Neglect	Referred Back – Rights Issue	5/30/12	6/1/12	6/5/12

#42155292	Physical Abuse	Referred Back – Other	5/22/12	6/1/12	6/5/12
Sample D.3	**Type of Incident**	**Date/Time of Incident Reported**	**Director Notification**		
#12-053	Serious Injury	5/23/12 7:21 am	5/23/12 8:15 am		
#12-051	Suicide Threat Encounter with Law Enforcement	5/15/12 11:20 am	5/15/12 10:30 am		
#12-050	Serious Injury	5/14/12 5:35 pm	5/15/12 7:45 pm		
#12-048	Serious Injury	5/11/12 5:45 am	5/11/12 5:45 am		
#12-045	Encounter with Law Enforcement	3/28/12 12:01 pm	3/28/12 12:50 pm		
#12-040	Sexual Incident	2/12/12 7:30 pm	2/12/12 8:15 pm		

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Kathleen Rocha, Facility Investigator
- Jessica Rodriguez, Acting Incident Management Coordinator
- Megan Lynch, Incident Management Coordinator
- George Schock, DADS Incident Management Coordinator
- Jackie Davis Sims, Assistant Director of Programs
- Gevona Hicks, Human Rights Officer
- Audrey Wilson, QDDP Coordinator
- Charlotte Fisher, Director of Behavioral Services

Observations Conducted:

- Observations at residences and day programs
- Unit Morning Meeting for Unit 1 and Unit 3 (8/22/12)
- Daily Clinical Services Meeting (8/21/12)
- Incident Management Team Meeting (8/22/12 and 8/23/12)
- Annual ISP meetings for Individual #281
- Human Rights Committee Meeting (8/23/12)
- Restraint Reduction Committee Meeting (8/23/12)
- ISPA for Individual #87 following an incident of peer-to-peer aggression

	Facility Self-Assessment: SASSLC submitted its self-assessment. It was updated on 8/7/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. For example, the facility reviewed a sample of six investigative reports between March 2012 and June 2012 to assess compliance with D3f and D3g. The facility was using a smaller sample size for most provision items than the sample that the monitoring team reviewed. The facility's review of its own performance found compliance with all provisions of section D with the exception of those relating to annual training (D2c); employee's acknowledgement of responsibility to report suspected abuse, neglect, or exploitation (D2d); educating individuals and their LARs on identifying and reporting abuse and neglect (D2e); and developing a system to track and trend unusual incidents (D4). The facility self-assessment indicated substantial compliance with 18 out of 22 items in section D. The monitoring team also found the facility to be in substantial compliance with 19 of the 22 provision items. The monitoring team found compliance with D2c and D2d based on the sample reviewed. The monitoring team, however, did not find compliance with reporting requirements (D2a). The facility should consider using a larger sample size to ensure that systems in place are achieving compliance with each item and any problems are identified and corrected. The IMC should review compliance ratings that conflicted with the monitoring team's assessment to determine if similar items were being reviewed. Trend reports should be used to analyze whether or not compliance with section D requirements has an impact on the number of incidents and injuries at the facility. Ultimately, a reduction in these numbers should be a result of improvements in the incident management system.

	Summary of Monitor's Assessment: According to a list provided by SASSLC, DFPS conducted investigations of 149 allegations at the facility between 12/1/11 and 5/31/12, involving 94 allegations of abuse, nine allegations of exploitation, and 46 allegations of neglect. Of the 149 allegations, there were three confirmed cases of physical abuse and eight confirmed cases of neglect. An additional 16 other serious incidents were investigated by the facility. There were a total of 946 injuries reported between 2/1/12 and 6/30/12. These 946 injuries included 10 serious injuries resulting in fractures or sutures. This was a slight decrease from the 966 injuries reported in the previous five months. It was not evident that the facility was adequately addressing the high number of injuries by developing and engaging in preventative actions. Documentation indicated that a large number of injuries were resulting from individuals bumping into things and falls. The facility needs to aggressively address trends in injuries and implement protections to reduce these incidents and injuries. Some positive steps taken to address the provision items of section D included: • A poster inventory checklist was created to ensure ANE information posters were in place in all buildings. Campus coordinators and campus administrators were now educating individuals on using the ANE hotline. • Reminders were now being sent to department heads when employees were delinquent with training requirements • QDDPs were trained on documenting when ANE information was shared with individuals and their families. • The facility was sufficiently documenting follow-up to recommendations and concerns in individual investigation files. • Monthly department Quality Assurance Meetings were being held to discuss compliance with the Settlement Agreement and facilitate interdisciplinary discussion among departments regarding systemic issues. Recommendations resulting from investigations, incidents, and injuries should include a focus on systemic issues that are identified and action steps should be developed to address those issues. According to data gathered by the facility, some systemic issues that contributed to a large number of incidents and injuries at SASSLC included: • Mobility issues (bumping into objects and falls), • Failure to carry out support plans as written, • Lack of adequate individualized planning and supports, • Communication issues, • Behavioral issues, and • Lack of attention to risk factors. A Performance Improvement Team had recently been appointed to review trends and data in regards to ANE and develop a plan of improvement.

#	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 director or designee. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility	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 • Theft by staff, and • Unauthorized departures.	Noncompliance

#	Provision	Assessment of Status	Compliance
	Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	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, investigations of 149 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 2/1/12 and 6/30/12. From these 149 allegations, there were: • 94 allegations of physical abuse: o 3 were confirmed, o 67 were unconfirmed, o 10 were inconclusive, o 8 were referred back to the facility for further investigation, and o 5 outcomes were pending. • 46 allegations of neglect: o 8 were confirmed, o 14 were unconfirmed, o 1 was inconclusive, o 8 were unfounded, o 14 were referred back to the facility for further investigation, and o 1 outcome was pending. • 9 allegations of exploitation: o All were pending outcomes (these were likely one case involving nine individuals). The facility reported that there were 16 other investigations of serious incidents not involving abuse, neglect, or exploitation between 2/1/12 and 6/30/12. This included: • 1 sexual incident, • 1 choking incident, • 3 suicide threats, • 2 encounters with law enforcement, • 8 serious injuries, and • 1 other unclassified serious incident. From all investigations since 1/1/12 reported by the facility, 22 investigations were selected for review. The 22 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 (12 cases).	

#	Provision	Assessment of Status	Compliance
		• Sample #D.2 included a sample of facility investigations that had been referred to the facility by DFPS for further investigation (4 cases). • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (6 cases). Based on a review of the 12 investigative reports included in Sample #D.1: • 12 of 12 reports in the sample (100%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. • 12 of 12 (100%) indicated the facility director or designee was notified within one hour by DFPS. • 11 of 11 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. • 1 of 12 (8%) indicated that the state office was notified as required. Exceptions were DFPS cases #4838823, #41994898, #42148612, #42060132, #42080435, #42074473, #42083412, #42137432, #42240152, #42238993, and #42321440. In reviewing Sample D.3 (serious incidents), documentation indicated: • Six of six (100%) were reported immediately (within one hour) to the facility director/designee. • Documentation of state office notification, as required by state policy, was found in four of six (67%) UIRs. Exceptions were UIR #12-050 and UIR #12-040. 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 that contained information about notifications was included in: • 12 out of 12 (100%) investigation files in Sample #D.1. • 10 of 10 (100%) investigation files in Sample #D.2 and Sample #D.3. 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 a random sample of 23 employees at the facility. All employees (100%) in the sample had signed this form. The facility needs to document notification of the state office as required by policy.	

#	Provision	Assessment of Status	Compliance
	(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 policy 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 12 investigation reports included in Sample D.1, in 12 out of 12 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status. The monitoring team was provided with a log of employees who had been reassigned since 2/2/12. The log included the applicable investigation case number and the date the employee was returned to work. All allegations were discussed in the daily IMRT meeting and protections were monitored through meeting minutes for each open investigation. In 12 out of 12 cases (100%), there was no evidence that the employee was returned to his or her previous position 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. This typically consisted of three actions, including placing the AP in a position of no client contact, a head-to-toe assessment by a nurse, and an emotional assessment. The facility was in substantial compliance with this provision.	Substantial Compliance
	(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. A random sample of training transcripts for 23 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 23 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 10 (53%) of 19 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		incidents (UNU0100) refresher training within the past 12 months. • 15 (79%) of the 19 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. Based on interviews with six direct support staff in various homes and day programs: • Six (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation. There were still a number of employees who failed to complete training in a timely manner, therefore, training was not completed annually as required by state policy. The IMC had recently begun tracking delinquent training and notifying department heads when training was not completed on time. It was not evident that this had been an effective approach to ensuring that training was completed on time. The facility remained out of compliance with this provision.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	According to facility policy, all staff were required to sign a statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS immediately during pre-service and every 12 months thereafter after completing ABU0100 training. The facility self-assessment indicated that forms were not being signed annually as evidenced by delinquent training reports audited between March 2012 and June 2012. A sample of this form was reviewed for a random sample of 23 employees at the facility. All employees (100%) in the sample had a current signed acknowledgement form. A review of training curriculum provided to all employees at orientation and annually thereafter emphasized the employee's responsibility to report abuse, neglect, and exploitation. The facility reported that there were no cases where employees failed to report abuse, neglect, or exploitation or did not cooperate with investigators during an investigation in the past six months. The monitoring team assigned a substantial compliance rating to this provision, however, the facility needs to ensure that acknowledgement to report abuse and neglect forms are reviewed and signed annually by all employees.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report 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. It was a clear and easy to read guide to recognizing signs of abuse and neglect and included information on how to report suspected abuse and neglect. A sample of 10 ISPs developed after 2/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #208, Individual #13, Individual #198, Individual #199, Individual #220, Individual #256, Individual #195, Individual #226, Individual #47, and Individual #191. • Eight (80%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. The exceptions were the ISPs for Individual #208 and Individual #256. The new ISP format included a review of all incidents and allegations along with a summary of that review. This should be useful to teams in identifying trends and developing individual specific strategies to protect individuals from harm. The QDDP shared information regarding recognizing and reporting abuse and neglect with Individual #281 and his family at the ISP observed during the monitoring visit. In informal interviews with individuals during the review week, all individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. Most individuals named a staff member that they were comfortable telling they had a problem. At least three allegations in the sample were self-reported by the individual indicating that at least some individuals at the facility knew how to report abuse or neglect to DFPS. The facility self-assessment indicated that, based on a review of ISPs for inclusion of documentation that reporting information was shared with the individuals and/or the LAR (100%), a noncompliance rating was given for this provision item. It was based on the lack of data for the recently implemented ISP process. For the sample reviewed by the monitoring team, this information was included in 80% of the ISPs. Therefore, the facility was found to be in substantial compliance with this item. The new ISP format will be reviewed during the next monitoring visit to ensure that the facility maintains compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	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 human rights officer with her name, picture, and contact information. The facility remained 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 notified law enforcement and OIG of the allegation in all (100%), as appropriate. The facility remained in substantial compliance with this provision item.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • SASSLC Policy addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of SASSLC. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this occurred. • The facility had created a poster that stated "Retaliation or False Reporting is Not Tolerated at SASSLC." This poster was placed in all buildings at the facility. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. The facility reported no cases where fear of retaliation was reported. Based on a review of investigation records (Sample #D.1), there were no other concerns noted related to potential retaliation for reporting.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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.	Staff were required to notify the facility director and DFPS of injuries of unknown origin where probable cause cannot be determined and to DADS Regulatory if the injury was deemed serious. The facility: • Reviewed all injuries, including injuries at the Incident Management Team meeting daily to discuss probable cause and develop corrective action. • Quarterly data reports were used to identify trends in injuries. The monitoring team observed daily unit meetings held the week of the onsite review. All injuries were reviewed and discussed by the team. Recommendations were made by the team for follow-up. Additional information was requested when appropriate. A sample of serious client injuries was reviewed for serious injuries occurring in the past six months to determine if injuries were reported for investigation. All serious injuries were routinely investigated by facility investigators. The facility remained in substantial compliance with this provision item.	Substantial Compliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		

#	Provision	Assessment of Status	Compliance
	(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. One of the Campus Administrators was late completing his refresher training. • Seven (100%) had completed Root Cause Analysis according to training transcripts reviewed. The Campus Coordinators had not completed this course. There was no evidence that they had completed any of the investigations in the sample. • Seven (100%) had completed the requirements for training regarding individuals with developmental disabilities by completing the course MEN0300. Trained investigators were completing all investigations at the facility. 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 needs to ensure that all required trainings are completed within the mandated timelines.	Substantial Compliance
	(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 indication in one case that staff failed to cooperate with the investigators. The employee received disciplinary action for failing to cooperate.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	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), all had been reported to law enforcement agencies. OIG investigated seven of the incidents. In the investigations completed by both OIG and DFPS, it appeared that there was adequate coordination to ensure that there was no interference with law enforcement's investigations. • There was no indication that the facility had interfered with any of the investigations by OIG in the sample reviewed. The facility 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. Video surveillance was in place throughout SASSLC, and investigators were regularly using video footage as part of their investigation. The facility remained in substantial compliance with this item.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	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: • Investigations noted the date and time of initial contact with the alleged victim. o Contact occurred within 24 hours in only 1 of 12 (8%) investigations. In 25% of the investigations, initial contact with the alleged victim did not occur until the 3rd day of the investigation. o Twelve (100%) investigations indicated that some type of investigative activity took place within the first 24 hours. This included gathering 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. • Six of 12 (50%) were completed within 10 calendar days of the incident. Extensions were filed in the five of six cases (83%) that were not completed within 10 calendar days. There was no documentation that an extension was filed in DFPS case #42083412. It was reported on 5/15/12 and completed on 5/29/12. Investigations #42321440 and #41994898 were the lengthiest investigations in the sample. Both were completed on the 17th day. o Even though these were lengthy investigations, DFPS provided additional detail regarding the complexity of each of these investigations. Even so, when such a large percentage of investigations require extensions, a review of the investigatory process seems warranted and is recommended. • It was not evident that extensions were always due to extraordinary circumstances. For example, in DFPS case #42137432, an extension request indicated that additional time was needed to review the AP's training record. Evidence in the case indicated that physical abuse had occurred. His training record was not relevant to the confirmation. • All 12 (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 eight of the 12 DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Five of those cases resulted in referrals back to the facility for further investigation. Concerns were appropriate based on evidence gathered during the investigation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Facility Investigations The following summarizes the results of the review of investigations completed by the facility from sample #D.3: • Six (100%) of the UIRs reviewed indicated that the investigation began within 24 hours. • Six of six (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Six of six investigations included recommendations for corrective action. The facility maintained substantial compliance with this provision. In order to maintain this compliance, actions will need to be demonstrated if the percentage of DFPS investigations that require extensions remains high and there is no action taken by DFPS. The facility, however, did complete facility investigations and follow-up on DFPS investigations in a timely manner.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including	DADS Incident Management Policy required a UIR to be completed for each serious incident. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the facility (Sample #D.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 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 It could not be determined whether all sources of evidence were considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. DFPS investigations now included a statement	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	indicating that previous investigations were reviewed and either found relevant or not relevant to the case. This blanket statement provided no analysis of the facts (i.e., whether there were previous allegations for the alleged perpetrator). It would be clearer if this information were included in the investigation report. In meetings in December 2010 and June 2011, DFPS indicated that investigators reviewed previous investigations electronically and only commented in the investigation report if there was relevance. However, this did not provide a mechanism for the monitoring teams to ascertain whether this had been done. DFPS agreed to include a statement summarizing findings from this review in future investigative reports. o In 12 (100%), the investigator's findings; and o In 12 (100%), the investigator's reasons for his/her conclusions. An allegation of physical abuse was reported to DFPS in case #42155292 when it was discovered that Individual #204 had a broken arm. DFPS referred the case back to the facility citing that the case did not meet the TCA definition of abuse. There was no basis for this determination cited in the referral form. DFPS failed to thoroughly investigate the incident to rule out abuse. Video surveillance tapes were not reviewed and witness statements were not taken from all staff that might have had information regarding the incident. DFPS later provided the monitoring team with additional information regarding its decision to not investigate this case. <u>Facility Investigations</u> The following summarizes the results of the review of six facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In six (100%), each serious incident or allegations of wrongdoing; o In six (100%), the name(s) of all witnesses; o In six (100%), the name(s) of all alleged victims and perpetrators when known; o In six (100%), the names of all persons interviewed during the investigation; o In six (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 six (100%), all documents reviewed during the investigation; o In six (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim known to the investigating agency.	

#	Provision	Assessment of Status	Compliance
		o In six (100%), the investigator's findings; and o In six (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item, however, DFPS will need to follow through with including a summary regarding previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency.	
	(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 16 DFPS investigations included in Sample #D.1 and #D.2: • In 16 (100%) investigative files reviewed from Sample #D.1 and #D.2, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission. UIRs included a review/approval section to be signed by the Incident Management Coordinator (IMC) and director of facility. For UIRs completed for Sample #D.1, • 12 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. o 12 of 12 (100%) were reviewed by the facility director and Incident Management Coordinator within five working days of receipt of the completed investigation. DFPS noted concerns or made recommendations in six (50%) of the cases in sample #D.1. The facility maintained documentation of follow-up action taken to address concerns and recommendations. • Documentation of follow-up to all DFPS concerns was found in six (100%) of the investigation files in the sample. Sample #D.2 included four investigations that were referred back to the facility for further review. • DFPS Case #41226339 was a clinical issues referred back for further review by the facility regarding the lack of a medical assessment following an incident. Documentation was found indicating that the medical assessment did occur. No further review was necessary.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• DFPS Case #421552292 was referred back to the facility by DFPS when the investigator determined that it did not meet the TCA definition of abuse. As noted in D3f, it was not clear why the investigator made this determination. The facility failed to document any concerns with the investigation or investigate the case further to rule out abuse or neglect. The facility should have requested further clarification or investigation by DFPS. • DFPS Case #42217009 was referred back to the facility as a right's issue. The IDT met to follow-up on concerns and made appropriate recommendations. • DFPS Case #42355957 was referred back to the facility for follow-up after DFPS ruled out neglect. The facility put protections in place prior to submission of the referral. Two daily review meetings (IMRT) were observed during the monitoring team's visit to the facility. Completed investigations were reviewed at the daily IMRT meetings. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> • In six of six (100%) UIRs from sample #D.3 reviewed for investigations completed by the facility, the form indicated that the facility director and IMC had reviewed the investigative report upon within five working days of completion. • All of the UIRs included recommendation for follow-up. Documentation of follow-up was included in all of the investigative records. This item was in substantial compliance.	
	(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 22 out of 22 (100%) unusual incidents in the sample. A 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	Documentation was reviewed to show what follow-up had been completed to address the recommendations resulting from investigations in the sample. Three of 12 investigations in Sample D.1 included confirmed allegations of abuse or neglect. Documentation provided by the facility indicated that disciplinary action had been taken in three of three cases where allegations were confirmed.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	track and document such actions and the corresponding outcomes.	In six of 12 DFPS cases reviewed from Sample #D.1, DFPS documented additional concerns or recommendations. In six of those six cases (100%), the facility investigation file included documentation that concerns or recommendations were addressed. Recommendations for programmatic actions were made in six of six cases reviewed for facility investigations in Sample #D.3. The facility was tracking and documenting follow-up action to ensure completion. The facility had developed a form for IDT review of serious injuries. The form prompted staff to look at: • Action taken after the injury occurred, • Action taken to protect the person from further injury, • The root cause of the injury, • Any injury trends, and • Recommendations to minimize the risk of further incidents. IDTs were completing the form for each injury and documenting discussion of incidents. Meaningful recommendations were being developed by teams to reduce the risk of similar incidents occurring. 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.	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	The facility had recently implemented the new statewide system to collect data on unusual incidents and investigations. Data were collected through the incident reporting system and trended by type of incident, staff alleged to have caused the incident, individuals directly involved, location of incident, date and time of incident, cause(s) of incident, and outcome of the investigation. Positive steps taken towards compliance included: • The facility had initiated a new process of compiling data on a monthly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and	Noncompliance

#	Provision	Assessment of Status	Compliance
	incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	injuries. Trend reports were up-to-date and included an analysis of the data gathered by the facility. Recommendations for action to address trends were not included in the trend reports. There was no evidence that the facility had developed a plan of correction to address systemic issues identified in trend reports. The facility had recently formed a Performance Improvement Team to look at data collected in regards to ANE. The team was still trying to decide how to proceed with information gathered. Information collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to 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. The monitoring team expects to see the incident management department take a role in the facility's overall approach to addressing the frequency of occurrence of unusual incidents and injuries at SASSLC. They should help to determine and address factors that contributed to incidents and injuries at the facility.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	background checks were completed. 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 205 applicants. There were a total of 10 applicants who failed the background check in the hiring process and therefore were not hired. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. A sample was requested for 23 employee's acknowledgement to self report criminal activity forms. • Signed acknowledgement forms were submitted for 23 of 23 employees (100%). The facility remained in substantial compliance with this provision item.	

Recommendations:

1. The facility needs to document notification of the state office as required by policy (D2a).
2. The facility needs to ensure that all employees complete training annually as required by state policy (D2c).
3. The facility needs to ensure that acknowledgement to report abuse/neglect forms are reviewed and signed annually by all employees (D2d).
4. When a large percentage of investigations require extensions, a review of the investigatory process by DFPS seems warranted and is recommended (D3e).
5. DFPS investigations should include a summary regarding previous investigations of serious incidents involving the alleged victim(s) and alleged perpetrator(s) known to the investigating agency and whether or not that information was relevant to the current investigation (D3f).
6. 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:** Documents Reviewed: o DADS policy #003.1: Quality Enhancement, new policy revision, dated 1/26/12 o SASSLC facility-specific policies: • Three remained the same from last review: QA Plan 12/1/10, Participating in QAQI Council 12/5/10, and Data Collection 1/1/11 • Two were new/revised: Quality Assurance draft 8/16/12, P&P Guidelines draft 6/7/12 o Email from DADS assistant commissioner describing the formation of the statewide SSLC leadership council, 3/5/12 o Draft Section E self-assessment tool from state office, revised draft July 2012 (though page one was still dated April 2012) o SASSLC organizational chart, undated, but probably July 2012 o SASSLC policy lists, undated, but probably 6/30/12 o List of typical meetings that occurred at SASSLC, undated o SASSLC Self-Assessment, 8/7/12 o SASSLC Action Plans, 8/9/12 o SASSLC Provision Actions Information, most recent entries 8/3/12 o SASSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/20/12 o SASSLC DADS regulatory review reports, 1/6/12 through 5/30/12, no annual survey o List of all QA department staff and their assigned responsibilities, undated o SASSLC QA department meeting notes, February 2012 through 8/20/12 (9 meetings) o SASSLC data listing/inventory, hard copy, undated o SASSLC facility database shared folder table of contents, undated o SASSLC QA plan narrative, undated o SASSLC QA plan matrix, undated o Set of blank tools used by QA department staff (6 of a total of 10 reported) o Trend analysis reports, all four data sets, two quarters, ending 2/29/12 and 5/31/12 o Variety of subgroup notes and minutes, 5/16/12 through 6/27/12 o Subgroup I meeting handouts and agenda for 8/22/12 meeting o SASSLC QA Reports, monthly, January 2012 through July 2012 (7) o QAQI agenda and meeting minutes from 4/26/12 through 8/9/12 (7 meetings) o QAQI Council agenda and handouts, for 8/23/12 meeting o Unit QA monthly team meeting notes, 8/22/12 o SASSLC Corrective Action Plan, tracking, 13 pages, undated but likely August 2012 o QA staff training on CAPs, 5/15/12 o DADS SASSLC family satisfaction survey online summary, January 2012 through June 2012, 41 respondents

	o Blank phone family survey form o Blank community business satisfaction survey form o Draft SASSLC employee satisfaction questionnaire o Email regarding self-advocacy group participation in developing an individual satisfaction survey, 7/15/12 o Employee Advisory Committee Forum information, monthly, February 2012 through July 2012 o Quarterly facility newsletter, Spring 2012 and Summer 2012 o List of self-advocacy leadership 2012, and list of self-advocacy activities for 2012 o Self-advocacy monthly meeting minutes, monthly February 2012 through July 2012, 11 meetings o Notes from San Antonio self-advocates meeting 6/5/12, and self-advocacy officer training 3/9/12 o Notes about other self-advocacy group activities since February 2012 o Home meeting agenda and notes (none) <u>Interviews and Meetings Held</u>: o Laurence Algueseva, Director of Quality Assurance o QA department: Larry Algueseva, Andy Rodriguez, Mandy Pena, Kevin Elder, Mary Saunders, Paula Reed (DADS mentee), and Paula McHenry (Lufkin QA director) 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 One meeting with family member of one individual <u>Observations Conducted</u>: o Subgroup I meeting, 8/22/12 o QAQI Council meeting, 8/23/12 o QA department staff meeting, 8/20/12 o Self-advocacy group, 8/22/12
	Facility Self-Assessment The QA director improved upon what he presented last time by including additional activities and outcomes. In that regard, he made progress in that he was trying to look at actual activities and outcomes for each provision item. The most important next step is for the QA director to make sure that he includes everything in his self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in his self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. At this time, there was no self-monitoring tool for section E (though one was in development at state office). For example, for E1, the QA director self-assessed by looking at QA policies, the QA matrix, QA plan, QA

	report, and self-monitoring tools. These were all good items to include in the self-assessment. These were part, however, but not all, of what the monitoring team looks at. For example, the self-assessment reported on the presence of self-monitoring tools (that was good), but did not report on the presence of key indicators. The monitoring team looks for the following when assessing the QA matrix: • Includes all Settlement Agreement self-monitoring tools • Includes all data collected by QA department. • Includes other key indicators. • Includes satisfaction measures and follow-up Further, the monitoring team did not agree with all of what the QA director wrote in the results sections. For example, the monitoring team did not agree with the QA director's comments about the QA plan (E1, item 4 in the self-assessment). Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the QA director and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all five provision items of section E. The monitoring team agreed with these self-ratings, however, as noted in the narrative report below, progress continued to be evident since the time of the last onsite review.
	Summary of Monitor's Assessment: SASSLC continued to make good progress towards substantial compliance with many of the items of provision E. This was due to the extensive efforts of the QA director, the SAC, and the QA staff. A good working relationship was evident between the QA director and the Settlement Agreement Coordinator. The facility specific QA policy, dated 8/16/12, appeared to be a combination of the last two statewide policies and, therefore, did not appear to be useful at all to the facility. The QA director should fix this policy. The QA department had only made a small amount of progress towards the creation of a comprehensive data listing inventory. The QA Plan should consist of a QA narrative and a QA matrix. SASSLC made good progress on both of these. The narrative included components from a variety of other documents, policies, and job descriptions. Instead, the QA director should write a two to three page narrative with headings suggested in E1 below. A set of important key relevant indicators/data need to be added to the QA matrix and QA report for each of the Settlement Agreement provisions. SASSLC had begun to revise or create new self-monitoring tools or to create new tools. This was reported to have occurred for sections S, U, and some of the 12 M tools. The QA director made very good progress in developing satisfaction measures. He had developed a family

	phone survey, a process and tool for community businesses, a draft of a tool for staff satisfaction, and the beginnings of work with the self-advocacy committee on a way to assess satisfaction of individuals. The monthly employee council, led by the ADOP, showed good activity over the past six months. This group might be helpful in developing an satisfaction tool. Moreover, their comments and minutes from their meeting might provide some information related to staff satisfaction that could be used by the QA department. The next steps are data collection, summary and analysis of findings, and creation and implementation of any required actions. The self-advocacy committee had improved since the last review. The group met very often. The rights officer made sure there were regular relevant topics. Overall, she helped the individuals who participated (about a dozen) to know that their voices were heard. A number of QA-type activities were occurring at SASSLC. The QA director should incorporate these into his overall QA program. Examples were in medical, nursing, and habilitation. Since the last onsite review, four QA subgroups were formed and unit-level QA meetings were initiated. A monthly QAD-SAC meeting with each discipline department was in the planning stages. The QA report continued to evolve and improve. Each month, edits, changes, and additions were made to make it more complete, readable, and logical. Suggestions are provided regarding format and organization, important indicators/data, and editorial. The QAQI Council meeting observed by the monitoring team was more engaging and on topic than the one observed during the previous monitoring review. There was, however, little discussion or participation by attendees. It may be that they did not know in what ways they could participate. The QA director was still developing a system to meet the CAP requirements. Tasks included ensuring what should and should not be a CAP, what type of evidence and reporting was required, how to more formally show dissemination to the proper responsible person, and a system for ensuring and monitoring implementation, outcome, and modifications when needed.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	SASSLC continued to make good progress towards substantial compliance with many of the items of provision E. This was due to the extensive efforts of the QA director, the SAC, and the QA staff. <u>Policies</u> The state's QA policy was finalized and disseminated shortly before the last onsite review. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		SASSLC had five facility-specific QA-related policies. Three were unchanged from the time of the last onsite review (QA Plan 12/1/10, Participating in QAQI Council 12/5/10, and Data Collection 1/1/11). Two were new since the last review. One was called Quality Assurance draft 8/16/12. It appeared to be a combination of the last two statewide policies and, therefore, did not appear to be useful at all to the facility. The QA director should fix this policy. There is no need to copy the entire state policy. Instead, facility-specific policies should describe only that which is specific to the facility. The other new policy was a set of guidelines for the development of new policies and procedures. This seemed to be a useful and needed set of guidelines for the facility. As recommended in the previous monitoring report, training and orientation of both the state and facility policies and their requirements should: • Be provided to QA staff. • Be required for senior management, including but not limited to QAQI Council. Documentation in the 6/21/12 QAQI Council minutes indicated that the QA director presented the state policy to the attendees. When the facility policies are updated and finalized, training/presentation of those should also occur. 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 and was disseminated more than six months ago, edits may already be needed. State office should consider this. <u>QA Department</u> Larry Algueseva remained as the QA director. It was good to see stability in this important position at SASSLC. Mr. Algueseva was moving the facility forward in the development of its QA program. Mr. Algueseva must ensure that the QA program always keeps the "big picture" in sight. That is, the role of the QA program is to help guide and manage data systems so that important information is made available to senior management for decision making and intervention. QA programs often get caught up in processes (e.g., collecting data, making action plans, writing reports) that do not meet the goals of quality assurance and quality improvement. Thus, the SASSLC QA staff should (along with department leads) be coming up with a mix of important indicators for each provision of the Settlement	

#	Provision	Assessment of Status	Compliance
		Agreement (i.e., the QA plan matrix). Problems should be identified and reviews conducted thoroughly and appropriately (e.g., intense case analysis, route cause analysis). Mr. Algueseva was present at many meetings and presentations during the week of the onsite review. His participation in these many facility meetings will be beneficial to the QA program at SASSLC. Also noteworthy was the good working relationship that was evident between Mr. Algueseva and the Settlement Agreement Coordinator, Andy Rodriguez. The QA director held staff meetings twice per month, one meeting was for announcements and one was more for discussion of QA activities and for professional development. Relevant topics appeared to be discussed. The addition of the professional development component was good to see and, if anything, should be expanded. During the meeting observed by the monitoring team, a selection from the writings of Avedis Donabedian was presented by the QA director, and a new monitoring tool was presented by one of the program auditors. <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. The QA department had only made a small amount of progress towards this. The listing was five pages long and included 18 subsections. The previous listing was only four pages long. The listings were incomplete and not every department was included even though the Provision Action Information report noted that updates occurred in February 2012, March 2012, and April 2012. The monitoring team recommends that the QA director format the listing inventory in an electronic spreadsheet. It may be helpful for him to see what the San Angelo SSLC and El Paso SSLCs had done, as examples. Given that the data listing inventory was incomplete and inadequate, the monitoring team had little upon which to comment. Therefore, as the QA director improves this for the next onsite review, he should also look at the comments in the monitoring reports for the other SSLCs (especially San Angelo SSLC and El Paso SSLC). The comments made about those SSLC's data listings are likely to be helpful to the SASSLC QA director. The monitoring team found a number of sources of additional information that the QA director should use as he further develops the data listing inventory. For example, the SASSLC facility database shared folder included some data sets from about half a dozen departments at the facility. It did not appear that all of these were in the current data listing inventory.	

#	Provision	Assessment of Status	Compliance
		In addition, there might be a system put in place for communication with other SSLCs to share relevant data listing inventory related information. First, the actual data listing inventory electronic spreadsheets might be shared, so that QA directors can see how their colleagues were meeting this requirement. Second, whenever there is a serious problem identified related to an important set of data, each facility might be updated and asked to ensure the data are being collected, managed, and reviewed correctly. <u>Quality Assurance Plan Narrative and Matrix</u> The QA Plan should consist of a QA narrative and a QA matrix. SASSLC made good progress on both of these and the QA director was looking forward to feedback from the monitoring team. The QA plan narrative was four pages long and although an improvement from the time of the last review, needed much work to be adequate and useful to the reader. The narrative seemed to include components from a variety of other documents, policies, and job descriptions. Instead, the monitoring team recommends the QA director write a two to three page narrative with the following suggested headings below. Each should be no more than one or two short, but descriptive paragraphs. The purpose of the QA plan narrative is to give the reader an understanding of the QA program at SASSLC. • Comprehensive data listing inventory • QA matrix o Key important indicators o Self-monitoring tools • How data are summarized and analyzed • QA-SAC-Discipline meetings • Subgroups • QA report • QAQI Council • Corrective Actions o CAPs o Route cause analysis, intensive case analysis, fishbone diagram The QA plan matrix was not much improved from the previous report. The purpose of the QA matrix is to show all of the data that the QA department will track, trend, and comment upon (or will assist the discipline department in doing). Some, but not all, will go into the QA report, and some, but not all, will be reviewed by QAQI Council. The QA director and the monitoring team discussed this at length. Currently, 100% of the QA matrix was included in the QA report, and 100% of the QA report was presented at QAQI Council. This is acceptable, but ends up limiting the utility of the QA matrix and QA report.	

#	Provision	Assessment of Status	Compliance
		The monitoring team provides the following guidance to the QA director as he further develops the QA matrix. • All items in the QA matrix are data that are to be submitted to the QA department. • All items in the QA matrix receive review by the QA department. o Some of the summarizing and graphing of the data, however, can be done by the discipline/department prior to submission to the QA department (see E2 below). o All data should be trend-able data, or if not, should have some pre-determined red flag type of criterion to alert the QA department as to a possible problem. • The selection of what items are in the QA matrix should come from: o QAQI Council, o Clinical, service, and operational department heads, and o The QA director and SAC. • Typically, this will result in a number of "types" of items, such as: o A list of data that the QA staff collect themselves. o A list of tools to monitor each of the provisions of the Settlement Agreement. Usually, these are the statewide self-monitoring tools, ▪ plus any other self-monitoring tools used by the department. o Key important key indicators. There should be key indicators for every Settlement Agreement provision. At SASSLC, they were called monthly and quarterly data. o Any other data that the QA department wishes to receive from the facility's many departments. o Any data that the discipline department heads determine are important to submit to the QA department. • All items on the QA matrix should also appear in the data list/inventory. This was not the case at SASSLC. <u>QA Activities</u> • QA Staff Activities: SASSLC had a very good group of QA staff members and the monitoring team, as always, thoroughly enjoyed meeting with them. They were engaging, committed, knowledgeable about their tasks, and completely interested in doing their jobs at a quality level. QA staff spent their time collecting data implementing their department's own QA tools (there were about 10), completing statewide self-assessment tools primarily to assess interobserver agreement, and participating on various committees and in meetings. Data from their tools were part of the QA matrix, QA report, and QAQI Council agenda.	

#	Provision	Assessment of Status	Compliance
		The QA director was not yet regularly assisting the discipline departments in creating data collection tools, graphs, and databases. The QAD-SAC-Department meetings described below may help set the occasion for this to occur more regularly. • Self-Monitoring Activities: The DADS state office had recently given new direction to the facilities regarding these tools. The monitoring team's understanding was now that each facility could choose to use the current statewide tools, modify the current tools, or develop new tools. Thus, Settlement Agreement self-monitoring tools could become facility-specific. State office approval was not required, however, the facility department head was supposed to collaborate with his or her state office discipline coordinator. Further, state office did not require the facility to have any specific type of facility-level review and approval process, other than the involvement of QAQI Council. On the other hand, it seemed that the state office discipline coordinator could require the facilities to all use the same tool. SASSLC had begun to revise some of the current tools or to create new tools. This was reported to have occurred for sections S, U, and some of the 12 M tools. Self-monitoring tools can be very helpful if done correctly and if they direct managers to important areas and activities. That is, the content needs to be valid and needs to line up with what the monitoring team is assessing. Thus, the self-monitoring tools should become an important part of the self-assessment process for each provision. It may be that a well-designed and comprehensive self-monitoring tool <u>is</u> the self-assessment, or it may turn out that self-monitoring tool is but one of a number of sources of data and information that the department uses in self-assessing its substantial compliance with each provision item. The monitoring team has commented on the facility's self-assessment of each Settlement Agreement provision at the beginning of each section of this report. There are some important considerations as the facility revises/creates self-monitoring tools (some of the following is repeated from the previous monitoring report): • Again, the content of the tools should be relevant and valid. • Some items in each tool may be more important than others. These should be highlighted in some way (e.g., weighted, asterisked, labeled as essential). • Consideration should be given to the frequency of completion of each tool. Some might only need to be completed periodically. • Attend to duplication of efforts, such as two observers sitting in the same ISP meeting when it might have been done by one observer.	

#	Provision	Assessment of Status	Compliance
		• Satisfaction Measures: The QA director made very good progress in developing satisfaction measures. In addition to the statewide online family survey (41 respondents since the last onsite review, overall, positive ratings), he had developed a family phone survey, a process and tool for community businesses, a draft of a tool for staff satisfaction, and the beginnings of work with the self-advocacy committee on a way to assess satisfaction of individuals. The next steps are data collection, summary and analysis of findings, and creation and implementation of any required actions. The self-advocacy committee had improved since the last review. The group met very often. The rights officer made sure there were regular relevant topics. Overall, she helped the individuals who participated (about a dozen) to know that their voices were heard. As a group, they addressed problems regarding sidewalks and vending machines. They learned about voting and community living, including having a former resident speak about her life after moving to a community group home. At the meeting observed by the monitoring team, individuals were engaged, attended to, and participatory. Holding frequent, but relatively short (e.g., 30 minute) meetings was a successful way of keeping interest high. <u>Other QA Activities at SASSLC</u> A number of QA-type activities were occurring at SASSLC. The QA director should incorporate these into his overall QA program, that is, include the data in the listing inventory, QA plan narrative, and QA matrix, as appropriate, and review data and reports, as appropriate. • Medical: The medical director and medical compliance nurse developed a new continuous quality improvement program. It contained eight indicators with two more to be added for a total of 10 (see section L). • Nursing: The excellent work of the QA department's QA nurse (Mandy Pena) and the nursing department's QA nurse (Robert Zertuche) again deserves special mention (this is the third consecutive report). Their system of managing the 12 nursing tools had not only improved, it now included additional measures and interventions. The monitoring team wants to point out some highlights: o Progress was reported from 2011 to 2012. Timeliness of quarterly and annual nursing assessments had improved. Their data system allowed them to identify and address barriers. o Their next topics included ▪ Quality of reports ▪ Number of RNs on duty per shift ▪ 12 nursing action skills that they called bedside competencies o The continued to document and follow-up on every item rated no on every one of the tools.	

#	Provision	Assessment of Status	Compliance
		o The process demonstrated good principles that other departments might apply, such as self-assessing, and taking repeated data. • Chief Nurse Executive: The CNE implemented a fishbone diagram route cause analysis to work with her nursing staff on improving medication administration in response to an incident in which medication was given to the wrong individual. • The habilitation therapies director presented a number of key indicators at QAQI Council. Her choice of indicators reflected important processes and outcomes related to provisions O, P, and R. Many of the indicators lined up directly with what the monitoring team looks at during its review of those provisions. • Statewide trend analysis: Four important sets of data have been reviewed for a number of years. The trend analysis reports were very well done and contained relevant presentations of the data. o The trend analysis data were summarized within the QA reports and QAQI Council presentations of section C (for restraints) and section D (for allegations, incidents, and injuries). This was a good way to proceed. QAQI Council members were aware that the full trend analysis was available to them, 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, QA-related meetings, the QAQI Council, the use of performance improvement activities, and the management of corrective actions and corrective action plans. Continued progress was demonstrated by SASSLC. <u>QA Data Management and Analysis</u> The 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 to be summarized. This was not yet occurring for all of the items in the QA matrix. The importance of QA department review of data plays a very important role in the QA process. To reiterate from previous reports, summarizing of data is typically done in the form of a graph or a table. Most typical, and most useful, will be a graph. The graphic presentations should show data across a long period of time. The amount of time will have to be determined by the QA director, perhaps in collaboration with the department or discipline lead. For most types of data, a single data point on the graph will represent the data for a month, two-month period, or quarter. The graph line should run for no less than a year. A proper graph takes time to initially create, but after that, only requires an	Noncompliance

#	Provision	Assessment of Status	Compliance
		additional data point to be added each month, quarter, etc. The facility should set an expectation for the service departments to submit data and graphic summaries each month of their self-monitoring and their key indicator data. Some of this might be accomplished during QAD-SAC-Department meetings, which are discussed below. Many of these graphs can be inserted into the QA report and be presented to QAQI Council. But again, the QA department should be managing all of the data on the QA matrix of which some, but not necessarily all, will end up in the QA report. <u>Subgroup Meetings</u> Since the last onsite review, four subgroups were formed. Each subgroup included each of the leaders a subset of the 20 provisions of the Settlement Agreement. They met once each month to present (and discuss) their provisions in more detail than can be done at a QAQI Council, as well as to help prepare for QAQI Council. To assist with preparing for the subgroup meeting, each lead completed a two page 11-item worksheet. A smattering of these were given to the monitoring team. Overall, they contained little information for the reader. The worksheets referred to the self-monitoring tools, however, equally important are the key indicators for each provision. These should be included, too. <u>Unit Level QAQI meetings</u> At the QAQI Council, the monitoring team learned that each of the three unit directors was going to begin having a monthly QA meeting with his key staff. This had recently begun with one of the units and was described very positively by the unit director. He said there was excellent attendance and good participation. A large packet of information was handed out and reviewed at the meeting. The QA director should ensure that relevant information comes from, and goes to, these unit QA meetings. <u>Two Possible Additional QA-Related Activities</u> • Monthly QAD-SAC meeting with discipline departments o The monitoring team recommends there be a monthly meeting of the QA director, SAC, and the lead person responsible for each provision of the Settlement Agreement. During these one-hour meetings, review QA-related actions, review the data listing inventory, discuss/determine key indicators and outcomes, review conduct of the self-monitoring tools, create corrective action plans, and review previous corrective action plans. A set of graphs can portray the discipline's performance on the metrics that are part of the meeting agenda. The monitoring team	

#	Provision	Assessment of Status	Compliance
		believes these meetings, although time consuming for the QA director and SAC, can be an excellent part of the QA program. o The monitoring team, the QA director, and the SAC discussed this at length during the onsite review. The QA director said he was planning to start these meetings. He was unsure if they would replace the subgroups. • QA director presentation to senior management o Although data are presented and there can be opportunity for discussion at subgroup meetings, QAD-SAC-Department meetings, and QAQI Council, the monitoring team recommends that the QA director have an opportunity to present to the senior management team (if such a team exists) or directly to the facility director. This would be for the QA director to bring to this executive team whatever he thinks is important for them to know about. <u>QA Report</u> The QA report continued to evolve and improve. This was evident even in the reading of the reports over the past six months. Each month, edits, changes, and additions were made to make it more complete, readable, and logical. Overall, there was consistency in the way data were presented. New bar graphs and line graphs were included in each of the sections. This was another improvement. Overall, the QAQI Council members appeared to be comfortable with the format because they were seeing it regularly (each month) and, as a result, the document was now a standard part of their professional activity at SASSLC. The report continued to contain one section for each of the 20 provision items of the Settlement Agreement, followed by a section of other indicators. The QA director requested detailed feedback and commentary on the QA report. It is provided below. Many changes occurred to the QA report beginning in May 2012. As a result, the monitoring team's comments are based, primarily, upon the May 2012, June 2012, and July 2012 reports. Format and organization: • The report should be divided into sections and should have a table of contents. One possible way to organize the report is as follows: o Settlement Agreement provisions (all 20 provisions, this will be the largest section of the QA report) and will include: ▪ the statewide (or facility-made) self-monitoring tools ▪ other key important indicators (see below) o DADS regulatory ICF/IID information	

#	Provision	Assessment of Status	Compliance
		o FSPI information o PIT updates o CAPs update/summary • There was progress as provisions were added over the past few months, such as Q. Some provision items, however, were not yet included, such as G, H, and J. Some had disappeared, such as there being no data for N or V for July 2012. The URC had resigned which might explain no data being submitted for V for that month. It was not clear why no data were included for N. • A short explanatory paragraph should be included in each section. The narrative paragraph should <u>not</u> be primarily about the mechanics of the data collection or a description of the scores. Instead, it should be an analysis paragraph. It might read, for example, "The three most important things to know about this month's data are…" • Some CAP information should be in the report. The monitoring team recommends a simple piece of data, such as the number of CAPs that are active at this time. This could be in E or could be within each provision section. Individual CAPs should not be included in the QA report. Important indicators/data: • The provision leaders should present other key, important, relevant data in addition to the statewide (or facility-made) self-monitoring tool data. The purpose of the QA report is to present the status of progress in each provision, therefore, data in addition to self-monitoring tools is required. o QAQI Council could help the department head determine what else to present. One way would be for the QAQI Council to refer to the data listing inventory to see what other types of data were being collected in the department. o Determining what other key indicator data to present could also be a topic during the new monthly QAD-SAC-department meetings. o Consider key indicators/data related to what is reviewed by the monitoring team. o Consider the major issue(s) raised in the previous monitoring review. • In the May 2012 QA report, there were some additional important M indicators, but these were not presented in June 2012 or July 2012. • O, P, and R were presented in more detail and with more indicators in the QAQI Council presentation. Some of those indicators might be good to include in the QA report, too.	

#	Provision	Assessment of Status	Compliance
		Editorial: • Start each new provision on a new page; sometimes the title of the provision was the last line on a page, which made it difficult to easily determine where a provision's data began. • In many of the graphs, if there were no observations (i.e., no data available), it was graphed as a zero on the graph line. This made the graph useless in showing trends because the zero looked like the score was zero. Instead, those months with no data should have no data point, that is, be skipped over. • Do not put individual practitioner or clinician names in the report, especially not associated with specific data findings. This occurred in section L and should be discontinued. • For M, the monitoring team recommends that the QA director obtain suggestions from the two QA nurses regarding how to best present data in the QA report. Section M had 12 or more tools. Mr. Zertuche and Ms. Pena presented a good deal of it on one piece of paper in their own presentation to the monitoring team. • Engagement data were presented twice, for many pages, in both in E and in S. This should be combined somehow and shortened. • The family survey part of the report was much too long, 17 of 63 pages. Only questions of particular note, if any, should be included. • Note that the section E items took up 30 of the 63 pages of the July 2012 report. <u>QAQI Council</u> This meeting plays an important role in the QA program and is to be led by the facility director. Since the last onsite review, the QAQI Council met four times each month, according to the SAC. Minutes reflected this frequency of meetings only since April 2012. With the increase in frequency, the meetings were limited to being only one hour long. This was a good thing and may greatly increase participation. Further, as recommended in the last report, the facility director now took the lead role in facilitating and leading the meeting. The meetings included old business, new business, monthly topics, quarterly topics (presentations of provisions), and tracking of follow-up to things for which the QAQI Council needed or requested follow-up. This seemed to be a reasonable agenda. The monitoring team reviewed the minutes of these meetings since the last onsite review. The topics were updated in the minutes from meeting to meeting, which was a fine way to keep them. It was not apparent, however, that all monthly topics were addressed at least once during the month. It did not seem so. If the monthly topics are for review of key important indicators, then there should be some way to ensure they are	

#	Provision	Assessment of Status	Compliance
		indeed reviewed regularly. The meeting observed by the monitoring team was more engaging and on topic than the one observed during the previous monitoring review. This was good to see. Most impressive was the presentation by the director of habilitation therapies for provisions O, P, and R. She had numerous graphs that were easy to understand (though the small print was difficult to read), represented important indicators (including many that lined up with what the monitoring team looks at), and was fairly consistent across all three provisions (e.g., assessment completion, assessment quality, integration into the ISP, outcome graphs). The monitoring team agreed with her decision to not present the statewide self monitoring tool data because those data were not considered valid or useful, for the most part. The presentation by the risk management director regarding workers comprehensive claims, payments, and injuries was also very on topic and well presented. There was, however, little discussion or participation by attendees. It may be that they did not know in what ways they could participate. To promote meaningful discussion (i.e., one of the main purposes of QAQI Council), the presenter might involve attendees by asking questions and allowing time for answers. Questions might be regarding ways other disciplines could help support any problems identified, and ways that the presenter's data can be useful to any of the attendees. Presenters could also be more dynamic by standing up while presenting and engaging the audience. A topic for QAQI Council might be how to make this happen. The time seems right to move to this next level because QAQI Council was occurring regularly, provision presentations were happening, data were being shown, and attendees were attentive. <u>Performance Improvement Teams</u> SASSLC improved in its organization of PITs. Managers regularly talked about PITs and there seemed to be little hesitancy in initiating one. Further, at least when the monitoring team was present, there seemed to be little hesitancy in volunteering to join one. There appeared to be PITs for desensitization, consents, and clinical meeting attendance. The QA report and the QAQI Council minutes should clearly reflect/list all of the PITs at the facility so that their up to date existence is readily available.	

#	Provision	Assessment of Status	Compliance
		Corrective Actions The QA director had made some progress in the creation and management of corrective actions and corrective action plans. First, managers and clinicians often referred to CAPs, indicating that this was becoming a regular part of the operating culture at SASSLC. Second, the QA director abandoned the 70% criterion, as recommended in the previous monitoring report. Third, the number and variety of CAPs had grown from three nursing CAPs on one page to 14 CAPs on 13 pages across a variety of departments and disciplines. The QA director, however, was still developing a system to meet the CAP requirements of provision item E2, and provision items E3, E4, and E5. Tasks included ensuring what should and should not be a CAP, what type of evidence and reporting was required, how to more formally show dissemination to the proper responsible person, and most importantly a system for ensuring and monitoring (a) implementation, (b) outcome, and (c) modifications when needed. The monthly QAD-SAC-Department meetings can also present an opportunity for the review and documentation of the status of every CAP. Lastly, the QA director should maintain some simple data regarding CAPs (as noted above in the QA report section), such as the number of CAPs that are active at this time. The CAPs data system created by the QA director at El Paso SSLC can provide one example.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	SASSLC was not in compliance with this provision item, however, progress was observed. 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, however, progress was observed. 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. Re-write the facility-specific policy for quality assurance (E1).
2. Complete or initiate training to QA staff, and senior management and clinical staff on any QA-related facility-specific policies (E1).
3. Implement the statewide discipline QAQI committees, as per the new state policy (E1).
4. Ensure the comprehensive listing/inventory of all data collected at SASSLC is complete. Ensure it includes all of the items from the QA matrix, key indicators, databases, etc. (E1).
5. Edit the QA plan narrative as suggested in E1 (E1).
6. Follow the suggestions regarding the QA matrix presented in E1 (E1).
7. Develop key indicators/data for each of the Settlement Agreement provisions. See guidance provided in E1 and E2 (E1, E2).
8. Determine how to best use the statewide self-monitoring tools. Consider the suggestions made in E1 regarding development of facility-specific self-monitoring tools (E1).
9. Determine if any actions are needed based upon findings of satisfaction surveys (E1).
10. Ensure that the QA department reviews of all data on data matrix (E2).
11. QA director and unit directors should collaborate, as needed and as appropriate, regarding the new QA unit meetings (E2).
12. Hold monthly QAD-SAC-Department meetings. Structure them and document the meeting (E2).
13. Consider a periodic presentation by the QA director to the facility's senior management (E2).
14. Consider the suggestions provided in E2 regarding the QA report regarding format, indicators/data, and editorial (E2).
15. Ensure that all items designated by the QAQI Council as monthly are indeed presented and reviewed every month (E2).
16. Help QAQI Council members know ways in which they are expected to participate in the meeting. Help presenters know how to best foster engagement, participation, and discussion (E2).
17. Keep a list of the many committees and work groups at SASSLC (E2).
18. Create a system to meet the CAPs requirements (E2-E5).
19. Keep simple data on CAPs (E2).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Supported Visions: Personal Support Planning Curriculum o DADS Policy #004: Personal Support Plan Process o DADS Procedure: Personal Focus Assessment dated 9/7/11 o SASSLC Self-Assessment o List of all serious injuries for the past six months o List of all injuries for the past six months o SASSLC Section F Presentation Book o A sample of completed Section F audits done by SASSLC o Pre-ISP Meeting Minutes for Individual #281 o ISP, ISP Addendums, Assessments, PFAs, SAPs, Risk Rating Forms with Action Plans, Quarterly Reviews: • Individual #256, Individual #198, Individual #191, and Individual #281. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Kathleen Rocha, Facility Investigator o Jessica Rodriguez, Acting Incident Management Coordinator o Megan Lynch, Incident Management Coordinator o Jackie Davis Sims, Assistant Director of Programs o Gevona Hicks, Human Rights Officer o Audrey Wilson, QDDP Coordinator o Charlotte Fisher, Director of Behavioral Services <u>Observations Conducted</u>: o Observations at residences and day programs o Unit Morning Meeting for Unit 1 and Unit 3 (8/22/12) o Daily Clinical Services Meeting (8/21/12) o Incident Management Team Meeting (8/22/12 and 8/23/12) o Annual ISP meetings for Individual #281 o Human Rights Committee Meeting (8/23/12) o Restraint Reduction Committee Meeting (8/23/12) o ISPA for Individual #87 following an incident of peer-to-peer aggression

	Facility Self-Assessment: SASSLC continued to use the self-assessment format it developed for the last review. It had been updated on 7/23/12 with recent activities and assessment outcomes. The QDDP Coordinator was responsible for the section F self-assessment. There were a number of provision items where she noted that an adequate audit system was not in place to determine compliance. The most important next step is for the QDDP Coordinator to make sure that she includes everything in her self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment. The current assessment process relied heavily on the statewide section F audit tool. Many of the provision items in section F, however, required more than just a review of the ISP. For example, section F2e required confirmation that staff were competent at implementing training in the ISP. Interview and observation would be effective for measuring compliance. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the QDDP Coordinator and believes that the facility was continuing to proceed in the right direction. The QDDP Coordinator was recently trained on the new ISP process that was designed to meet the requirements of the Settlement Agreement. This should be very beneficial in developing an assessment process that measures compliance with the requirements in section F. The facility self-rated itself as being out of compliance with all provision items in section F. The monitoring team agreed.
	Summary of Monitor's Assessment As noted in the last report, DADS had revised the ISP process and hired a set of consultants to help the SSLCs move forward in developing person-centered ISPs developed by an integrated support team. Training had recently been provided on the ISP process and risk identification by DADS consultants. The monitoring team observed one ISP meeting in the new format. The IDT was not yet competent at developing an integrated plan that included all needed supports and services based on preferences and needs of each individual. It was apparent that the IDT was attempting to follow the format of the new ISP process and include all required information in the plan. A major part of the meeting, however, was devoted to the risk identification process. Although this was very important (see section I), the QDDP failed to keep the risk discussion moving along, resulting in a very lengthy meeting where very little long range planning occurred and minimal focus was placed on the individual's preferences, how he might like to spend his day, and other important supports and services. Planning was focused on what supports would be provided to maintain Individual #281's health over the next year. The IDT did not discuss opportunities for him to develop new relationships, gain greater control over his day, or develop new skills. The facility audit indicated that assessments were not being submitted prior to the annual IDT meeting.

	Without an adequate assessment process and participation by all team members in planning, IDTs could not develop plans to address individual's preferences and needs. For needs that had been identified, a service delivery system was not in place to ensure that supports were competently provided and progress or regression documented. Training was not being consistently implemented and documented while in the community. There continued to be a focus on providing active treatment at the facility. Observation of both homes and day programs did not confirm that individuals had adequate opportunities to participate in activities based on their individualized preferences and specific training needs. In May 2012, DADS State Office had revised Policy #004.1: Individual Support Plan Process, and had provided the Monitoring Teams with a draft copy. The three Monitoring Teams were in the process of reviewing the policy, and any comments will be provided jointly. DADS state office recognized that the previous ISPs did not meet the requirements of the Settlement Agreement. As a result, using a group of consultants as well as work groups that included state office and facility staff, the ISP planning and development processes had been revised and reflected in the draft policy. In July 2012, SASSLC QDDPs and many team members had been provided training on the new process. In consultation with the parties, it was agreed that beginning in August 2012, the monitoring teams would only review and comment on the ISP documents that utilized the newest process and format. SASSLC had recently received training on the new process from state office consultants. The first IDT meeting held in the new format was during the week of the monitoring visit. The new ISP process had not been completed for any individuals at SASSLC. The intention of limiting the monitoring teams' review to newer plans is to provide the state and facilities with more specific information about the revised process. Compliance will then be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement Agreement requirements.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed one ISP meeting in the new format. The completed written plan was not yet available for review. The QDDP facilitated the meeting. Progress definitely continued to occur and was evident, with regard to the facilitation of meetings. Based on the observation of the annual IDT meeting for Individual #281, some of the areas in which progress had begun included: • More effort was being made to elicit information from all team members. • There was an increase in the use of specific clinical data to support risk ratings. • The QDDP came to the meeting prepared with a draft Integrated Risk Rating Form and a draft ISP format. These documents provided team members with some relevant information and assisted the team to remain focused. The QDDP failed to keep the risk discussion moving along resulting in a very lengthy meeting where very little long range planning occurred and minimal focus was placed on the individual's preferences and how he might like to spend his day, and other important supports and services. The QDDP Coordinator was attending ISP meetings to evaluate the facilitation skills of QDDPs. The facilitation tool used to assess compliance rated: • The QDDP's knowledge, preparedness, and whether he/she could demonstrate inclusiveness and assertiveness, • The QDDP's ability to solicit information using the ISP prompts, and • The QDDP's ability to guide team members through the ISP process. While progress had been made towards meeting substantial compliance, it will be important for the QDDPs to continue to develop facilitation skills that will allow them to keep the teams on track and ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The facility remained out of compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Policy #004 described the Individual Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified in the Personal Focus Meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Personal Focus Assessment (PFA) was the document that should have identified the team composition based on the individual's preferences, strengths, and needs. The facility had begun to track data on attendance at IDT meetings. QDDPs participated in Webinar training on the PFA process. All relevant team members were in attendance at the ISP meeting observed for Individual #281. The facility used the PFA process to identify team members required to attend the annual ISP meeting. The state, however, recently developed a new tool to assess personal preferences and support needs. The Preferences and Strength Inventory (PSI) was intended to replace the PFA. The facility had not begun using the PSI. The facility audit indicated that the individual and LAR at annual ISP meetings for the 12 ISPs reviewed was 16%. The facility self-assessment indicated 0 of the 12 attendance sheets reviewed indicated full participation by all members of the IDT. The self-assessment indicated that the facility was not yet in compliance with requirements for integrated team participation. The monitoring team agreed.	Noncompliance
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.	DADS Policy #004 defined "assessment" to include identification of the individual's strengths, weaknesses, preferences and needs, as well as recommendations to achieve his/her goals, and overcome obstacles to community integration. According to the facility self-assessment, the QDDP Coordinator had begun to gather data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. The facility self-assessment indicated that accurate data were not yet available to determine if assessment were being submitted prior to the annual ISP meeting. 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).	Noncompliance

#	Provision	Assessment of Status	Compliance
		All needed assessments were not submitted prior to the annual IDT meeting for Individual #281. The team was not able to discuss his dental status because the dentist had been unable to assess his status over the past year. The team agreed at the IDT meeting that a comprehensive dental evaluation needed to be completed. A timeline was not set for completing the assessment. An updated neurology assessment was scheduled for the week following his annual IDT meeting. He had experienced breakthrough seizures during the past year, but a neurology consultation had not been obtained following the increased seizure activity. The facility was using Personal Focus Assessment (PFA) as a screening tool to find out what was important to the individual, such as goals, interests, likes/dislikes, achievements, and lifestyle preferences. The facility self-assessment noted that teams were still not consistently completing PFAs during the quarter prior to the annual team meeting. The state had recently developed a new tool to assess personal preference and support needs. The Preferences and Strength Inventory (PSI) was similar to the PFA, but was designed to be a rolling document that could be updated throughout the year as new preferences were identified or as preferences changed. Since the PSI is likely to result in the identification of other assessments needed, it should be completed early enough to allow for identified disciplines to complete assessments recommended prior to the annual IDT meeting. A list of preferences had been developed based on information in the PSI for Individual #281. This list was still not as comprehensive as it should be, but offered a good start for discussion at the ISP meeting. Discussion regarding the development of outcomes based on preferences was not as in-depth as it should have been in part due to time restrictions of the meeting. Much of the discussion at this meeting was dedicated to health and risks review. The facility self-rated F1c as not in compliance based on the timely submission of assessments. The self-assessment, however, did not look at the adequacy of assessments submitted. 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.	

#	Provision	Assessment of Status	Compliance
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As described in F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting. The facility began to review this provision item in June 2012 with a sample of two ISPs. The self-assessment indicated that those two ISPs were both in compliance with requirements to ensure assessment results were used to develop the ISP. The facility, however, 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. Recommendations resulting from these assessments need to be addressed in the ISPs either by incorporation, or by evidence that the IDT considered the recommendation and justified not incorporating it. Plans should be clear and easy to follow for all non-clinical staff responsible for providing daily supports. The facility attempted to do a better job of integrating the PNMP into the newer ISPs than in previous reviews by allowing the IDT to outline what changes needed to be made to the existing plan based on discussions during the annual meeting. Further, this also permitted integration of information from other team members into the plan. Typically, however, there was only a statement that the team had reviewed the plan and it was to continue. The elements of the plan were not listed, nor was there evidence that the team had a meaningful discussion about the effectiveness of the strategies in the plan.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (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. The ADA and Olmstead Act require that individuals receive services in the most integrated setting to meet their specific needs. Training provided to the facility by DADS consultants included facilitating the living options discussion to include input from all team members. The facility self-assessment indicated that of the 12 ISPs it reviewed, it was agreed at the annual ISP meeting that four (33%) of the individuals in the sample could live in a more integrated setting. None of the individuals in the facility's sample had been referred for community placement. The facility placed only one individual in the community since the last monitoring visit, and this occurred during the week immediately prior to this onsite review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The IDT members for Individual #281 discussed activities that he enjoyed in the community, but did not develop a plan for additional community exposure or training opportunities. Community placement was discussed at his annual meeting. The team, along with his mother, agreed that he could receive adequate supports in the community. Action steps were developed to explore community living options further. The facility acknowledged that structured training was rarely occurring in the community and staff were not yet consistently documenting individual's responses to training opportunities while in the community. The facility should continue to formalize training opportunities by developing individualized strategies and providing training to support staff on implementing training while in the community. Documentation should be maintained so that IDTs can build on training opportunities. Progress, however, was occurring, as noted in S3b below. The facility self-assessment determined that this item was not yet in substantial compliance. The monitoring team agrees with this self-rating. This provision is discussed in detail later in this report with respect to the facility's progress in addressing section T.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed,	DADS Policy #004 at II.D.4 indicated that the Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the IDT "will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." In order to meet substantial compliance requirements with F2a1, IDTs will need to identify each individual's preferences and address supports needed to assure those	Noncompliance

#	Provision	Assessment of Status	Compliance
	identifies the supports that are needed, and encourages community participation;	preferences are integrated into each individual's day. The IDT for Individual #281 did not discuss how identified supports would be integrated throughout his day. Furthermore, observation across the SASSLC campus by the monitoring team did not support that individuals were spending a majority of their day engaged in activities based on their preferences. There was minimal improvement in some of the homes in offering active treatment opportunities based on preferences. Compliance with active treatment requirements appeared to be based upon whether or not staff were actively engaged, rather than the individual's participation level. In many homes, staff were standing in front of small groups of individuals talking or attempting to lead activities while the individuals in the group were sleeping or engaged in self-stimulatory behavior showing no interest in the trainer. There was a newly developing system to track training (and leisure) opportunities in the community as well as progress achieved through community training. As noted in F1e, there was minimal, though growing, focus on training in the community. The facility was not in compliance with this item.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Examples of where measurable outcomes were not developed to meet specific health, behavioral, and therapy needs can be found throughout this report. The facility had just begun to assess compliance with this provision in June 2012. Adequate data were not available for the facility, or the monitoring team, to determine compliance (i.e., no new style ISPs were yet available for review). The facility will need to assess whether or not IDTs are adequately identifying each individuals preferences, support needs, and barriers to living in a more integrated setting prior to assessing compliance with the requirements of F2a2.	Noncompliance
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The outcome of the new ISP process should be a plan that integrates all protections, services and supports, treatment plans, and clinical care plans. The new ISP template included prompts to guide the IDT discussion and ensure that important information would not be omitted during the planning process. At the ISP meeting observed, the team engaged in an integrated discussion regarding his support needs, particularly in terms of identified risks. Due to the length of the risk discussion, very little time was spent on developing strategies to integrate his supports into meaningful training based on his preferences. For example, the team identified that communication supports were needed, but failed to integrate those supports into	Noncompliance

#	Provision	Assessment of Status	Compliance
		training based on his preferences. There was no discussion regarding how he liked to spend his day or what supports were needed to ensure that his preferences and needs were met. The facility self-assessment process found that assessments were not always submitted 10 days prior to the annual IDT meeting and available for review by team members, so that information could be integrated among disciplines. 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.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The facility self-assessment indicated a 100% compliance rate with the requirements of this provision item based on a sample of two ISPs. The facility acknowledged that a larger sample would be needed before this provision could be considered in compliance. When assessing compliance with this provision, consideration will need to be given to whether or not assessment recommendations are adequately incorporated into teaching strategies. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Minimal functional learning opportunities were observed during the week of the monitoring visit. The facility needs to develop specific functional objectives to be implemented at both the facility and in the community. Training provided in the day programs observed throughout the monitoring visit did not support that training was provided in a functional way. Most training was offered in a classroom setting. Few, but a growing number of formal training opportunities were offered in the community. The facility self-assessment indicated that an adequate sample had not yet been reviewed for compliance with this provision. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy #004 specified at II.D.4.d that the plan should include direction regarding the type of data and frequency of collection required for monitoring of the plan. ISPs in the new format will be reviewed for compliance during the next monitoring review. See section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	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 also 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 G1 regarding the coordination and integration of clinical services. The facility self-assessment indicated that this provision was not in compliance based on insufficient data. As noted in F1b and F1c, adequate assessments were often not completed prior to the annual meetings. IDTs will need to work together to develop ISPs that coordinate all services and supports. Recommendations from various assessments should be integrated throughout the ISP. The facility did not have a process to ensure coordination of all components of the ISP.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	A sample of individual records was reviewed in various homes at the facility. Current ISPs were in place in 13 out of 16 (81%) records reviewed. Risk action plans were not found to be a part of the ISP in the individual notebooks. IDTs were spending a considerable amount of time developing risk action plans as part of the ISP process. The outcome of this deliberation should be to develop a plan that staff can access and use as a guide for minimizing risks for an individual. A system needs to be put into place to ensure records contain current ISPs that include all action plans. Three of the 21 individuals' records reviewed for section M failed to have a current, annual ISP, and one record did not have an ISP. The majority of the remaining 17 sample individuals had current annual ISPs that were completed in the previous ISP format. None of the ISPs, however, adequately referenced the individuals' health problems, needs, and risks and/or how their health impacted their daily living and participation in work, leisure, community activities, etc. For example, four individuals' annual ISPs were	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed in June 2012 and July 2012. Only Individual #288's referenced her current active diagnoses, health-related problems and needs, health risks, and medications. The facility's self-assessment indicated that for a sample of two ISPs, 100% compliance had been met. The self-assessment did not indicate what criteria was used to determine compliance. The provision was rated as noncompliant due, in part, to the limited sample. As the state continues to provide technical assistance in ISP 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.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	Quarterly reviews by the QDDP were completed for each individual using the monthly reviews from each discipline. It was not apparent that data were collected and reviewed for all supports and services. For example: • The quarterly reviews dated for Individual #191 (2/16/12), Individual #256 (3/26/12), and Individual #198 (5/17/12) did not include data for a majority of outcomes reviewed. The QDDP noted "maintained" for each reporting period in the quarter. QDDP comments for each objective did not adequately summarize progress or lack of progress. • The quarterly review for Individual #198 did not include a summary of healthcare supports. The QDDP noted "see physician's orders and nursing assessment" in the area for review of medical status. 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.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully	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 23 employees indicated that 23 (100%) had completed the new training on ISP process entitled Supporting Visions. The facility was still waiting for additional training to be provided by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format.	Noncompliance

#	Provision	Assessment of Status	Compliance
	complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	The facility was aware of deficits in the implementation of the ISP and was providing additional monitoring and training to direct support staff. This had improved implementation in some homes, but had little impact on training that was occurring in day programs. The facility's self-assessment indicated that data were not available regarding training on specific plan implementation. The facility self-rated the provision as being out of compliance with this requirement. The monitoring team agreed with that assessment.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	The facility reviewed a sample of new admission ISPs and the ISP calendar to assess compliance with this provision item. Results of the self-assessment indicated that ISPs met timelines for completion. The facility did not yet have a system in place to determine if ISPs were implemented within required timeframes following completion. As noted in F2c, a sample of plans was reviewed in the homes to ensure that staff supporting individuals had access to current plans. Current plans were available in 13 of 16 individual notebooks in the sample. Informal interviews with staff indicated that not all staff were not adequately trained on the requirements of individual ISPs. The facility was rated as being out of compliance with this provision item.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The facility was using the statewide section F audit tool to monitor requirements of section F. Other tools had been developed to measure timeliness of assessments, participation in meetings, facilitation skills and engagement. Quality enhancement activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility staff had made some progress in this area. They had just begun to analyze findings and develop corrective action plans. The facility self-assessment acknowledged that sufficient data were not yet available to determine compliance ratings for most provision items.	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 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 (F1a).

3. Efforts need to be made to ensure all team members are in attendance at IDT members in order to ensure adequate integration occurs during planning (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 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, January 2012 – May 2012 Interviews and Meetings Held: o Carmen Mascarenhas, MD, Medical Director o JoAnn Smith, RN, Medical Compliance Nurse o Liesl Schott, MD, Primary Care Physician o Yenni Michel, DO, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN 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 o ISP for Individual #281
	Facility Self-Assessment: The facility submitted its self-assessment, an action plan, and a list of completed actions. For the self-assessment, the facility described for each of the two provision items, activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. For provision G1, there was a single activity listed. Audits were conducted of standing committees and other activities to determine participation of core members. The monitoring team believes that assessment of integration of clinical services requires more than this single activity. It may be important to consider other activities, as well, such as the quality and outcomes of the meetings. The assessment of provision G2 included reviews of the internal and external audits, as well as independent audits related to the

	requirements for consultations. In moving forward, the monitoring team recommends that the medical director review this report. For each provision item in this report, the medical director should note the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Again, the state draft policy should also be reviewed for additional guidance. 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. The monitoring team disagreed with the self-rating of substantial compliance for G2.
	Summary of Monitor's Assessment: The facility continued to make progress in this area. There were no new major initiatives specifically related to the integration of clinical services. There were, however, a number of actions that were taken to address several issues that would promote the integration of services. The clinical integration policy was implemented in early 2012 and facility staff were working to ensure that the activities included in that policy occurred as required. The monitoring team had the opportunity to meet with the medical director and medical compliance nurse to discuss integration activities at the facility. The integration policy listed a series of committees that were important in directing activities critical to integration. The medical director, therefore, believed it was important to determine if the standing committees were functioning as required. The facility's primary activity in assessing this provision was conducting audits of participation of core committee members. The medical director and medical compliance nurse also provided examples of activities that occurred in an integrated manner. 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 facility continued to make progress in this area. The medical director served as the lead for this provision. The facility focused on ensuring that activities described in the clinical integration policy were actually occurring. The policy described 23 activities that promoted integration of clinical services, and many of the activities were committees. To that end, the medical compliance nurse conducted audits of the various committees, clinics, and activities to determine if participation occurred as required. The results ranged from excellent participation in activities, such as psychiatry clinic to poor participation in Behavior Therapy Committee and the absence of development of desensitization plans. The monitoring team would like to emphasize that integration of clinical services refers to the services received by the individuals. The various committees and activities are surrogate metrics and are not the actual end measures. The daily clinical services meetings were excellent opportunities to facilitate the integration of services, however, occurrence of the meeting in and of itself did not imply that integration of services occurred. Departments, such as habitation services and psychology, were required to develop policies and procedures that outlined how their departments integrated with other clinical services. These policies remained in draft form. 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: • During the onsite review, the monitoring team attended one of the facility's ISP meetings, which was held to complete Individual #281's annual ISP, integrated risk rating form, and integrated health care plan. Although the meeting was very well attended and all relevant clinical services were represented at the meeting, the QDDP made several references to the fact that the attendance at the meeting was not usual and probably due to the attendance of the monitoring team. On the other hand, it was the first time any QDDP at the facility implemented the newest iteration of the ISP process. • Daily Clinical Services Meeting – The facility continued to conduct this meeting each weekday morning. 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. Minutes were recorded for this meeting and posted on the shared drive. The minutes	Noncompliance

#	Provision	Assessment of Status	Compliance
		reviewed were improved and provided more information on follow-up of unresolved issues. • The monitoring team attended several committee meetings which brought together various disciplines to review clinical issues at the facility and promote the integration of services: o Pharmacy and Therapeutics Committee o Pneumonia Review Committee o Medication Variance Committee o Polypharmacy Oversight Committee o PNMP Committee Details related to the function and activities of these committees are provided throughout the report. • The dental clinic continued its daily summary that included important events of the day, such as missed appointments and each individual's response to sedation administered. This information was forwarded to the IDTs and medical staff. • The dental consultation consensus was developed for clinical services members to review proposed medications for sedation/TIVA and provide a consensus on the best treatment options. • Quarterly Drug Regimen Reviews were completed by the clinical pharmacist and recommendations made to prescribers. • The PNMT met routinely for individuals identified with needs for review. IDT members had recently begun to attend these meetings again to ensure integration of clinical findings and recommendations into the ISP and specific health plans for implementation. During the meeting observed, it was noted that there was excellent participation and collaboration among the PNMT and IDT members yielding a more cohesive and coordinated plan. • There was integration among nursing, psychiatry, psychology, and pharmacy evident in psychiatry clinic. Unfortunately, there had been a turnover in pharmacy staff and, as such, there had not been a presence of pharmacy in psychiatry clinic for some time. With the recruitment of a new clinical pharmacist, who began work in August 2012, it is hoped that this will improve. • The SLP had begun to attend the BSC meetings with the intention of ensuring effective collaboration related to communication skills for individuals with behavioral challenges. There was no evidence of this in the documentation, but there was generally improved consistency between the communication plans and the BSPs.	

#	Provision	Assessment of Status	Compliance
		The monitoring team also noted several areas in which there was a definite lack of integration: • The development of strategies to overcome barriers to dental treatment was intended to be collaboration between psychology, dental, and medical. It was clear that integration was lacking in this area. The lack of cooperation and integration resulted in significant treatment delays. This is discussed further in section Q2. o A PIT (performance improvement team) was newly formed to develop a process inclusive of triage, assessment, and development with regard to desensitization protocols. • Consent for dental treatment was cited as a collaborative effort between the dentist, QDDPs, and human rights officer. The outstanding issues related to dental treatment and informed consent indicated that there were significant problems integrating these services. This resulted in delays in treatment for many individuals as discussed in section Q2. • Lacking was integration with psychology (other than morning meeting and psychiatry clinic attendance). Previously, there was a weekly meeting of the director of behavioral services and the lead psychiatrist. With changes of staff in both these positions, it was necessary to reinstitute these meetings. • Multidisciplinary clinical protocols were issued by state office. While the medical department moved forward on implementing the protocols, there were no notable efforts on the part of the facility to develop an overarching plan to ensure that all disciplines received adequate training on the content of all the protocols that were issued. This would be an important step in ensuring delivery of integrated services.	
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 good progress with this provision item. The medical service policy provided clear direction on the requirements for this provision item. The medical director reported that the primary care physicians were documenting the summary of consults in the integrated record within the required timelines. The facility implemented a database to track consults. The medical compliance nurse tracked consults in a database in order to ensure timely documentation and follow-up. The consults and IPNs for eight individuals were requested. A total of 35 consults completed after January 2012 (including those from the record sample) were reviewed: • 29 of 35 (83%) consultations were summarized by the medical providers in the IPN within five working days; all of the consults reviewed were initialed and dated by the medical providers indicating review of the consults.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Providers summarized the recommendations of the consultants and stated agreement or disagreement with the recommendations. They frequently noted that the plan was discussed with the nurse. This was a significant improvement for the medical department. Nonetheless, medical policy required that the primary providers document that the recommendations were referred to the IDT for integration with existing supports and services. There was no evidence that this was consistently done. During the February 2012 review, the medical director reported that, a copy of all consults and the IPN were forwarded to the QDDP for discussion at the team meetings. This practice was abandoned. The medical director explained that each primary provider made a decision about when to refer recommendations to the IDT for discussion. Record reviews reveled some, but not many, IPN entries in which the PCP disagreed with the consultant and documented the disagreement. There was no indication that this disagreement and rejection of the recommendations was communicated to the IDT. While the medical staff were doing a good job of documenting consultation recommendations in a prompt manner, there was no evidence that the individuals' IDTs consistently reviewed the non-facility clinicians' recommendations and/or the SASSLC physicians' plans of care, which were based upon the recommendations, for integration with the individuals' existing supports and services. To achieve substantial compliance, the facility will need a system to ensure that the IDTs are informed of the recommendations of the consultant. This is particularly important when supports must be integrated and when the PCP disagrees and elects not to implement the recommendations. The medical compliance nurse was tracking consults at the time of the compliance review, it was reported that the process had been discussed with nursing management a decision was made to have the RN case managers track the consults for their caseload. This appeared to be a reasonable approach and would serve to provide the case mangers with timely information.	

Recommendations:

1. Departments providing clinical services should develop procedures or at least a statement/philosophy regarding the department's role in the provision of integrated services. Guidelines, philosophies, and procedures should be formally adopted and promoted within the departments. (G1).

2. The facility should continue to monitor the functions of the various committees ensuring that they are functioning as stated in policy with the required participants (G1).

3. The facility needs to explore the development of other metrics to assess if integration of clinical services is actually occurring. This will require creating measurable actions and outcomes (G1).

4. Physicians must refer the recommendations of consultants to the IDT in order that plans are integrated with existing services. A plan for ensuring this is consistently done should be developed (G2).

5. 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 o SASSLC Provision Action Plan 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, January 2012- May 2012 Interviews and Meetings Held: o Carmen Mascarenhas, MD, Medical Director o JoAnn Smith, RN, Medical Compliance Nurse 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: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) the provision action information. For the self-assessment, the facility described for each of the seven provision items, several activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating Overall, this was a great improvement in the assessment process. To take this process forward, the monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. 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 Provision H2 and in noncompliance with all other provision items. The monitoring team was in agreement.
	Summary of Monitor's Assessment: The facility made some, but not much progress, in this area. It appeared that momentum had slowed. The medical director continued to serve as lead for this provision. The facility specific policy remained in draft form and most of the efforts were targeted at provision H1. It appeared that the facility was awaiting guidance from state office in the form of a finalized policy. The management of assessments needed attention because many key assessments were not completed in a timely manner. Moreover, the facility did not provide any evidence that the quality of these assessments was consistently monitored. The medical department in conjunction with nursing had developed a set of clinical indicators to review through the quality process. That set of indicators will require expansion. Much of the work that needed to be done in this area will hinge on the development of a robust set of indicators that can be utilized across the continuum of treatment and evaluation of treatment.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Minimal 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. During the discussions with the medical director and medical compliance nurse, they presented information on compliance with medical assessments. There were no data presented in this meeting or in the self-assessment on the status of the assessments in other areas. The medical director reported that a centralized database, maintained by QA, tracked all assessments. Discipline heads were required to review the quality of assessments. However, there were no tools developed to complete these assessments. In order to address the need for periodic assessments, a sick call request form was implemented. This would allow the medical department to determine if individuals were seen promptly when acute medical issues arose. The form was being piloted in home 674.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Prior to the February 2012 review, SASSLC drafted a procedure on the Minimum Common Element of Clinical Care. The document was actually a list of the activities and processes that the facility engaged in to meet compliance. It described all of the various assessments that were completed. The policy remained in draft. 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 2011. The content and quality of the AMAs improved with this change. Audits of the records and the document sample showed 86% of AMAs were current. The facility data showed the 60% of AMA were submitted at least 10 days prior to the ISP. • The completion of Quarterly Medical Summaries was suspended, resulting in no QMSs being completed for the current quarter. • Quarterly Drug Regimen Reviews were not completed in a timely manner. This is discussed further detail in section N2. • Low compliance rates for completion of the Annual Dental Assessments continued, with 61% of assessments completed in a timely manner. • Regularly scheduled quarterly and annual nursing assessments were present in 100% of the records included in the 21 record sample. This was an improvement from the findings of prior reviews. Nonetheless, a review of the individuals' nursing assessments revealed that although there were some improvement in some areas of the nursing assessments, assessments failed to provide one or more components of 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. • The facility was behind with regard to Appendix B evaluations. They had currently completed 41 comprehensive psychiatric evaluations. Given that 189 individuals received treatment via psychiatry clinic, 79% of the individuals still required a comprehensive psychiatric assessment. Of these 41 completed evaluations, eight were completed by prior treatment providers and were not of acceptable quality. Eleven evaluations had been completed during 2012. • Psychiatry clinic was providing quarterly medication reviews that were, in general, timely. The majority of individuals were seen within the previous quarter. • Assessments were completed on an annual basis for all individuals by OTs, PTs, and SLPs in a single document that addressed all PNM needs in one assessment.	

#	Provision	Assessment of Status	Compliance
		The communication assessment was a stand-alone document, though a brief description of communication was included in the combined assessment as well. Post-hospitalization assessments were completed by the PNMT nurse, but this was not consistently done by the therapists unless there was a specific request, such as a physician's referral. Documentation was routinely noted and in most cases, this was thorough. Other change of status reviews were noted with documentation in the IPNs for such things as fractures, but again, generally per referral rather than routine. • Initial psychological assessments were not completed for all individuals. • Functional assessments were not completed for all individuals with PBSPs and annual psychological assessments were not completed for all individuals.	
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. The medical staff received training in ICD/DSM nomenclature in January 2012. The facility audits showed 100% compliance with use of the ICD nomenclature. This was based on a review of the APLs. The self-assessment reported compliance with the requirements for psychiatry, but provided no data. 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. However, documents, such as QDRRs frequently did not use ICD nomenclature when listing the indications for medications. Diagnoses, such as rash and sleep, were utilized. • 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 individuals that indicated a particular diagnosis. • Audits by the medical compliance nurse, such as those completed for osteoporosis, also indicated incorrect diagnoses. • Across all sample individuals' reviewed, the conclusions (i.e., nursing diagnoses) drawn from the assessments failed to capture the complete picture of the individuals' clinical problems, needs, and actual and potential health risks. The medical director will need to ensure that the diagnoses in the assessments are consistent with disease presentation, symptomatology, and results of diagnostics.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The medical department developed a set of clinical indicators. It was not clear that all departments had developed similar indicators. The multidisciplinary protocols and various guidelines should be utilized to expand the set of indicators including those that can be used in a practical manner on a daily basis to assess response to treatment. The medical department reviewed data in several areas, such as osteoporosis, diabetes mellitus, and aspiration pneumonia to determine if treatment was timely and appropriate. The facility determined that 67% of individuals with aspiration pneumonia received timely treatment. The monitoring team noted the following through observations and record reviews: • The absence of complete nursing diagnoses 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. Thus, the majority of the individuals reviewed failed to have HMPs that referenced specific, individualized nursing interventions developed to address all of their care needs, including their needs associated with their health risks. o Of note, the process of health care planning was changing. At the time of the review, SASSLC began its implementation of the state's integrated health care planning process. None of the individuals selected for the sample had an integrated health care plan. • A limited number of direct interventions were implemented by OT, PT, or SLPs, though there were an increased number of interventions integrated into SAPs for implementation by technicians/DSPs, not requiring skilled therapy. Documentation of direct intervention was not consistent and frequently did not clearly establish the purpose of the intervention, measurable outcomes, consistent review of actual progress and clear justification to continue, modify, or terminate the intervention. There was no consistent review of SAPs implemented by others to address the effectiveness of these programs as they related to mobility or communication, for example. • Interventions for individuals with conditions, such as recurrent pneumonia and osteoporosis were frequently not appropriate. Disease management is discussed in section L1. • Pharmacological interventions were timely. There remained, however, a need to enhance both the identification and implementation of non-pharmacological interventions.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	As discussed in section H3, the facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. Clinical indicators assess particular health processes and outcomes. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas. The current local draft policy addressed only medical indicators. Specific examples related to clinical indicators include: • Across all records reviewed the clinical justification for the goals/indicators of the efficacy of treatments were unclear. For example, most individuals had goals that indicated that they would suffer one less untoward outcome(s) than they suffered over the past year. During the onsite review, the monitoring team attended one individual's ISP meeting where components of the individual's risk assessments/risk action plans were reviewed. It was clear that the individuals' team would continue to benefit from additional training and support regarding outcome identification, measurement, and evaluation. It was unclear from the ISP discussion how the RN case manager would be armed with sufficient information to develop an integrated health care plan that addressed all of the individuals' health problems, needs, and risks. • There was no evidence of consistent routine review of interventions provided, particularly related to communication plans and the PNMPs. PNMPs should be reviewed to determine efficacy related to health status particularly for those at highest risk. In some cases, the assessments recommended that this be done on an annual basis only. • There was evidence of appropriate clinical documentation with regard to the choice of a particular psychotropic medication regimen.	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 self-assessment reported on the risk process as the means of assessing health status. The facility had a number of processes capable of monitoring health status, but had failed to adequately link these processes into a comprehensive system of monitoring health status. Some of the processes were in the developmental stages or had yet to be fully implemented. The monitoring team noted several components that would contribute to monitoring health status, including the risk process, requirements for periodic assessments (medical, nursing, therapies, and pharmacy), the revised sick call procedure, and the medical quality program. Thus, an individual's care and monitoring could be assessed across this continuum of activities. In the case of osteoporosis, an individual's risk assessment might indicate a risk for loss of bone density. Providers would determine how to limit risks. Perhaps the individual received medications that increased risk, but those medications could be limited in order to mitigate risks. An appropriate screening would be done. If the individuals required	Noncompliance

#	Provision	Assessment of Status	Compliance
		pharmacologic therapy due to the diagnosis of osteoporosis, there would be periodic and routine assessments by medical, nursing, and therapists to do determine if treatment was effective or if side effects developed. Therapy would be altered based on the results. If the individual experienced acute problems, medical, nursing and therapies staff would evaluate the individual and the physician would formulate a diagnosis and treatment plan in conjunction with the IDT. At the end of the spectrum, the medical quality program would periodically review data to determine if this individual and others received appropriate therapy. Interspersed in these activities are the clinical pathways that provided guidance on treatment and assessment of the outcomes. Developing a comprehensive format to monitor health status will require collaboration among many disciplines due to the overlap between risk management, quality, and the various clinical services. The facility will need to expand the set of clinical indictors to define what is important to the individuals and what is important that the facility monitor. The facility should utilize, but not limit itself, the clinical protocols in the development of additional indicators.	
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.	The medical department established a set of indictors. As discussed, additional indicators are needed. Practitioners can use these indicators in daily practice through various assessments to determine if treatment is effective for an individual. The facility's quality program would assess the care of particular individuals who crossed the threshold for review and would also look at overall aggregate data. Observations by the monitoring team during this review included: • There was limited routine review of clinical indicators to make a judgment as to the effectiveness of the plans provided to address these. This is an essential element to the provision of these supports and services for those considered to be at highest risk • There was little evidence that changes in individuals' health status and/or their progress or lack of progress toward achieving their objectives and expected outcomes resulted in revisions to their HMPs. For example, individuals with plans to address constipation were not modified in response to their failure to have regular bowel movements; individuals with plans to address their risk of dehydration were not modified in response to actual episodes of dehydration, hyponatremia, etc.; and individuals with plans to address the risk of side effects of their medications, especially psychotropic medications, were not modified in response to episodes of adverse reaction(s) to medication(s).	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.	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. This should not be limited to the Active Problem Lists. Correct nomenclature should be used for all documentation (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. 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 List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year o List of all choking incidents o List of individual at risk for aspiration o List of individuals with pneumonia incidents in the past 12 months o List of individuals at risk for respiratory issues o List of individual with contractures o List of individual with GERD o List of individuals at risk for choking o Individuals with a diagnosis of dysphagia o List of individuals at risk for falls o List of individuals at risk for weight issues o List of individuals at risk for skin breakdown o List of individuals at risk for harm to self or others o List of individuals at risk for constipation o List of individuals with a pica diagnosis o List of individual at risk for metabolic syndrome o List of individuals at risk for seizures o List of individuals at risk for osteoporosis o List of individuals at risk for dehydration o List of individuals who are non-ambulatory o List of individual who need mealtime assistance o List of individuals at risk for dental issues o List of individual receiving enteral feedings. o List of individuals with chronic pain. o List of individuals considered missing or absent without leave o List of individuals required to have one-to-one staffing levels o List of 10 individuals with the most injuries since the last review o List of 10 individuals causing the most injuries to peers for the past six months o ISPs, Risk Rating Forms, Risk Action Plans for:

	• Individual #191, Individual #281, Individual #195, Individual #199, Individual #256, Individual #13, Individual #198, Individual #226, and Individual #208. Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Kathleen Rocha, Facility Investigator o Jessica Rodriguez, Acting Incident Management Coordinator o Megan Lynch, Incident Management Coordinator o Jackie Davis Sims, Assistant Director of Programs o Gevona Hicks, Human Rights Officer o Audrey Wilson, QDDP Coordinator o Charlotte Fisher, Psychology Coordinator o Iva Benson, DADS Field-Based Operations Coordinator o Connie Horton, APRN, DADS Nursing Consultant Observations Conducted: o Observations at residences and day programs o Unit Morning Meeting for Unit 1 and Unit 3 (8/22/12) o Daily Clinical Services Meeting (8/21/12) o Incident Management Team Meeting (8/22/12 and 8/23/12) o Annual ISP meetings for Individual #281 o Human Rights Committee Meeting (8/23/12) o Restraint Reduction Committee Meeting (8/23/12) o ISPA for Individual #87 following an incident of peer-to-peer aggression
	Facility Self-Assessment: SASSLC submitted its self-assessment. It was updated on 8/9/12. Along with the self-assessment, the facility had two others documents that addressed progress towards meeting requirements of the Settlement Agreement. One listed all of the action plans for each provision of the Settlement Agreement and one listed the actions that the facility completed towards substantial compliance with each provision of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. The facility had implemented an audit process using similar activities implemented by the monitoring team to assess compliance. A sample of risk assessments was reviewed using the statewide section I audit tool. In conjunction with the section I audit tool, the facility looked at other relevant data collected by the facility. Findings from the facility self-assessment were similar to findings by the monitoring team. The facility

	rated each of the three provision items in section I in noncompliance. The monitoring team agreed. As the facility gains a better understanding of the risk process, it will be important for the audit process to evaluate quality and efficacy of risk assessments and plans.
	Summary of Monitor's Assessment: While progress had been made on meeting compliance through an initial attempt to ensure all individuals were accurately assessed and action plans were in place to address risks, the facility was not yet in compliance with the three provisions in section I. Plans were not in place to address all risks identified. Risk plans were not being reviewed and updated as changes in health or behavioral status warranted. Risk plans did not include clinical indicators to be monitored or specify the frequency of monitoring and review. As noted in section F, assessments were not being consistently completed prior to ISP meetings. 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. Teams should be carefully identifying and monitoring indicators that would trigger a new assessment or revision in supports and services with enough frequency that risk areas are identified before a critical incident occurs. Teams were waiting until a critical incident occurred before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm. Consultants from the state office had recently provided training at SASSLC. Additional training will be needed to move teams further towards integrating the risk process into the ISP development process.

#	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. The state office hired a team of consultants to work with facilities on developing person-centered support plans. This was to include a risk identification process that would result in one comprehensive plan to address all support needs identified by the IDT. The risk identification process had undergone several revisions in the past year. As noted in section F, the consultants had provided training and technical assistance to SASSLC on the risk process in July 2012. The facility was rolling out the new procedure with one	Noncompliance

#	Provision	Assessment of Status	Compliance
		home's IDT. The monitoring team was able to observe one ISP meeting in the new format while onsite. The risk discussion was now held during the annual ISP meeting. At the ISP meeting observed for Individual #281, all disciplines contributed to the risk discussion. Data were available for review by all team members. Risk determinations were based on integrated discussion. The risk discussion, however, still remained a largely separate part of the ISP meeting. Supports to address risks were not discussed in relation to the individual's preferences. The risk discussion dominated the ISP meeting and little time was left to discuss programming for the upcoming year. Once an individual's primary risks are identified and adequate supports are in place, teams will be able to focus on new risks or changes in risk ratings at future meetings. QDDPs will need to ensure that all supports needed are integrated into one comprehensive plan (the ISP). The ISP should be accessible and offer clear guidance to all staff on providing supports throughout the person's day. All supports should be frequently monitored and revised when the desired outcome is not achieved. The state policy required that all relevant assessments were submitted at least 10 days prior to the annual ISP meeting and accessible to all team members for review. As noted in section F, all disciplines were not routinely completing assessments prior to annual ISP meetings or attending ISP meetings. The facility had begun using a database to track submission of assessments by discipline and attendance at IDT meetings. These databases will be a useful tool when the facility begins consistently collecting and analyzing data. As noted in section F, the submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. 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). • Ensure that assessments are updated and submitted prior to annual ISP meetings and all relevant disciplines attend meetings and participate in discussions regarding risks. • 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.	

#	Provision	Assessment of Status	Compliance
		• 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. • Ensure that data collected regarding incidents and injuries is frequently analyzed for indication that supports may not be adequate for safeguarding individuals. The facility was using the statewide section F audit tool to assess compliance with section I. The quality assurance department reviewed a sample of nine individuals from March 2012 through June 2012. Compliance ratings ranged from a low of 77% to a high of 95%. A noncompliance rating was assigned based on data indicating that IDTs were not consistently documenting the rationale for each risk rating using data and assessment results. The monitoring team agreed with this assessment.	
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. As noted throughout this report, it was still not evident 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. Additionally, there continued to be problems with health risk ratings that were not consistently revised when significant changes in individuals' health status and needs occurred. A sample of records was reviewed to determine if changes in circumstance should have resulted in an assessment of current services and support, risk ratings, and/or plan revisions. Although it appeared that teams were usually meeting immediately following a critical incident, it was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time. ISPAs were used to document initial discussion when a change in status was identified. There was not always documentation of follow-up when recommendations were made by the IDT. IDTs were not consistently addressing risk prior to the occurrence of a critical incident. For example, • Individual #191 was discharged from the hospital on 6/20/12 after he fell hitting his head on the floor. The team met on 6/21/12, but failed to reassess his risk for falls or develop appropriate supports. On 8/17/12, he fell again,	Noncompliance

#	Provision	Assessment of Status	Compliance
		sustaining a serious head injury. His wheelchair was being held for repairs at the time. The team had not met to discuss alternative supports while his wheelchair was being repaired prior to the occurrence of a critical incident. One of the most important aspects of a health risk assessment process is that it effectively prevents the preventable and reduces the likelihood of negative outcomes through the provision of adequate and appropriate health care supports and surveillance. A way in which this is accomplished is through the timely detection of risk, and proper assignment of level of risk based on adequate assessment. The facility self- assessment indicated that a sample of post hospitalization ISPAs were reviewed to determine if the IDT met and began the assessment process within five working days of the individual being identified as at risk. Assessment results indicated that in three of four (75%) cases, the IDT met and began assessment within five days. As noted above, the facility will need to look at whether or not non-critical injuries and incidents are reviewed for changes in status in order to prevent a serious incident from occurring. The facility was not yet in compliance with this provision item.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the 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 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, plans were not in place to address all risks for those individuals designated as high risk or medium risk in specific areas. The facility had made progress in identifying individuals at risk and it was good to see that they were collecting, and looking at, data related to the numbers and percentages of individuals with plans in place. The next step will be developing plans to address those risk identified.	Noncompliance

#	Provision	Assessment of Status	Compliance

High Risk Category	Number of Individuals Rated as High Risk or Medium Risk	Individuals with Plan in Place to Address Risk/ Percentage of Total
Aspiration	114	51/45%
Respiratory	76	40/53%
GERD	106	63/59%
Choking	139	38/27%
Falls	120	35/29%
Weight	93	54/58%
Skin Integrity	106	62/58%
Constipation	176	119/68%
Causing harm to others	175	101/58%
Seizures	74	54/73%
Dehydration	46	10/22%
Osteoporosis	99	56/57%

See additional comments throughout this report regarding the monitoring of healthcare risks. The facility self-assessment 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. Ensure attendance or at least input by all relevant team members in the risk process (U1)
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. 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 (I1 and I2).

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 for 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 One examples of dental desensitization plans o Two examples of skill acquisition plan for dental clinic. 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 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 #155, Individual #5, Individual #183, Individual #195, Individual #149, Individual #118, Individual #266, Individual #232, and Individual #101 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 on site:</u> o Sample template for neurology clinic. o Five examples of completed neurology consultation with corresponding psychiatry documentation. o List of all individuals who have undergone TIVA. o Minutes from polypharmacy and pharmacy and therapeutics meeting 8/22/12. o Minutes from the PIT group meeting for medication consent and desensitization. o All data presented, physician consents, progress notes, and orders from Dr. Luna's clinic dated 8/20/12 regarding the following individuals: Individual #168, Individual #173, Individual #134, Individual #348, Individual #138, Individual #208, and Individual #86. o All data presented, doctor's progress notes, and doctor's orders from Dr. Ferraz's clinic 8/20/12 regarding the following individuals: Individual #15, Individual #344, Individual #89. o Copies of desensitization plans for Individual #114, Individual #77, Individual #160, and Individual #118. o All documentation from the ISP dated 8/21/12 regarding Individual #123. o Two examples of the daily dental report sent to the IDT. o All data presented, doctor's progress notes, and doctor's orders from Dr. Ferraz's clinic 8/22/12 regarding the following individuals: Individual #316, Individual #155, and Individual #319. o These documents: • Demographic Data Sheet • Consent Section (last six months) • Personal Support Plan and addendums (last six months) • Behavioral Support Plan • Psychological Evaluation • Reiss Screen • Positive Behavioral Support Plan Summary and Addendums • Human Rights Committee review of Behavioral Support Plan

	• Restraint Checklists for the previous six months. • Annual Medical Summary • Active Medical Problem List • 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 • Annual weight graph • Seizure graph o For the following individuals: • Individual #140, Individual #220, Individual #294, Individual #191, Individual #205, Individual #95, Individual #320, Individual #168, Individual #194, Individual #13, Individual #232, Individual #252, Individual #86, Individual #17, Individual #56, Individual 82, Individual #199, Individual #51, Individual #184, and Individual #123. <u>Individual Interviews and Meetings Held</u>: o Carmen Mascarenhas, M.D., Medical Director o Charlotte Fisher, M.A., LPC-S, BCBA, Director of Behavioral Services o Marla Lanni, R.N., J.D., Chief Nursing Executive o Sergio Luna, M.D., lead psychiatrist; Melvin Rivera, R.N., psychiatric nurse; and Megan Lynch, psychiatry assistant o Amy Jo Hush R.D.H., and Joanne Smith R.N. o Sergio Luna, M.D., lead psychiatrist and Melvin Rivera, R.N, psychiatric nurse o Nicole Cupples, Pharm.D., clinical pharmacist o Reynald Ferraz, M.D., psychiatrist o Melvin Rivera, R.N, psychiatric nurse o Megan Lynch, psychiatry assistant o Joyce M. Munoz, DDS, MBA, facility dentist <u>Observations Conducted</u>: o Clinical Services Meeting 8/21/12 o ISP regarding Individual #123 o Dr. Luna's clinic dated 8/20/12 regarding: Individual #168, Individual #173, Individual #134, Individual #348, Individual #138, Individual #208, and Individual #86.

	o Dr. Ferraz's clinic 8/20/12 regarding the following individuals: Individual #15, Individual #344, Individual #89. o Dr. Ferraz's clinic 8/22/12 regarding the following individuals: Individual #316, Individual #155, and Individual #319. o Pharmacy and Therapeutics meeting o Polypharmacy Review Committee meeting o Subgroup meeting for sections C, K, J, N, and Q. o Observation of individuals on various homes and in the day program.
	Facility Self-Assessment: SASSLC submitted its self-assessment. In it, the facility lead psychiatrist listed relevant activities that the department conducted towards each of the provision items, and described what activities they engaged in to assess whether they were meeting each provision item. Review of this monitoring tool indicated that facility staff had reviewed the monitoring report and were performing a review similar to that performed by the monitoring team. 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 can be utilized to refine their self-assessment. The facility self-rated itself as being in compliance with seven of the provision items of section J. The monitoring team agreed with three of these ratings (J1, J2, and J12). With regard to J7, data presented during this and previous monitoring reviews did not indicate that individuals not currently participating in psychiatry clinic had the required baseline Reiss screen, nor was there an indication of the process for Reiss screening following a change in status. With regard to J11, given the ongoing challenges with data review, timeliness of QDRRs, and the need to demonstrate consistency with regard to the facility level review of polypharmacy regimens, this provision was rated in noncompliance. With regard to J13, 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). It will also be necessary for psychology to provide the psychiatrist with an interpretation of said data, or a hypothesis of what particular data mean. Given the deficiencies with regard to data presentation and accuracy, the facility remained in noncompliance for this item. With regard to J15, while the monthly neurology clinical consultation was positive, the present neurology resources were inadequate to provide needed consultation and follow-up. There were 40% of individuals with comorbid seizure disorder and psychiatric diagnoses that were delayed in the receipt of annual neurology clinic follow-up. As such, this item also remained in noncompliance.

	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 were expanded to include all facility homes. In the intervening period since the last monitoring report, there had been a turnover in the psychiatric clinic staff. This resulted in some challenges for the IDT members present in psychiatry clinic, in that they had to adjust to new providers. It was apparent that the new providers were integrating themselves into the treatment milieu, and as the prior lead psychiatrist had developed a game plan to achieve substantial compliance, it is recommended that the current psychiatry clinic staff follow her lead. There remained challenges with respect to this enhanced psychiatric 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 continued 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 had 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. The psychiatrists were not always 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.	Qualifications The one full time psychiatrist currently providing services at the facility was designated as the lead psychiatrist. He was board certified in adult psychiatry by the American Board of Psychiatry and Neurology. The lead psychiatrist was also board eligible in Child and Adolescent psychiatry. The second psychiatrist, while working full time at the facility, was provided via a locum tenens agreement. This physician was board certified in adult psychiatry by the American Board of Psychiatry and Neurology. 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. Experience The lead psychiatrist had practiced at the facility for approximately three months, and had previously provided services at another SSLC for a total of 18 months experience working in the field of developmental disabilities. The facility self-assessment reported this psychiatrist had a total of 7.5 years of experience in the field of developmental disabilities. The locum tenens provider indicated no previous experience in the field of developmental disabilities, however, the facility self-assessment revealed a total of two years eight months of experience. Although the two psychiatrists practicing at the facility at the time of this monitoring review were making strides with regard to the provision of psychiatric services, there have been road blocks to the full implementation of policy and procedure that will be necessary for psychiatry services to meet generally accepted professional standards. As stated in the previous monitoring report, and in this report, psychiatry will need administrative and interdisciplinary support in order to move forward. Monitoring Team's Compliance Rating Based on the qualifications of the FTE psychiatrists at SASSLC this item was rated as being in substantial compliance.	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, 186 of the 275 individuals (68%) received psychopharmacologic intervention at the time of this onsite review. There were a limited number (41) of evaluations completed in Appendix B format (discussed in J6). There were concerns regarding the limited psychiatric resources (addressed in J5) as one of the factors resulting in the insufficient number of completed evaluations.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Evaluation and Diagnosis Procedures Via the monitoring team's observation of three psychiatry clinics during the monitoring review, it was apparent that the team members attending the clinic 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 #113: The Quarterly Clinic Addendum Treatment Plan Review dated 7/18/12 reviewed the diagnostic criteria required for a particular diagnosis and indicated which of the required symptoms the team had observed. The document was not signed, but indicated discussion with the IDT. This type of documentation was characteristic of what was noted in the 20 records reviewed. In addition, this document gave detailed information regarding the rationale for the prescription of psychotropic medication (additional examples are below in J10, J11, and J13). The lack of signature was uncharacteristic of this facility. In reviewing forms, it was apparent that there was a separate signature page that was not included in the documentation received. 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. Tracking Diagnoses and Updates The facility maintained a spreadsheet that indicated changes in Axis I diagnoses. The sheet noted the previous diagnosis, the new diagnosis, and documented a brief justification for the change in diagnosis. For example, for Individual #195, a diagnosis of Polysubstance Dependence, in full remission due to a controlled environment, was added. Per the justification for this diagnostic addition, "he endorses use of numerous inhalants, alcohol, and marijuana…in full remission due to living in a controlled environment. IDT will need to be vigilant about monitoring for signs and symptoms of intoxication when returning from extended home visits; no evidence at this time to support use of these agents when he went on home visits." Given this information, and the review of 20 records, it was apparent that the psychiatric physicians were making good effort to justify diagnoses appropriately. Monitoring Team's Compliance Rating 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, this rating will remain. In order to maintain this rating, however, the facility psychiatric staff must continue their current level of documentation	

#	Provision	Assessment of Status	Compliance
		and attend to the number of Appendix B comprehensive assessments that were 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. It was recognized that there had been a turnover with regard to the psychiatric physicians at the facility. The current lead psychiatrist was encouraged to follow the lead of his predecessor and expand upon what had already been developed.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	<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 20 records, all had diagnoses noted in the record inclusive of a review of symptoms and justification for said 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. 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, and needed outgrowth of this. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 PBSP documents did not include a signature from the treating psychiatrist, even though the medication regimen, medication side effects, and medication changes were described in detail in the PBSP. Although it was good to see this information in the PBSP, 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 psychiatrist input into the PBSP as well as IDT participation in the case 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. <u>Emergency use of Psychotropic Medications</u> It appeared that the facility use of emergency psychotropic medication for individuals during periods of agitation/aggression (i.e., chemical restraint) had decreased. During the prior monitoring period, there were a total of 26 incidents involving nine different individuals. During this monitoring period, there were a total of 17 incidents involving eight individuals. A review of the documentation regarding the last seven individuals who required chemical restraint revealed that, in all instances, a psychiatrist's clinic note regarding the incident was included. For Individual #111 there were two instances occurring 1/20/12 and 2/3/12. While both instances were documented in the physician's progress notes, they were addressed contemporaneously in the psychiatric clinic note. Documentation from psychiatry included the justification for the use of additional medication. There was documentation of the IDT response to the individual's experience of behavioral challenges and the need for additional medications, however, in only two instances were alterations to the individuals PBSP documented. For Individual #184 documentation dated 2/17/12 revealed plans to maintain this individual on 1:1 monitoring over the upcoming weekend and to reconvene in the next week for further interventions. For Individual #232, documentation dated 5/15/12 revealed plans to "implement restrictions on his behalf to keep [him] and others safe." The document did not include a description of these restrictions.	

#	Provision	Assessment of Status	Compliance
		During the previous monitoring review, the simultaneous use of multiple psychotropic medications as a chemical restraint was discussed. At that time, there were 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 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. Data reviewed for this monitoring period revealed both a reduction in the frequency of the utilization of chemical restraints, and a reduction in the number of agents utilized. For example, of the total of 17 incidents, eight included the use of two medications, and the remaining 11 utilized one psychotropic medication. 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. Monitoring Team's Compliance Rating The facility self-rated this item in noncompliance due to inconsistent integration between psychiatry and psychology regarding treatment planning, non-pharmacological interventions, and behavior support planning. They did note progress with regard to the reduction in the utilization of chemical restraints. Given the discussion noted above, the monitoring team was in agreement with the facility self-assessment.	
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.	Extent of Pretreatment Sedation There was a listing of individuals who received pretreatment sedation for either medical or dental clinic. This listing indicated that from 1/4/12 to 6/27/12, 32 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 (also see section Q). Of the 32 individuals listed receiving pretreatment sedation for dental treatment, 15 (46%) 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 was more regularly scheduled, with the first regularly scheduled clinic in July 2012. Since that time, there were four TIVA clinics with a total of 12 individuals receiving TIVA. 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 or TIVA for medical or dental 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		date IDT review to minimize the need for the use of this medication. Interdisciplinary Coordination There were 10 examples provided of multidisciplinary consultation regarding the utilization of pretreatment sedation for individuals in dental clinic. This process was evident during the previous monitoring review and had continued. Examples reviewed were comprehensive and included representatives from dentistry, primary care, psychiatry, and clinical pharmacy. As recommended in the prior monitoring report, the facility had added a section to this document that noted the consensus and plan utilizing the clinical consultation information that was reviewed during the morning clinical services meeting. Desensitization Protocols and Other Strategies A list of all individuals with medical/dental desensitization plans and date of implementation were requested. A list of one individual (Individual #77) was provided with an implementation date of 1/11/12. Two other plans were provided for review, these were designated as skill acquisition plans for Individual #160 and Individual #114. In previous monitoring visits, 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 could 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. As such, SASSLC had developed a PIT (performance improvement team) including the human rights officer, director of behavioral services, dental hygienist, representative from medical, and a representative from psychiatry. The first meeting of this group occurred 8/10/12. It was their goal to develop a system for identification, triage, and development of desensitization strategies and plans.	

#	Provision	Assessment of Status	Compliance
		Monitoring After Pretreatment Sedation A review of documentation regarding the nursing follow-up and monitoring after administration of pretreatment sedation revealed that nursing documented assessment of the individual and vital signs. There had also been an expansion of nursing monitoring due to the implementation of regular TIVA clinics. A nurse was assigned to the dental clinic to monitor individuals following TIVA. In order for the nurse to be experienced with TIVA, nursing staff and dental clinic staff had identified one staff member to participate regularly. If individuals recovered appropriately from TIVA, they were returned to their home for monitoring via their regular nursing staff. If there were any concerns, the individual would spend the night in a home with 24 hour nursing services. This was a very conservative practice and appropriate given the higher risk associated with the utilization of TIVA or other sedation in this population. 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. In addition, there was a need to determine the extent of pretreatment sedation for medical clinic, to develop a clinical consultation process for this similar to that utilized for dental clinic, and to include individuals requiring pretreatment sedation for medical procedures in the development of desensitization plans or strategies.	
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 189 individuals) received psychopharmacologic intervention requiring psychiatric services at SASSLC as 8/20/12. There were two FTE psychiatrists providing services. 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 a good addition to the psychiatry clinic team. During this monitoring visit, this staff member received a promotion. Efforts were in progress to recruit a new candidate to fill this position, and as the current psychiatry assistant was going remain at the facility, she pledged to assist with training her replacement.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A psychiatric nurse had also joined the psychiatry clinic as of 6/1/12. He was a registered nurse with 15 years of psychiatric experience. He did not have experience in the field of developmental disabilities, but was energetic and interested in learning. 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 approximately eight of these assigned to administrative duties. It was apparent, however, that the administrative responsibilities of the lead psychiatrist were more encompassing than eight hours. Ancillary psychiatry staff consisted of the psychiatry assistant and the psychiatric nurse. 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. The facility self-assessment included information regarding the number of the above activities each psychiatric physician participated in over the course of the previous six months. These data did not include parameters, such as time requirements for each activity and/or an analysis of the data to determine either the adequacy of current FTE or an estimation of necessary FTEs. Monitoring Team's Compliance Rating 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.	Appendix B Evaluations Completed SASSLC psychiatry staff reported that a total of 41 individuals had psychiatric evaluations performed according to Appendix B. Given that 189 individuals received treatment via psychiatry clinic, 79% of the individuals still required a comprehensive psychiatric assessment. Of these 41, eight were completed by prior treatment providers and were not of acceptable quality. It was noted that 11 evaluations had been completed during 2012. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		were, however, making valiant efforts that resulted in improvements in other areas (e.g., justification of psychotropic medication and determination of diagnoses). There was 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, 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 10 individuals: Individual #155, Individual #118, Individual #149, Individual #101, Individual #232, Individual #67, Individual #195, Individual #5, Individual #266, 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. All of the examples included a five-axis diagnosis and documented a detailed discussion regarding the justification of each diagnosis. While earlier evaluations documented the participation of other team members in the evaluation and diagnostic formulation process, more recent evaluations (i.e., Individual #266 and Individual #232) did not, but should, include this information. All Appendix B evaluations reviewed included 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. Treatment recommendations inclusive of non-pharmacological interventions were included in the documentation in eight of the 10 examples. In two cases (i.e., Individual #266 and Individual #232) the psychiatrist did not include individualized information regarding non-pharmacological interventions. For example, "consistent implementation of current positive behavior support plan" was noted in the document regarding Individual #232. For Individual #266, the statement indicated, "psychology department is in the process of reviewing and updating the positive behavior support plan used in the previous residential facility." As these evaluations are completed, quality assurance via peer review should begin in an effort to ensure that all pertinent information is	

#	Provision	Assessment of Status	Compliance
		included and individualized. <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 data indicated that an average of 1.8 Appendix B comprehensive assessments were completed each month. At this rate, it would take approximately seven years to complete the remainder of the Appendix B evaluations. Per interviews with the psychiatry clinic staff, there were plans to perform four comprehensive psychiatric evaluations per psychiatric clinician per month. At this rate, it would take approximately 1.5 years to complete the remainder of the Appendix B evaluations.	
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 six new admissions for the previous six months with all of these individuals being administered a Reiss screen an average of four days following admission. • All newly admitted individuals received a comprehensive psychiatric evaluation. This evaluation occurred an average of 19 days following completion of the Reiss screen. There was one individual who did not receive a comprehensive psychiatric evaluation within 30 days of admission. Individual #5 was evaluated 41 days following admission and 36 days following 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 275 with 189 individuals enrolled in psychiatry clinic. Therefore, 86 individuals were eligible for baseline Reiss screening. Documentation of Reiss screens completed June 2011 through June 2012 revealed the names of 20 individuals. Of these, 15 were currently participating in psychiatry clinic with five of the 15 admitted to the facility during the current monitoring period. Of the five 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, which were screened due to a change in behavior or circumstance and then entered the clinic, and which had received a required baseline screening.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Referral for Psychiatric Evaluation Following Reiss Screen The process entitled "psychiatry consult note procedure" had been implemented as of September 2011. 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 timelines (e.g., one week for initiation of consultation following a positive screen, 30 days to complete the comprehensive psychiatric evaluation). Monitoring Team's Compliance Rating The facility self-rated this provision in substantial compliance, however, given the challenges with the data presentation noted above, it was not possible to determine if this provision was in substantial compliance. In addition, data presented during this and previous monitoring reviews did not indicate that individuals not currently participating in psychiatry clinic had the required baseline Reiss screen, nor was there an indication of the process for Reiss screening following a change in status (e.g., death of a family member or caregiver, relocation, health issues).	
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 three 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, however, challenges noted with the receipt of information from psychology with regard to behavioral data.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Data were presented in graph format, but did not regularly show medication changes or significant life events that may have contributed to changes in frequency of events being tracked. 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 30 minute) observations/interactions with the individuals, as well as a review of information provided during the time of the clinic. In the three 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. Due to turnover in psychiatry clinic staff, all psychiatric physicians were relatively new to the facility and, as such, the teams were in the process of adjusting to the new physicians. While there was discussion among the IDT members, it was somewhat subdued and not as interactive as noted during prior visits. This may be due to the staff changes, and hoped to improve over time as staff become better acquainted and familiar with each other. A review of the psychological and psychiatric documentation for 20 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 (41 had been completed). Appendix B evaluations were performed via a separate psychiatry clinic where IDT members, including psychology, were present in 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	

#	Provision	Assessment of Status	Compliance
		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> In previous visits, 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 behavioral services. Due to staff turnover in both the lead psychiatrist and director of behavioral services, this meeting had not been continued. Interviews with both staff members revealed 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 identification and implementation of 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 PBSP. There was sporadic documentation of specific interventions noted in Appendix B evaluations. When interventions were noted, implementation was variable. For example, in the Appendix B evaluation of Individual #155 performed 2/1/12, non-pharmacological interventions, including relaxation techniques and the use of an exclusionary time out for aggression, were documented as being in the BSP. A review of psychology progress notes revealed that this individual was receiving relaxation training and was monitored with regard to utilization of these strategies. It was not possible to determine if these were utilized during periods of disruptive behavior and what the result of the use was, or if they were being taught and reinforced during periods of calm. There was no documentation regarding the use of an exclusionary time out for aggression. Further psychology documentation for the month of July 2012 revealed, "challenging month behaviorally...frequency of disruptive behavior has increased significantly possibly due in part to the combining of several target behaviors that serve same function and defined as disruptive…further titration of Zoloft recommended…" This documentation was problematic because it indicated increased frequency of behaviors as a result of the method of data reporting, not necessarily due to an actual increase in frequency. In this case, it would be useful for psychology not only to present the data,	

#	Provision	Assessment of Status	Compliance
		but to analyze the data in order to provide the psychiatrist and other IDT members with reasoning, such as causative factors for either exacerbations or improvements in behavioral challenges. Monitoring Team's Compliance Rating Due to the paucity of completed combined assessment and case formulation, this 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.	Psychiatry Participation in BSP and other IDT activities Per interviews with 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 asked 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. Given the presence of the IDT in psychiatry clinic, the PBSP could be reviewed annually during a regularly scheduled quarterly clinic, with additional reviews as clinically indicated. Per interviews with psychiatry clinic staff, there were plans to incorporate the PBSP review into the individual's third annual quarterly clinic. Per the facility self-assessment, there were 42 PBSP reviews incorporated into 179 psychiatry clinics held during the previous six months. The self-assessment further indicated that in 35 of these 42 reviews, there was indication of "a discussion of strategies to reduce the use of emergency medications and generate a hypothesis regarding behavioral-pharmacological interventions as evidenced by the prescribing psychiatrist[s] written documentation on the reviewed PBSP." It would be helpful in future monitoring reviews for psychiatry clinic staff to indicate where this review was	Noncompliance

#	Provision	Assessment of Status	Compliance
		documented in the record and to provide the names of those individuals who were reviewed, so that these individual's records can be selected for review. A review of documentation in 20 records did not reveal the psychiatrist's signature on the PBSP. There was documentation of PBSP review in some comprehensive psychiatric evaluations. For example: • Individual #5- Included in the comprehensive psychiatric evaluation dated 6/11/12, "the psychologist does not anticipate significant revisions to…PBSP…mittens are currently being used as a non-pharmacological intervention to prevent him from pulling out his colostomy and G tube, incidents that apparently occurred when mittens were not utilized in the LTAC setting. A calm, quiet environment with minimal people around appears to be helpful for him and is reflected so in the BSP. One point of guidance to offer is making sure that lighting cues are appropriate for him to prevent sundowning…blinds need to be up and open with lights turned on during the day to help regulate circadian rhythm…staff should orient him when possible noting the day of the week, where he is…what time of the day it is…gentle reassurance…can be helpful…visual cues can be helpful as well such as a calendar." o This example noted the psychiatrist's review of the BSP as well as specific non-pharmacological interventions that can be utilized to assist this individual. Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. There were 105 total meetings attended by psychiatry. Of those, 62 were categorized as ISPA meetings that occurred during psychiatry clinic. There were nine meetings categorized as ISP meetings. The remainder were categorized as emergency psychiatry clinic, comprehensive psychiatric evaluation, or training. There were no PBSP meetings included in the listing. Treatment via Behavioral, Pharmacology, or other Interventions 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 #82 – per the psychiatry clinic documentation 8/20/12, this individual had a history of diagnoses including Attention Deficit Disorder and Pervasive Developmental Disorder. Reportedly, medication had not been effective in addressing his behavioral challenges. As such, the medications were tapered, but he continued to experience behavioral outbursts, which the psychiatrist and IDT indicated were related to sensory issues. They indicated that their treatment plan was to continue to reduce medications and find treatment alternatives. Unfortunately, due to a lack of coordination in	

#	Provision	Assessment of Status	Compliance
		treatment, this individual had not had consultation with occupational therapy with regard to other interventions that might have assisted with his behavioral challenges. The monitoring team suggested this, and as a result, occupational therapy was consulted during psychiatry clinic. 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 behavioral challenges were not appropriately addressed via the PBSP, and were not addressed via consultation with occupational therapy, psychiatric and medical treatment was impeded, and 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 members who were present. While the comprehensive psychiatric evaluation documents 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. 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 or that would be beneficial in assisting with symptom amelioration. Please review to the example regarding Individual #5 above. <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. 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. There were also	

#	Provision	Assessment of Status	Compliance
		reports of psychiatric review of PBSP during the individual's annual third quarterly clinic. The monitoring team, however, could not locate this in the documentation.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	<u>Policy and Procedure</u> 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 20 individuals at the facility who were prescribed various psychotropic medications as well as information provided regarding the psychiatric clinics performed during this monitoring review, and information provided regarding informed consent revealed numerous examples of completed forms entitled "New Psychotropic Medication Initiation Form." This form was initiated 11/1/10 in order to document the risk/benefit analysis with respect to new medication prescriptions. 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. As discussed below in J14, there were examples noted of "Psychiatry Department Consent for Use of Psychoactive Medication for Behavior Support." This document included information regarding the individual's diagnosis, medications, potential side effects, and potential benefits. It should be noted that the listing of potential side effects documented via this list was not complete in all examples and therefore, would not suffice for consent (example included in J14).	Noncompliance

#	Provision	Assessment of Status	Compliance
		The following are examples typical of the documentation included on the "New Psychotropic Medication Justification Form." • Individual #324 – dated 6/4/12, the "New Psychotropic Medication Justification Form" indicated that the harmful effects of "Insomnia related to MDD [Major Depressive Disorder]" outweighed the possible harmful effects of Melatonin. Additional documentation stated, "this individual is medical fragile, so use of hypnotic class of agents carries inherent greater risk than use of melatonin…improvement in sleep disturbance want her to sleep at least four consecutive hours nightly." 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 #318 – dated 5/23/12, the "New Psychotropic Medication Justification Form" indicated that the harmful effects of "impulsivity, affective instability related to Borderline Personality Disorder, psychosis related to MDD, with psychotic features" outweighed the possible harmful effects of Risperidone. Additional documentation stated, "his current medication regimen does not address symptoms related to Borderline Personality Disorder-specifically impulsivity and affective instability. This individual has medication compliance issues, as a result is on liquid formulations. Risperidone comes in liquid formulation." This example illustrated the indication of the prescribed medication and the rationale for the use of this medication rather than an alternate medication within the same class. 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 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	

#	Provision	Assessment of Status	Compliance
		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. Observation of Psychiatric Clinic During the psychiatric clinics observed by the monitoring team, the psychiatrist was well prepared. The psychiatric rationale for a particular medication regimen was discussed with the IDT and 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 during 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 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. Human Rights Committee Activities A risk-benefit analysis authored by psychiatry, yet developed via collaboration with the IDT, would then provide pertinent information for the Human Rights Committee (i.e., likely outcomes and possible risks of psychotropic medication and reasonable alternative treatments). 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. Monitoring Team's Compliance Rating Although there were improvements noted with regard to psychiatric participation in the development of risk/benefit/side effect documentation, challenges remained. While the currently implemented form will address newly prescribed agents, it does not address previously prescribed agents currently included in the regimen. 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.	

#	Provision	Assessment of Status	Compliance
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 the inaugural polypharmacy overview committee meeting on 6/22/12, and a draft policy and procedure dated 8/1/12 was authored. Since the inaugural meeting, there were two additional monthly meetings conducted. This meeting was observed during the monitoring visit and consisted of a review of the pharmaceutical regimens of selected individuals with question and answer by the pharmacist requiring the treating psychiatrist to justify medication regimens. Significant issues were noted with regard to the reporting and review of adverse drug reactions (ADRs). These were reviewed during the pharmacy and therapeutics meeting 8/21/12. It was noted that of the 12 individuals reviewed, there were ADRs dated back to September 2011. This delay in reporting and review was unacceptable. For example, Individual #40 had an ADR documented 2/14/12. It was noted that he had restlessness attributed to psychotropic medication. This may have been akathisia, an internal restlessness and inability to remain still, which is attributed to treatment with psychotropic medication. Unfortunately, because this information was not presented to the physician, medication regimen alterations were not made and, ultimately, this individual received emergency chemical restraints 7/17/12. The initial medication trialed was an antipsychotic medication, and this dosage was reported as ineffective, which would not be surprising if the behavioral challenges were related to akathesia. A second event occurred 7/18/12, which was noted as effective when the antipsychotic was combined with a benzodiazepine and antihistamine. Benzodiazepines are frequently utilized to treat akathisia. For additional information regarding adverse drug reactions please see section N6. <u>Review of Polypharmacy Data</u> Documentation presented during the polypharmacy oversight committee meeting 8/21/12 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 41. This was an increase from 38 individuals in February 2012. • The total number of individuals residing at the facility prescribed three or more psychotropic medications was 92. This was a reduction from 97 individuals in February 2012. • The total number of individuals residing at the facility prescribed any psychotropic medication was 186. • Therefore, 72% of the individuals prescribed psychotropic medications at SASSLC met criteria for polypharmacy.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. 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, seven individuals with intraclass polypharmacy for antidepressant medications, two individuals with intraclass polypharmacy for anxiolytic medications, and eight 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 38 individuals who met criteria for intra-class polypharmacy per this grid. It should be noted that this differed from the polypharmacy oversight data where this number was reported as 41. There were challenges with the review of these data regarding intraclass polypharmacy. AED medications and mood stabilizers (including Lithium) were reported together. This skewed the data for review of individuals prescribed two or more AEDs either due to a seizure diagnosis or for psychiatric purposes. The facility should consider reviewing these data and revising the presentation. Pharmacy quarterly drug regimen documents were located in 19 of 20 individual records. The available documentation revealed timely reviews in 12 of 20 cases. There were a total of seven cases where documentation was delinquent (e.g., not performed during the previous quarter). There were three reviews dated in April 2012 (Individual #168, Individual #123, Individual #140), three reviews dated in March 2012 (Individual #86, Individual #220, Individual #252), and one review dated in February 2012 (Individual #199). One individual had no QDRR documentation (Individual #184). Per interviews with pharmacy staff, they were behind approximately six weeks in completion of the QDRRs. A new clinical pharmacist joined the staff as of 8/10/12 and there were plans to remediate this delinquency. One challenge noted was the scheduling of the QDDR. Currently, completion was performed based on the birthdate of the individual. Instead, it would be useful to complete the QDDR just prior to the individual's quarterly psychiatric clinic. The QDDRs were comprehensive and offered appropriate guidance and recommendations to the psychiatrist. In all of cases, the treating psychiatrist signed the review. In cases where recommendations were provided, the psychiatrist indicated his or her response (e.g., that specific labs recommended were ordered or that a diagnosis	

#	Provision	Assessment of Status	Compliance
		would be clarified). 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, justify the clinical hypothesis guiding said treatment. This justification must then be reviewed at a facility level review meeting. This forum should be the place for a lively discussion regarding reviews of the justification for polypharmacy derived during psychiatry clinic. This element was in its infancy as the facility had held three meetings, reviewing the regimens of approximately seven individuals meeting criteria for polypharmacy. Review of Polypharmacy Justifications Documentation regarding polypharmacy in the record of Individual #148 dated 7/18/12 discussed the rationale for treatment with the current medications as well as plans to taper antipsychotic medications, "diagnosis of Bipolar disorder…Topamax was beneficial, but the therapeutic effect…did not last. Lithium…very effective…tolerating frustration…more patient …redirectable …brighter …aggression decreased…managed with two antipsychotics…ineffective…Zyprexa…will be discontinued today…tapering of Fanapt will be started 7/25." The document went on to discuss specific side effects and laboratory monitoring that had been occurring and the individual's response to the current regimen. 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. This type of documentation was typical for the psychiatrists at SASSLC. Monitoring Team's Compliance Rating The facility has made strides with regard to this provision item, however, given the ongoing challenges noted above with regard to data review, timeliness of QDRRs, and the need to demonstrate consistency with regard to the facility level review of polypharmacy regimens, 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	Completion Rates of the Standard Assessment Tools (i.e., MOSES and DISCUS) 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 January 2012 through June 2012. The data were presented for each month, including the individual's name, DISCUS score, MOSES score, and the dates of completion. The manner in which the data were presented made it difficult to follow the completion of the instruments over the course of time because data were not sequential. Therefore, it was not possible to easily compare scores over time.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	and/or changing needs, but at least quarterly.	In addition, data reviewed revealed that instruments were not always completed in a timely manner. For example, for individuals treated with antipsychotic medications, the MOSES should be completed semi-annually, and the DISCUS quarterly. A review of the data did not reveal this was occurring in all cases. • Individual #5, who was prescribed the atypical antipsychotic medication Seroquel, had both MOSES and DISCUS performed in January 2012. These examinations were not repeated until June 2012, indicating that there was a delay in the DISCUS examination, which should have been performed in April 2012. A revision in the presentation of data into a spreadsheet may assist with tracking both completion of the instruments over time and changes in scores requiring further clinical evaluation. A review of the facility self-assessment revealed that per the facility audit, 100% of individuals receiving psychiatric services had a MOSES and DISCUS score completed on a quarterly basis from January 2012 through June 2012. <u>Training</u> Per the response to the 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." In the previous monitoring report, it was noted that an inservice training occurred 6/22/11 where 21 nurses attended. Additional information received during this visit revealed that MOSES and DISCUS are included in the annual nursing competency assessments. <u>Quality of Completion of Side Effect Rating Scales</u> 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 #183, documentation included on the completed MOSES dated 6/13/12 stated, "tongue tremor, hand tremor (fine) may be related to one or more of his psychotropics, likely Mellaril." In previous document reviews, the MOSES and DISCUS results were included on the "Psychiatry Clinic" form. This form was revised in September 2011, and the requirement for the documentation of the results was removed from the form. This was curious because, in previous monitoring reports, 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	

#	Provision	Assessment of Status	Compliance
		psychiatry clinic. Nine individuals were noted to have the diagnosis of tardive dyskinesia (TD). This was a reduction from 12 individuals identified in the previous monitoring report. 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. <u>Monitoring Team's Compliance Rating</u> 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 psychiatric leadership consider including prompts in the psychiatric clinic note regarding review of the MOSES and DISCUS evaluations so that this practice is reinforced as well as reorganizing data regarding date of completion/scoring of the instruments for ease of review and comparison.	
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	<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 20 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 #111, the quarterly clinic addendum treatment plan review documentation revealed a review of the criteria	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	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, "started on Clozaril in October 2011 due to sudden occurrence of psychotic behaviors. Topamax was tapered, but was titrated back to previous dose because the tapering led to deterioration…polypharmacy is required. Clozaril, that can't be increased, has been very beneficial, but both Lithium and Topamax have contributed to…stabilization. The dose of Lithium has remained low because further increase led to toxicity." 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." <u>Psychiatric Participation in ISP Meetings</u> At the time of the onsite monitoring review, there was some psychiatry participation in the ISP process. Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. There were 105 total meetings attended by psychiatry between the dates of 1/2/12 and 6/22/12. Of those, 62 were categorized as ISPA meetings that occurred during psychiatry clinic. There were nine meetings categorized as ISP meetings. The remainder were categorized as emergency psychiatry clinic, comprehensive psychiatric evaluation, or training. Given the manner of the data, it was not possible to determine what percentage of the total number of meetings the psychiatrist attended. 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, three psychiatry clinics (for a total of 13 individuals) were observed. In all but one instance, the individual was present for clinic. One individual declined to come to clinic because he wanted to go on an outing (in this case,	

#	Provision	Assessment of Status	Compliance
		the psychiatrist and psychologist went out to the van and observed the individual). All treatment team disciplines were represented during these clinical encounters. The team did not rush clinic, spending an appropriate amount of time (often 30-40 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 graphing was variable. For some, data were provided in tabular form. Graphed data were also variable in presentation as some appropriately included time stamps indicating changes in medication dosage or significant life events, whereas others did not. This variability made data based decision making difficult for the psychiatrist because medication changes and other events that may affect behavior or psychiatric symptoms were not consistently 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 current quarter. There were a total of 26 individuals (of a total caseload of 189) who were delayed with regard to psychiatric follow-up. Of these, 25 were last seen in April 2012 and one was last seen in March 2012. It was allowed that this delay may have been due to the recent turnover in psychiatric physicians. <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 physician can determine the benefit, or lack thereof, of a medication adjustment. This was standard practice at SASSLC. <u>Monitoring Team's Compliance Rating</u> 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	

#	Provision	Assessment of Status	Compliance
		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 20 records revealed appropriate documentation for the psychiatric reviews. Per a review of the facility self-assessment, this provision was rated in substantial compliance. The monitoring team rated this provision 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). It will also be necessary for psychology to provide the psychiatrist with an interpretation of said data, or a hypothesis of what particular data means. Given the deficiencies with regard to data presentation and accuracy, the facility remained in noncompliance for this item, however, with these improvements, it is possible that substantial compliance may be achieved in the near future.	
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.	<u>Policy and Procedure</u> 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 staff interviews and the facility self-assessment, psychiatry services was in the process of revising the current "SASSLC Psychiatry Clinical Services Policy" to "address the need for the prescribing practitioner to disclose to the LAR the risks, benefits, side effects, alternatives to treatment and potential consequences for lack of treatment, as well as ensure LAR's understanding of the information." <u>Current Practices</u> Per the facility self-assessment, 49% of individuals prescribed a new psychotropic	Noncompliance

#	Provision	Assessment of Status	Compliance
		medication had a LAR who was contacted by the psychiatrist in order to obtain consent. For other individuals, consents were obtained from the SASSLC facility director. The assessment also indicated that IDT members signed 100% of "New Psychotropic Medication Justification" forms. It was reported that psychiatry did not participate in the annual consent process for psychotropic medication. This process remained inappropriately delegated to psychology staff. A review of information provided regarding the five individuals enrolled in psychiatric clinic who were most recently admitted to the facility revealed that while all were prescribed psychotropic medications, consent documentation was only included for Individual #149. The consent information provided, however, did not include the "New Psychotropic Medication Justification Form," but instead consent information was included in "Psychiatry Department Consent for use of Psychoactive Medication for Behavior Support." The document included documentation of both common and serious/rare side effects of prescribed medications, which included Seroquel, Prozac, and Depakote. This document met generally accepted standards with one exception: it did not include the signature of the person providing the information to the individual's guardian, that is, specifically the psychiatrist. This document was an improvement over previous document reviews because it identified the generation of a consent form reviewing psychotropic medication side effects from the prescribing practitioner. A review of records for nine individuals residing at the facility most recently prescribed a new psychotropic medication revealed that for all nine Individuals (Individual #138, Individual #56, Individual #57, Individual #3, Individual #220, Individual #324, Individual #191, Individual #318, and Individual #85) documentation included the "New Psychotropic Medication Justification Form." In these nine examples, five individuals had a LAR identified, and documentation revealed that the prescribing practitioner had a telephone conversation with the LAR regarding medication consent. In all the other cases, the consent was obtained from the SASSLC facility director. In eight of nine cases, the "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 effects of medication to occur, and signatures of all involved parties. This documentation was missing from the record of Individual #3. Side effect information was included in documentation entitled "Consent for use of Psychoactive Medication for Behavior Support." In seven cases, this documentation was noted as provided via psychiatry. In three cases (Individual #85, Individual #56, and Individual #318), this documentation was noted as provided via psychology, which was inappropriate. The listing of potential side effects was not complete in all cases, and there was need for review of specific documented side effects to ensure that pertinent	

#	Provision	Assessment of Status	Compliance
		information was included. For example, Individual #138 was prescribed Depakote ER. Potential side effects did not include toxicity, liver effects, or pancreatic effects. In all cases without a LAR, the facility director signed this document, however, in no case did the document include the psychiatrist's signature indicating review of the side effects. Monitoring Team's Compliance Rating Even though there were improvements, 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.	
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 75 individuals. At the time of the previous review, there were 68 individuals listed that required neuropsychiatric intervention to coordinate the use of medications prescribed to treat both seizures and a mental health disorder. Data provided for this monitoring visit were confusing, as per a second source of information, namely the facility self-assessment, it was noted that there were only eight individuals receiving psychiatric services diagnosed with a seizure disorder who were prescribed medications to treat both seizures and a mental health disorder. These eight individuals were not identified in other data reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Of the 20 records available for review, five had a diagnosis of seizure disorder. A review of these five records revealed that in four cases, the last neurology consultation was approximately one year ago. Individual #294 was last seen in neurology clinic 5/17/11, Individual #191 was last seen 9/27/11, and Individual #199 was last seen 8/25/09. It was noted that Individual #199 had been seizure free since 1985 and was not prescribed antiepileptic medication for any reason. • Individual #220 was documented as having a pending consultation dated 7/31/12 with the most recent prior consultation dated 6/10/08. A review of documentation did not reveal a neurology consultation note, nor was there documentation located in the integrated progress notes on this date. There was indication of the necessity of neurological consultation documented in psychiatric progress notes dated 5/29/12 were it was noted that this individual was prescribed medications including Depakote, Zyprexa, and Dilantin, "she is on Phenytoin [Dilantin] for seizures which has multiple drug interactions including reduced efficacy of many psychiatric agents. Please consider neurology consult for use of other agents as appears to be affecting efficacy of Zyprexa." Subsequent documentation dated 6/5/12 revealed that this individual experienced an acute exacerbation of mania and required emergency room evaluation with administration of IV medications in the emergency room. Additional documentation noted 7/6/12 revealed plans to increase the dosage of Dilantin (subsequently ordered by the facility primary care physician) in the absence of consultation between neurology and psychiatry. It should be noted that there was a neurology clinic scheduled 6/26/12. This individual did not receive a consultation at this time. o This was an example of an individual who was apparently experiencing difficulties related to the metabolism of psychotropic medications in the presence of antiepileptic medications with increasing psychiatric symptoms requiring emergency room intervention and IV medications. As such, referral for neurology consultation would have been prudent prior to her experiencing decompensation. • Individual #56 was seen in neurology clinic 1/31/12. Documentation revealed consultation with psychiatry during clinic. Psychiatric documentation of 1/31/12 revealed that the psychiatric physician had discussed neurology recommendations with the IDT. During a subsequent psychiatry clinic dated 1/31/12 it was documented, "[neurology] thought it would be ok to try and decrease Ativan to see if it helps decrease aggression. He felt seizure risk was low." o This was a good example of integrated treatment where clinical information obtained via consultation between psychiatry and neurology was disseminated to the IDT.	

#	Provision	Assessment of Status	Compliance
		Adequacy of Current Neurology Resources 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. 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 75 individuals, there were no data regarding the most recent neurology clinic evaluation provided for eight individuals. In these cases, notations such as "no AED" indicating that the individual was not currently treated with antiepileptic medications were present in 13 instances. It was concerning that when reviewing data, it was noted that of the 75 individuals identified, 30 [not including the 13 individuals discussed above] individuals had not been seen in neurology clinic in the previous year. One individual was last seen in 2005, two individuals were last seen in 2006, one individual was last seen in 2007, three individuals were last seen in 2008, three individuals were last seen in 2009, nine individuals were last seen in 2010, and 11 individuals were last seen in the first half of 2011. Given these data, it was also evident of the need for additional clinical neurology consultation, as 40% 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. In May 2012, an additional monthly neurology clinic was added, for a total of two neurology clinics per month. A review of the clinic schedule from 1/31/12 through 6/26/12 revealed that this had occurred in the month of May 2012, but not in the month of June 2012. Additionally, there was not on-campus neurology clinic during the month of April 2012. As the physicians continue organizing and participating in this clinical consultation, they will need to determine if the current and/or expanded contract hours are sufficient (given a four hour clinic twice per month, 24 times per year, there would be a total of 96 hours of consultation time to allocate between 75 individuals identified as having a seizure disorder and psychiatric services [this does 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	

#	Provision	Assessment of Status	Compliance
		clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities. Per staff interviews, the facility was also accessing care for individuals with refractory seizures from the Comprehensive Epilepsy Center. Documents received revealed that SASSLC had submitted a contract for on-campus services from the Comprehensive Epilepsy Center and this contract was pending approval. It should be noted that this was reported during the previous monitoring period as well. Individuals with comorbid psychiatric and seizure disorder diagnosis were receiving neurology consultation via the on-campus clinic, such that psychiatric physicians could attend. <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 ongoing 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 that a substantial compliance rating was designated for this paragraph. While the monthly neurology clinical consultation was positive, the present neurology resources were inadequate to provide needed consultation and follow-up. There were 40% of individuals with comorbid seizure disorder and psychiatric diagnoses that were delayed in the receipt of annual neurology clinic follow-up. As such, this paragraph remains in noncompliance.	

Recommendations:

1. Develop quality assurance monitoring (e.g., record reviews, peer review process) for psychiatry (J2, J4, J6, J8, J9, J10, J11, J12, J13, J14).

2. 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).

3. 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 individual's current psychotropic medication regimen to determine adequacy in light of breakthrough symptoms, as well as

the individual's behavioral support plan (J3).

4. 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. This process was currently occurring for dental pretreatment sedation, but must be expanded to include medical pre treatment sedation (J4).

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

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

7. 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).

8. Fill the vacancy in the psychiatry assistant position and 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).

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

10. As Comprehensive Psychiatric Evaluations according to Appendix B format are completed, begin quality assurance via a peer review process (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 and monitoring 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. Given the plan continue the review of the PBSP in the individual's third annual quarterly psychiatric clinic, this should be added to the facility specific policy and procedure inclusive of documentation requirements for this review (J9).

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

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

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

19. Continue the monthly psychiatric polypharmacy committee meeting for a facility level review of the justification for the use of psychotropic polypharmacy (J11).

20. Ensure that QDRR's are timely. Consider coordinating completion of these reviews with the timing of quarterly psychiatry clinic (J11).

21. 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) and if altering the presentation of the data would be useful (J11).

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

23. 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).

24. 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).

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

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

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

28. 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 #268 (3/12/12), Individual #73 (5/4/12), Individual #314 (5/4/12), Individual #47 (4/27/12), Individual #2 (5/25/12), Individual #164 (6/6/12), Individual #104 (4/12/12), Individual #256 (6/5/12), Individual #170 (5/8/12), Individual #347 (6/1/12) o Positive Behavior Support Plans (PBSPs) for: • Individual #268 (3/26/12), Individual #73 (5/2/12), Individual #314 (5/21/12), Individual #47 (5/21/12), Individual #2 (5/22/12), Individual #164 (6/18/12), Individual #104 (4/14/12), Individual #256 (6/18/12), Individual #170 (5/21/12), Individual #232 (5/14/12), Individual #184 (7/23/12) o Annual Psychological updates for: • Individual #73 (3/4/12), Individual #314 (5/4/12), Individual #47 (4/27/12), Individual #2 (5/14/12), Individual #164 (6/6/12), Individual #104 (4/9/12), Individual #256 (5/31/12), Individual #170 (4/9/12) o Six months of progress notes for: • Individual #268, Individual #73, Individual #314, Individual #47, Individual #2, Individual #164, Individual #104, Individual #256, Individual #170 o Peer Review Committee Policy, dated 5/24/12 o 665 Rose Lane Target Behaviors and Replacement behaviors o Peer review committee minutes for the last six months o Positive Behavior Support Plan Checklist, undated o Interobserver agreement (IOA) for target behavior data collection, undated o IOA and data integrity data sheet, undated o Graphs for: • Individual #268, Individual #73, Individual #314, Individual #47, Individual #2, Individual #164, Individual #104, Individual #256, Individual #170, Individual #232, Individual #184, Individual #283, Individual #206, Individual #223, Individual #111 o List of individuals with functional assessments and annual psychological assessments, undated o Psychological Evaluations Checklist, undated o Section K Presentation Book, undated o For the past six months, minutes from meetings of the psychology department 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 Status of enrollment in BCBA coursework for each psychologist, undated o SASSLC self-assessment, 8/9/12 o SASSLC action plan, 8/9/12 <u>Interviews and Meetings Held</u>: o Charlotte Fisher, Director of Behavioral Services o Laura Lewis, Associate Psychologist III o Melanie Phillips, Associate Psychologist III o Alan Almogela, Associate Psychologist III o Mark Boozer, Associate Psychologist III o Gary Sarli, Associate Psychologist V o Juan Villalobos, Unit I Director; David Ptomey, Unit II Director; Greg Vela, Unit III Director <u>Observations Conducted</u>: o Behavior Therapy Committee (BTC) Meeting • Individuals presented: Individual #10, Individual #42, Individual #3 o Internal Peer review • Individual presented: Individual #205 o Individual Support Plan (ISP) meeting • Individual discussed: Individual #281 o Psychiatric Clinic meeting: • Psychiatrist: Dr. Ferraz • Individuals presented: Individual #316, Individual #155 o Observations occurred in various day programs and residences at SASSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals
	Facility Self-Assessment: The self-assessment included many relevant activities in the "activities engaged in" sections. As suggested in the last review, the monitoring team believes that the self-assessment should include activities that are identical to those the monitoring team assesses as indicated in this report. For example, for K4, SASSLC's self-assessment included a review of interobserver agreement (IOA), data collection reliability, and graphing of data; three topics that are included in the monitoring team's review of K4. The self-assessment, however, did not include several additional items that are necessary to achieve substantial compliance with K4 and are, therefore, included in the report. As the report below indicates, the critical items for K4 (and, therefore, the items that are suggested to be reviewed in the self-assessment) are: • A data system that includes the collection of target and replacement behaviors. • A data system that is simple and flexible.

	• Evidence that data collection is reliable. • Evidence that interobserver agreement (IOA) is collected, reliability goals are established, and attempts are made to ensure that those goals are achieved. • Graphing of data and progress review occur at least monthly, with more frequent graphing as necessary. • Evidence of progress, or evidence of some activity (e.g., modification of PBSPs, retraining of staff) to address lack of progress. • Evidence that data are used to make treatment decisions in psychiatric clinics, peer review meetings, ISP meetings, etc. The monitoring team suggests that the psychology department review, 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 the psychology department to have a more comprehensive listing of "activities engaged in to conduct the self-assessment." Then, the activities engaged in to conduct the self-assessment, the assessment results, the action plan, and the monitoring team's report, are more likely to line up with each other. SASSLC's self-assessment indicated that one item (K2) was in substantial compliance. The monitoring team's review of this provision, as detailed in this section of the report, was congruent with the facility's self-assessment. The 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 suggest 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 are discussed in detail in this section of the report.
	Summary of Monitor's Assessment: Although only one of the items in this provision was found to be in substantial compliance, the monitoring team acknowledges the considerable progress, as discussed in detail below, toward substantial compliance with this provision accomplished in the last six months. Those improvements include: • Establishment of a qualified director of psychology (K2) • Initiation of external peer review monthly (K3) • Initiation of the collection of data reliability (K4) • Initiation of the collection of interobserver agreement (IOA) data (K4, K10) • Simplified graphs and evidence of data graphed in intervals necessary to make data-based decisions (K4, K10) • Increase in the percentage of individuals with PBSPs that have functional assessments (K5)

	• Improvement in the quality of functional assessments (K5) • Increase in the number of individuals with annual psychological assessments (K7). • Improvement in the comprehensiveness of the annual psychological assessments (K7). • Improvements in the quality of PBSPs (K9) The areas that the monitoring team suggests that SASSLC work on for the next onsite review are: • Ensure that all psychologists that write PBSPs have completed or are enrolled in training to obtain their certification as applied behavior analysts (K1) • Simplify the system for collecting both target and replacement data (K4) • Modify the procedures for the collection of IOA (K4) • Establish IOA and data collection reliability goals, and ensure that those levels are achieved (K4, K10) • Ensure that data are used to make treatment decisions (K4) • Continue to increase the percentage of functional assessments for individuals with PBSPs (K5) • Ensure that all functional assessments include direct observations of target behaviors (K5) • Ensure that all annual psychological assessments contain the necessary components (K7) • Begin the graphing of replacement behaviors (K4, K10) • Develop a system to assess treatment integrity, and begin to collect treatment integrity data (K11)

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, none of psychologists at SASSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as applied behavior analysts (BCBAs). At the time of the onsite review, seven of 10 psychologists who wrote PBSPs (70%) were either enrolled, or completed coursework, toward attaining a BCBA. One of the three psychologists that were not enrolled or completed BCBA coursework had committed to begin coursework in the fall. This percentage of psychologists either enrolled in, or completed, BCBA coursework is the same as that reported in the last review. The facility should ensure that all psychologists that write PBSPs have BCBAs. The director of psychology was certified as a behavior analyst, and was providing supervision to the psychologists enrolled in BCBA coursework. SASSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance

#	Provision	Assessment of Status	Compliance
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The facility attained substantial compliance with this item. At the time of the onsite review, the director of psychology had a master's degree, was a certified applied behavior analyst, and had 15 years of experience working with individuals with intellectual disabilities. Supervisees interviewed indicated they had positive professional interactions with, and received professional support and leadership from, the director of psychology. Finally, under the director's leadership, several initiatives have begun leading toward the attainment of compliance with this provision.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	SASSLC began internal peer review meetings in March 2012, and added external peer review in June 2012. At the time of the onsite review, the external peer review meetings had not occurred long enough to demonstrate that they consistently occurred monthly, and, therefore, this item was rated as being in noncompliance. In addition to the review of PBSPs requiring annual approval (i.e., Behavior Therapy Committee meeting), the internal peer review meetings provided an opportunity for psychologists to present cases that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #205's PBSP. The peer review meeting included active participation from all of the department's psychologists, and appeared to result in the identification of several new treatment strategies to address Individual #205's target behaviors. Review of minutes from internal peer review meetings indicated that the majority of psychologists in the department regularly attended. Meeting minutes also indicated that internal peer review meetings consistently occurred weekly. Additionally, in the last three months prior to the onsite review, the facility conducted external peer review by including a BCBA from outside the facility. Operating procedures for both internal peer review committees were established. In order to achieve substantial compliance with this provision item, the facility needs to ensure that internal peer review consistently occurs weekly and external peer review consistently occurs at least monthly.	Noncompliance
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures	SASSLC has made progress in this area. In order to achieve substantial compliance, however, the facility now needs to modify the collection of interobserver agreement (IOA) for all individuals with a PBSP, establish acceptable data collection reliability and IOA levels, and ensure that those levels are achieved. Additionally, the facility needs to improve the collection of replacement behaviors and ensure the graphing of	Noncompliance

#	Provision	Assessment of Status	Compliance
	for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	replacement/alternative behaviors for all individuals with a PBSP. Finally, the facility needs to demonstrate evidence (e.g., from observations of psychiatric meetings) of data based 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. The facility continued to utilize 30-minute target behavior data collection in all residential and day programming sites. Additionally, 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. Requiring the recording of a target behavior, or a mark indicating that no target behavior occurred, increased 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 allowed 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 past onsite reviews, the monitoring team did its own data collection reliability by sampling individual data books across several residential units, and noting if data were recorded up to the previous recording interval for target behaviors. Although better than those reported in the last review, the results were disappointing: • The target behaviors sampled for only one of nine data sheets reviewed (11%) was completed up to the previous recording interval. This represented an improvement over the last review when none (0%) of the data sheets were completed up to the previous interval. • One data sheet (i.e., Individual #45's) was filled out through 5 pm; the observation, however, was at 4pm. These observations indicated that DCPs were not consistently recording 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. In response to these concerns, the facility recently initiated its own data collection reliability for all target behaviors. The results of their data collection reliability were consistent with those reported by the monitoring team. As discussed in the last report, one possible reason that data collection reliability was poor could be that the individual notebooks (which contain data sheets) were not always readily available to DCPs. The majority of data books reviewed by the monitoring team remained behind locked doors. In order to improve data collection reliability, it is	

#	Provision	Assessment of Status	Compliance
		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. Additionally, SASSLC needs to establish acceptable data collection levels, and ensure that those levels are achieved. One suggestion for improving staff access to data sheets is the use of data cards. This data collection system utilizes preprinted data cards (and a pouch to carry them in) that contain the target and replacement behaviors for each individual assigned to them. One advantage of the data card over SASSLC's current data collection system is that the card is easier for DCPs to access (because the DCPs always carry the card) and, therefore, increases the likelihood that data are recorded every 30 minutes. The monitoring team only found one data sheet (i.e., Individual #170's) that included replacement behaviors. The majority of replacement behavior collection at SASSLC was incorporated in skill acquisition plans (SAPs). When replacement behaviors require the acquisition of new behaviors, writing replacement behaviors as SAPs is recommended (see K9). SAPs, however, are typically only implemented at specified times of the day, and staff, therefore, might not record replacement behaviors when they occur at other times of the day. Additionally, several psychologists reported difficulty accessing the SAP data to graph their replacement data. It is, therefore, recommended that regardless of whether a replacement behavior is part of a SAP or not, replacement behaviors should be collected on a data sheet separate from the SAP. 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 interobserver 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. This is another area where the facility improved since the last review. SASSLC recently began to collect data reliability (i.e., IOA). At the time of the onsite review, the monitoring team reviewed the IOA procedures used by the facility and made some specific suggestions to modify it. It is recommended that the facility modify the procedure for the collection of IOA for all target and replacement behaviors. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals. Another area of improvement at SASSLC was the flexibility in the graphing of data in increments based on individual needs (rather than all individuals' data graphed in increments of one month). For example, Individual #111 and Individual #232's target behaviors were graphed in weekly increments to better understand recent changes in their behavior. Additionally, as recommended in the last report, the graphs were	

#	Provision	Assessment of Status	Compliance
		simplified by reducing the number of data paths and adding of phase lines to mark medication changes and/or other potentially important events (e.g., a new roommate). The monitoring team, however, did not encounter any graphs of replacement behaviors. It is recommended that replacement behaviors be graphed for all individuals with PBSPs. As discussed in the last report, useful graphs of target behaviors were not consistently available to assist in making data based treatment decisions. For example: • In a psychiatric clinic observed by the monitoring team, the psychiatrist wanted to evaluate Individual #155's anxiety. Graphed data were over three weeks old. Graphed data of Individual #155's target behaviors during the current month would have better allowed his treatment team to evaluate recent changes in his behavior. • Individual #316's graphed data showed a decrease in his target behavior, but an increase in medication. His progress note indicated that the decrease in his target behavior was the result of unreliable data, and that his target behaviors were, in fact, <u>believed</u> to be increasing! 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 ensuring it is reliable, and consistently graphing and presenting data in increments that encourage data based treatment decisions. In reviewing at least six months of PBSP data of severe behavior for 10 individuals, four (Individual #47, Individual #164, Individual #256, and Individual #232), or 40%, indicated no obvious improvement in severe behavior. This was an improvement from the last review when 62% of the individual's reviewed showed no obvious improvement in severe behavior. There was, however, no indication of a systematic action to address the lack of progress in these individuals. Clearly, the lack of treatment progress in all of these individuals was not likely to be solely the result of an ineffective PBSP, however, the monitoring team does expect that an analysis of the potential reasons for the lack of progress be conducted, and based upon the results of this analysis, appropriate corrective actions be initiated. Additionally, these actions (e.g., retraining of staff, initiation of a functional assessment, PBSP revision, etc.) should be documented in the progress note or PBSP. 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. Finally, although all the PBSPs reviewed contained progress notes, the facility's self-	

#	Provision	Assessment of Status	Compliance
		assessment indicated that only 80% of individuals with a PBSP had current monthly progress notes. All individuals with PBSPs should have current monthly progress notes. The monitoring team recognizes the substantial efforts the facility made on this provision item. Clearly, there has been a meaningful improvement, and SASSLC appeared to be on a very productive course toward future improvement in this area.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of initial (full) psychological assessments for all individuals, and the absence of functional assessments for each individual with a PBSP. <u>Psychological Assessments</u> The director of psychology reported that not all individuals at the facility had initial psychological assessments. No full psychological assessments were reviewed in this report because none were completed since the last review. All individuals at SASSLC should have an initial (full) psychological assessment. Additionally, these 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 assessment of medical status. <u>Functional Assessments</u> At the time of the onsite review, 163 of the 198 individuals with a PBSP (82%) had a functional assessment. This represents continued improvement in the percentage of individuals with PBSPs that had functional assessments from the last two reviews (i.e., 54% and 71%). All individuals with a PBSP should have a functional assessment of the variable or variables affecting their target behaviors. A list of all functional assessments completed in the last six months indicated that 69 were completed since the last review. Ten of those functional assessments (14%) were reviewed to assess compliance with this provision item. As found in the last report, the functional assessments included all of the components commonly identified as necessary for an effective functional assessment. The quality of some of these components, however, was insufficient for the functional assessments to be as effective as they could be. Ideally, all functional assessments should include direct and indirect assessment procedures. A direct observation procedure consists of direct and repeated observations of the individual, and documentation of antecedent events that occurred prior to the targets behavior(s) and specific consequences that were observed to follow the target behavior. Indirect procedures can contribute to understanding why a target behavior	Noncompliance

#	Provision	Assessment of Status	Compliance
		occurred by conducting/administering questionnaires, interviews, or rating scales. All 10 of the functional assessments reviewed included appropriate indirect assessment procedures. Six (i.e., Individual #73, Individual #314, Individual #2, Individual #104, Individual #170, and Individual #347) of the functional assessments reviewed (60%) utilized direct assessment procedures that were rated as complete. This was comparable to the last review when 62% of direct observations were rated as complete. An example of a complete direct assessment procedure is described below: • Individual #347's functional assessment described direct observations of her engaging in self-injurious behavior (SIB) that suggested antecedents (i.e., engaging in a non-preferred activity) to the target behavior. This direct observation revealed that Individual #347's SIB was most likely maintained by negative reinforcement (i.e., escape or avoidance of non-preferred activities). The remaining four functional assessments included direct observations, but none of those observations included an example of the target behavior and, therefore, did not provide any additional information about relevant antecedent or consequent events affecting the target behavior. Individual #73, Individual #314, and Individual #170's functional assessments also did not include direct observations of target behaviors. These functional assessments, however, indicated that the target behaviors occurred at a very low rate (e.g., Individual #73's target behaviors had not occurred in over a year), and, therefore, direct observations were unlikely to provide opportunities to observe target behaviors. Accordingly, these functional assessments were rated as complete. 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 that include 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. As discussed in the last report, one potentially effective way to collect direct functional assessment data is to use ABC (i.e., the systematic collection of both antecedent and consequent behavior) data. 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. It is recommended that all functional assessments include direct observation procedures that include observation of the target behavior (or an explanation why that was not possible), and provide information about relevant antecedent and/or	

#	Provision	Assessment of Status	Compliance
		consequent events affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. This represented a good improvement from the last two reports when 55% and 88% of the functional assessments included potential antecedents and consequences. As discussed in the last report, when comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (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. All 10 of the functional assessments reviewed (100%) included a clear summary statement. This represented another improvement from the last review when 62% of the functional assessments reviewed were judged to have a clear summary statement. As reported in the last review there was no evidence that functional assessments at SASSLC were reviewed and modified when an individual did not meet treatment expectations. Three functional assessments reviewed (Individual #256, Individual #47, Individual #347), however, were revised after one year. 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 as soon as possible (with a maximum of one year between reviews). Six (i.e., Individual #73, Individual #314, Individual #2, Individual #104, Individual #170, and Individual #347) of the 10 functional assessments reviewed (60%) were evaluated to be comprehensive and clear. This represented a dramatic improvement from the last two reviews when only 14% and 38% of the functional assessments were determined to be complete. The monitoring team was pleased with the progress SASSLC was making on 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	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

#	Provision	Assessment of Status	Compliance
	complete clinical and behavioral data.		
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In addition to the initial or full psychological assessment, an annual psychological update should be completed each year. The purpose of the annual psychological assessment, or update, is to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, the annual psychological assessment update should contain the elements identified in K5 and comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. A list of annual assessments indicated that they were not completed, or more than 12 months old, for 65 of the 275 individuals (24%) at SASSLC. This represented a sharp improvement in the number of annual assessments completed compared to the last report when 60% of individuals did not have annual psychological assessments. All individuals should have an annual assessment. The monitoring team reviewed eight of the 76 annual psychological assessments (11%) that were completed since the last onsite review, to assess their comprehensiveness. Four of the eight annual assessments reviewed (50%) contained all of the components described in K5. The other four annual assessments did not have a medical component. This represented a substantial improvement in the comprehensiveness of annual assessments from the last review when 25% were judged to be complete. All psychological updates need to contain all of the components described in K5. The director of psychology recently completed a new annual psychological assessment checklist that included all five components discussed in K5. The monitoring team is optimistic that the annual assessments will continue to improve. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. The facility's self-assessment indicated that only one of the last three admissions to the facility (33%) had a psychological assessment within 30 days.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the	There were no changes in this area since the last review, therefore, it continued to be rated as being in noncompliance. Psychological services other than PBSPs were provided for 12 individuals at SASSLC. Therapists outside of the facility provided the majority of these services. There were no treatment plans or progress notes completed in the last six months available for the monitoring to review to assess compliance with this provision item.	Noncompliance

#	Provision	Assessment of Status	Compliance
	efficacy of treatment.	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	
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.	Although improving, this item was rated as being in noncompliance because PBSPs reviewed did not consistently contain adequate use of all of the components necessary for an effective plan. A list of individuals with PBSPs indicated that 198 individuals at SASSLC had PBSPs, and 84 of these were completed since the last review. Eleven (13%) of these 84 PBSPs were reviewed to evaluate compliance with this provision item. All 11 of the PBSPs reviewed had the necessary consent and approvals. All PBSPs reviewed (100%) included operational descriptions of target behaviors. This represented an improvement from the last review when 92% of PBSPs were rated as operationally defined. All 11 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but three (i.e., Individual #268, Individual #73, and Individual #47) of these (27%) identified antecedents and/or consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, were not likely to be useful for weakening undesired behavior. This represented a slight improvement in the effectiveness of antecedent and consequent procedures reported in the last two reviews when 29% and 32% were judged to be inconsistent with the stated function. Examples of antecedent and consequent interventions that appeared to be incompatible with the hypothesized function included: • Individual #47's PBSP hypothesized that her SIB was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities). Individual #47's PBSP included, that following the occurrence of SIB, DSPs should encourage her to get involved in another task that occupies her hands. If, however, avoiding undesired activities was reinforcing for Individual #47 (as	Noncompliance

#	Provision	Assessment of Status	Compliance
		hypothesized in the PBSP), then this intervention would likely increase the likelihood of her SIB. Encouraging (and allowing) her to indicate that she wanted to leave an area BEFORE she engaged in the undesired behavior would potentially be an effective antecedent intervention. After the targeted behavior occurred, however, Individual #47 should not be allowed to escape the undesired activity until she appropriately requests it. If the nature of her 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) before she engages in physical aggression. The PBSP needs to clearly state that removal of the undesired activity should be avoided, whenever possible and practical, because it encourages future undesired behavior. • Individual #268's PBSP indicated that his SIB functioned to attain staff assistance when he was hungry, thirsty, needed to be changed, etc. His PBSP, however, did not include the encouragement and reinforcement of an acceptable alternative way (i.e., other than engaging in SIB), to access staff attention to address his needs. 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 is described below: • Individual #164's PBSP hypothesized that one function of his aggressive behavior was to gain others' attention. Antecedent interventions included "…lavishing him with social praise…." when he exhibited appropriate behaviors. His intervention following physical aggression included ensuring others safety, but minimizing attention to Individual #164 by "…not showing any emotion…" while he is upset. All PBSPs should include antecedent and consequent strategies to weaken undesired behavior that are clear, precise, and related to the identified function of the target behavior. Replacement behaviors were included in all of the PBSPs reviewed. Replacement behaviors should be functional (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when possible. 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 in two (i.e., Individual #268 and Individual #232) of the 11 (18%) PBSPs reviewed, replacement behaviors that could be functional were not functional. This represented a sharp improvement from the last report, when 60% of replacement behaviors that could be functional were not functional. An example	

#	Provision	Assessment of Status	Compliance
		of a replacement behavior that was not functional was: • Individual #232's PBSP hypothesized that his undesired behaviors were maintained by attention/access to preferred activities. His replacement behaviors were to attend and stay at school, and use anger management techniques. It clearly was important for Individual #232 to attend school, and anger management may help control his anger, however these behaviors were not functional (i.e., behaviors that serve the same function as his physical aggression). An example of a functional replacement behavior for a target behavior maintained by positive attention would include teaching/reinforcing another way to get obtain staff attention/getting desired items, such as earning the opportunity to meet with preferred staff and obtain desired items. Eight of the 11 functional replacement behaviors discussed above appeared to represent behaviors that staff needed to encourage and reinforce (i.e., skills that the individual already had in his or her repertoire), rather than new skills the individual needed to acquire. For example: • Individual #184's replacement behavior was asking staff for attention. The PBSP included instructions for staff to immediately respond to her in a friendly and upbeat manner. Based only on the reading of the PBSP, the monitoring team can only speculate as to if these replacement behaviors were in the individual's repertoire, or if they required the acquisition of a new behavior. The purpose of introducing this distinction is that when the replacement behavior requires the acquisition of a new behavior, it should be written in the new format skill acquisition plan (SAP, see S1). Although many of the replacement behaviors were written as SAPs, none encountered by the monitoring team were in the new SAP format. Overall, seven (Individual #314, Individual #2, Individual #164, Individual #104, Individual #170, Individual #184, and Individual #256) of the 11 PBSPs reviewed (64%) represented examples of complete plans that contained operational definitions of target behaviors, replacement behaviors (when possible), and clear, concise antecedent and consequent interventions based on the results of the functional assessment. This represented a dramatic improvement over the last review when 31% of the PBSPs reviewed were judged to be acceptable. The monitoring team was encouraged by the overall progress in the quality of PBSPs at SASSLC, and looks forward to continued improvements in this provision item.	

#	Provision	Assessment of Status	Compliance
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.	The monitoring team was encouraged by the initiation of the collection of IOA data at SASSLC (see K4). In order to achieve substantial compliance with this portion of this provision item, a system to regularly assess, track, and maintain minimum levels of agreement of PBSP data (i.e., IOA) across the entire facility will need to be demonstrated. Target behaviors were consistently graphed, however, there was no evidence that replacement behaviors were graphed. It is recommended that replacement behaviors be graphed across the facility. As discussed in K4, the quality and usefulness of these graphs had improved. The graphs reviewed contained horizontal and vertical axes and labels, condition change lines, data points, and a data path.	Noncompliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	SASSLC continued to make 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. The facility continued to attempt to decrease the number of target behaviors, and ensure that the language used was not above a sixth grade level. The monitoring team noted improvements in this area relative to the last review. These interventions would likely increase the probability that PBSPs would be implemented as written by DCPs. The only way to ensure that PBSPs are understood and implemented as written, however, 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.	Noncompliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they	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	Noncompliance

#	Provision	Assessment of Status	Compliance
	are responsible and on the implementation of those plans.	the strengths and weaknesses of the current training procedures during subsequent onsite reviews. There was no system in place to ensure that all staff (including relief staff) implementing PBSPs had been trained. The facility's self-assessment indicated that not all staff implementing PBSPs were trained. Additionally, there was no systematic way to identify all staff that required remedial training. In order to meet the requirements of this provision item, the facility will need to present documentation that every staff assigned to work with an individual has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter. This training should include a competency-based component. Finally, 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.	
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 275 individuals and employed 10 psychologists responsible for writing PBSPs. Additionally, the facility employed five psychology assistants, and one psychology technician. None of these psychologists, however, had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least 10 psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists who are writing Positive Behavior Support Plans (PBSPs) attain BCBA certification (K1).
2. Meeting minutes should reflect that internal peer review meetings occurred weekly, external peer review occurred monthly (K3).
3. 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 (K4).
4. Establish acceptable data collection levels, and ensure that those levels are achieved (K4).
5. Consider the use of data cards for improving staff access to data sheets, and improving data collection reliability (K4).

6. It is recommended that the facility modify their procedure for the collection of IOA for all target and replacement behaviors. Additionally, specific IOA goals should be established, and staff retrained or data systems modified, if scores fall below those goals (K4).

7. Replacement behaviors should be graphed for all individuals with PBSPs (K4).

8. It is recommended that the facility graph target and replacement data in intervals necessary to make data based decisions (K4).

9. If an individual is not making expecting progress, the progress note or PBSP should indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).

10. All individuals with PBSPs should have current monthly progress notes (K4).

11. All individuals should have an initial (full) psychological assessment that includes an assessment or review of intellectual and adaptive ability, screening or review of psychiatric and behavioral status, review of personal history, and assessment of medical status (K5).

12. All individuals with a PBSP should have a functional assessment of the variable or variables affecting their target behaviors (K5).

13. All functional assessments should include direct observation procedures that include observation of the target behavior (or an explanation why that was not possible), and provide information about relevant antecedent and/or consequent events affecting the target behavior. (K5).

14. 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) K5.

15. All individuals should have an annual assessment (K7).

16. All psychological updates should contain all of the components described in K5 (K7).

17. Psychological assessments should be conducted within 30 days for all newly admitted individuals (K7).

18. 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).

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 (i.e., should represent desired behaviors that serve the same function as the undesired behavior) when practical and possible (K9).

21. It is recommended that all replacement behaviors that require the acquisition of new behaviors include skill acquisition plans (SAPs) for training (K9).

22. It is recommended that replacement behaviors be graphed across the facility (K10).

23. It is recommended that a treatment integrity system be consistently used throughout the facility, data regularly tracked and maintained, and minimal acceptable integrity scores established and achieved (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 #009.2: Medical Care, 4/19/12 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 DADS Clinical Guidelines: • Aspiration Risk Reduction Interdisciplinary Protocol • Enteral Feedings Interdisciplinary Protocol • Constipation/Bowel Management Interdisciplinary Protocol • Urinary Tract Infections Interdisciplinary Protocol • Seizure Management Interdisciplinary Protocol o SASSLC Policies/Guidelines • Aspiration Pneumonia Guidelines, 7/2012 • Anaphylaxis Protocol, 12/2011 • Bowel Management, 10/2010 • Guidelines on management of Clostridium difficile, 12/2011 • Guidelines for care in diabetes, 12/2011 • Osteoporosis Guidelines, 11/2011 • Urinary Tract Infection Guidelines, 12/2011 • Seizure Management, 12/2010 o SASSLC Facility Medical Services Policy, 12/28/2011 o SASSLC Pneumonia Review Committee, 4/10/12 o SASSLC Medical Continuous Quality Improvement Committee, 4/17/12 SASSLC Lab Matrix o Infection Control Committee Meeting Minutes, 2012 o Pneumonia Review Committee meeting minutes o Medical Continuous Quality Improvement Committee Meeting Minutes o Clinical Daily Provider Meeting Minutes o Listing of Medical Staff o Medical Caseload Data o Medical Staff Curriculum Vitae o Primary Provider CME Data o APRN Collaborative Agreement o Medical Department Employee CPR Data

	o Copies of PCP Inservices on ICD and DSM Diagnostic Criteria o Mortality Review Documents o Avatar Pneumonia Tracking Forms o Clinic Tracking Log o Reports for Internal and External Medical Reviews 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 with diagnosis of malignancy, cardiovascular disease, diabetes mellitus, hypertension, sepsis, and GERD o Listing, Individuals hospitalized and sent to emergency department 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, MOSES/DISCUS forms, quarterly drug regimen reviews, consultation reports, physician orders, integrated progress notes, annual nursing summaries, MARs, annual nutritional assessments, dental records, and annual ISPs, for the following individuals: • Individual #5, Individual #67, Individual #113, Individual #256, Individual #304 Individual #60, Individual #341 Individual #89, Individual #157, Individual #201 o Annual Medical Assessments the following individuals: • Individual #294, Individual #42, Individual #270, Individual #34 Individual #95, Individual #24, Individual #65, Individual #330 Individual #38, Individual #137, Individual #35, Individual #17, Individual #77, Individual #133 o Neurology Notes for the following individuals: • Individual #94, Individual #336, Individual #30, Individual #96, Individual #302, Individual #250, Individual #241, Individual #36, Individual #165 o Consultation Referrals and IPNs and for the following individuals: • Individual #270, Individual #217, Individual #242 Individual #209, Individual #349, Individual #140, Individual #156, Individual #309 <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 Linda Fortmeier–Saucier, DNP, FNP-BC, RN o JoAnn Smith, RN, Medical Compliance Nurse o Marla Lanni, RN, JD, Chief Nurse Executive o Mandy Pena, RN, QA Nurse

	Observations Conducted: o Daily Clinical Services Meetings o Observations of o Observations of homes o ISP for Individual #281 o Pneumonia Review Committee Meeting
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) the provision action information. For the self-assessment, the facility described for each of the four provision items, several activities engaged in to conduct the self-assessment, the results of the self-assessment, and a self-rating. For Provision L1, the medical director assessed several of the items assessed by the monitoring team, such as compliance with preventive care, pneumonia rates, and compliance with state policy for DNRs. There were many other areas that the monitoring team assessed that were not included in the self-assessment, such as staffing, the provision of neurological services, and physician participation in the team process. For Provision L4, the activities included the review of policies to determine compliance, but audits were not completed. It is important that the self-assessment include all of the areas reviewed by the monitoring team. Overall, this was a great improvement in the assessment process. To take this process forward, the monitoring team recommends that the medical director review, for each provision item, the activities engaged in by the monitoring team, the comments made in the body of the report, and the recommendations, including those found in the body of the report. Such actions may allow for development of a plan in which the assessment activities provide results that drive the next set of action steps. 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 rated itself in noncompliance with all four provisions. The monitoring team concurred with the facility's self-rating.
	Summary of Monitor's Assessment: The medical department made progress in the provision of health care services. Process changes, databases, and development of oversight committees were successfully implemented. Many of the changes were relatively new and will require time to significantly alter outcomes. Nonetheless, there were improvements noted in preventive care services, follow-up of individuals, and documentation.

	The medical compliance nurse became an invaluable member of the medical department. She worked closely with many facility staff on a number of issues. She maintained data on the clinical indicators and tracked medical consultations, assessments, and preventive care for the individuals. Through this monitoring, physicians were alerted of the need to complete important services. The medical staff was complimentary of the work done by the compliance nurse and thought the efforts were helpful to them. Compliance with the guidelines for provision of preventive care services increased. In spite of remaining relatively low, the compliance for colorectal cancer screening was improved. With continued assessments and scheduling, even more improvement should be seen in the future. Follow-up of acute medical problems also improved. There was increased documentation of physician evaluations when individuals developed acute problems. Documentation of post-hospital assessments, labs, and consultations were all improved. Notwithstanding the notable improvements, much work remained. Problems related to the management of pneumonia were addressed with several changes. The aspiration guidelines were revised to include a section on the management of recurrent pneumonia. Unfortunately, the change in policy did not translate into any real change in how individuals were managed. Implementation of the osteoporosis protocols did not seem to take hold because many individuals were not treated in accordance with the guidelines. Record audits also identified individuals who experienced a change in status, but notification of a physician was not prompt. There were also instances in which physicians ordered treatment, but did not follow-up with evaluation of the individual. Several of these individuals were acutely ill and ultimately hospitalized for conditions, such as ruptured appendix, volvulus, and pneumonia. The provision of neurological care continued to be a cause for concern. The number of neurology clinic hours was inadequate to meet the needs of the individuals. Individuals were identified who had no neurology follow-up in several years in spite of receiving several AEDs. External and internal audits were completed, but problems related to same size and scheduling made the reliability and validity of the audits questionable. Mortality management remained problematic at SASSLC. There continued to be no organized process for ensuring implementation and follow-up of corrective actions. In fact, the medical director was not aware of all recommendations that were her responsibility. One particularly noteworthy area of improvement was the development of a medical quality program. A committee was developed to review medical quality based on selected indicators. The program was in its developmental stage, but the model implemented should provide good information for the facility. Related to the issue of quality was the development of clinical guidelines. The medical director had developed numerous guidelines that were reviewed during the February 2012 review. Since that time, state office issued new guidelines and updates. It appeared that SASSLC did not localize all state guidelines that were issued early in 2012.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of a medical director and two full time primary care physicians. A full time advanced practice registered nurse was hired on 8/1/12. The medical director carried a caseload of 20 while the APRN's caseload was about 50. The primary care physicians carried an average caseload of 102. The medical compliance nurse continued to report to the medical director. She assumed a great deal of responsibility within the medical department. Her management of the department's data relieved the medical director from data tracking duties. The collaborative agreement for the APRN was reviewed. It was signed and dated by all parties and appeared to be appropriately executed. CPR and CME information was requested for review. CPR certification was not current for one of the primary providers. CME information was submitted only for the medical director. Overall, four primary providers at SASSLC represented adequate staffing. The medical director should re-evaluate the caseloads of the PCPs and utilize the increased resources to decrease the caseload of the primary care physicians. Providing additional coverage for weekends would be another means of providing relief to the medical staff. **Physician Participation In Team Process** The facility continued its daily clinical services meeting. 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. Following this meeting, physicians completed rounds and participated in other activities, such as ISPs, ISP addendums, various meetings, and some clinics. The monitoring team attended several of the morning meetings and observed that this continued to be a valuable process in helping to achieve integration of services. It was noted that follow-up of issues was improved through documentation in the minutes and discussions during subsequent meetings.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Overview of the Provision of Medical Services The medical staff conducted rounds in the homes of the individuals. The individuals received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite neurology, dental, eye, podiatry, dermatology, gynecology, and psychiatry clinics. Other specialty services were provided at the university health sciences center or by community physicians. Individuals were admitted to Methodist Hospital or Mission Trail Baptist Hospital. Labs were drawn and processed at the facility and sent to Austin State Hospital. Beginning 9/1/12, stat labs would be sent to Mission Trails Hospital. A 24-hour mobile x-ray service was scheduled to begin providing services on 9/1/12. For the most part, individuals received care and physicians responded to their needs. Routine annual assessments were completed in a timely manner and individuals were assessed as problems arose. Individuals received their required vaccinations and routine screenings. Those who were acutely ill were transferred to acute care facilities. While the basic health needs of individuals were met, there was evidence that improvement was needed in many areas. Several records documented changes in the status of individuals without notification of the medical providers. Physicians were notified after hours of medical problems that began during normal work hours. There were also failures on the part of medical providers to assess some individuals when medical treatments, such as antibiotics were ordered. Improvement was noted for some cancer screenings, but screenings such as BMD were often lacking. The management of pneumonia continued to be problematic. In spite of the development of a pneumonia review committee and revision of the aspiration guidelines, several individuals had recurrent aspiration for which no adequate change in plans was identified. Discussion of the improvements as well as the opportunities for improvement are included throughout this report. **Documentation of Care** The Settlement Agreement sets forth specific requirements for documentation of care. The monitoring team reviewed numerous routine and scheduled assessments as well as record documentation. The findings are discussed below. Examples are provided in the various subsections and in the end of this section under case examples. <u>Annual Medical Assessments</u> Annual Medical Assessments included in the record sample as well as those submitted by the facility were reviewed for timeliness of completion as well as quality of the content.	

#	Provision	Assessment of Status	Compliance
		For the Annual Medical Assessments included in the record sample: • 10 of 10 (100%) AMAs were current • 9 of 10 (90%) AMAs included comments on family history • 9 of 10 (90%) AMAs included information about smoking and/or substance abuse history • 9 of 10 (90%) AMAs included information regarding the potential to transition The facility submitted a sample of 15 of the most recent Annual Medical Assessments along with a copy of the previous year assessment. For the sample of Annual Medical Assessments submitted by the facility: • 11 of 15 (73%) AMAs were completed in a timely manner. • 13 of 15 (87%) AMAs included comments on family history • 15 of 15 (100%) AMAs included information about smoking and/or substance abuse history • 15 of 15 (100%) AMAs included information regarding the potential to transition AMAs were now completed in conjunction with the individuals' ISPs. This required that several assessments be completed twice within a relatively short period due to the regulatory requirements for completion within 365 days of the previous summary. The format of the assessments was revised and this was an improvement. The interval history, preventive care, and immunization status were documented. The primary providers will need to improve the documentation for complex problems, such as aspiration. For individuals with recurrent aspiration, the AMA should document the approach to the medical management. If an individual continues to aspirate, there should be documentation of the suspected source of aspiration (gastric contents or upper airway secretions), what steps have been taken to identify the cause of recurrent aspiration, and what supports have been implemented. Plans such as "continue current medications" or "aspiration precautions" should be replaced with plans that are more definitive. Additionally, the dates of preventive services should be documented. For services that are not provided or completed, the risk/benefit assessment should be included. <u>Quarterly Medical Summaries</u> The medical director reported that Quarterly Medical Summaries were not being completed as required by the Health Care Guidelines. This requirement was temporarily suspended due to the increase in the number of annual assessments that needed to be completed.	

#	Provision	Assessment of Status	Compliance
		For the records contained in the record sample: • 0 of 10 (0%) records included current QMSs <u>Active Problem List</u> For the records contained in the record sample: • 10 of 10 (100%) records included an APL • 10 of 10 (100%) documents were signed and dated • 6 of 10 (60%) documents were updated The Active Problem Lists were identified in all records included in the sample. Several of the documents, however, did not include recent diagnosis or had inaccurate diagnoses. The problem lists should be updated as problems arise and/or resolve. <u>Integrated Progress Notes</u> Physicians generally documented in the IPN in SOAP format when the entry involved a clinical encounter. The notes were usually signed and dated. Pre-hospital notes were often not found even when the transfer occurred during the normal work hours. Post-hospital documentation was improved. In many cases, IPN entries were identified for two consecutive days following hospital return, but compliance with this requirement was provider specific. Providers also increased documentation of the results of diagnostics such as labs and x-rays and consultation recommendations. <u>Physician Orders</u> Physician orders were usually dated, timed, and signed. Record reviews reveled several medication orders that were incomplete usually due to the lack of an indication. Medication orders are discussed further in section N1. <u>Consultation Referrals</u> The facility implemented a database to track consults. The medical compliance nurse was responsible for this task. The consults and IPNs for eight individuals were requested. A total of 35 consults completed after January 2012 (including those from the record sample) were reviewed: • 29 of 35 (83%) consultations were summarized by the medical providers in the IPN within five working days; all of the consults reviewed were initialed and dated by the medical providers indicating review of the consults. Providers summarized the recommendations of the consultants and stated agreement or disagreement with the recommendations. They frequently noted that the plan was discussed with the nurse. The medical director explained that each primary provider made a decision about when to refer recommendations to the IDT for discussion.	

#	Provision	Assessment of Status	Compliance
		Record reviews reveled some, but not many, IPN entries in which the PCP disagreed with the consultant and documented the disagreement. There was no indication that this disagreement and rejection of the recommendations was communicated to the IDT. In general, the records did not support that the PCPs referred the recommendations to the IDT for integration with existing services. The monitoring team also noted that there were IPN entries by the medical providers for which no consultation was found in the record. This appeared to be an issue of record management. It is recommended that the PCPs notify the IDT when there is a disagreement with the recommendations of the consultant because further discussion may be warranted. The monitoring team also recommends that for every IPN entry, the medical provider indicate the type of consultation that is being addressed as well as the date of the consult (e.g., GI Consult, 1/1/12). **Routine and Preventive Care** Routine and preventive services were available to all individuals at 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. Recently completed AMAs included documentation of immunization status. Improvement was noted in colorectal and cervical cancer screenings, although the number of individuals who actually completed colonoscopies remained low. Compliance with prostate and breast cancer screenings was good. Preventive care services, such as cancer screenings and osteoporosis were tracked in databases. The medical department also maintained a seizure database. Data from the 10 record reviews listed above and the facility's preventive care reports are summarized below: <u>Preventive Care Flow Sheets</u> For the records contained in the record sample: • 10 of 10 (100%) records included PCFSs • 5 of 10 (50%) forms were updated 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 consistent with state issued guidelines. The documents were frequently not fully updated and there was no requirement for a physician signature resulting in the inability to determine which staff made the entries. The monitoring team recommends that the documents are updated with completion of quarterly and annual medical summaries. It would also be helpful if the sections for hearing and dental exams directed the reader to the appropriate consults by including the date of the most recent exam rather than	

#	Provision	Assessment of Status	Compliance
		simply state, "See audiology evaluation in the chart." Alternatively, the PCFS could include the dates of the exams as it does for the other items. <u>Immunizations</u> • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 9 of 10 (90%) individuals had documentation of varicella status. The documentation of varicella status improved. Many individuals now had serologic evidence to support their immune status. <u>Screenings</u> • 10 of 10 (100%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> • 3 of 5 males met criteria for PSA testing • 3 of 3 (100%) males had appropriate PSA testing A list of males greater than age 50, plus African American males greater than age 45, was provided. The list included 77 males: • 72 of 77 (94%) males had current PSA results documented • 4 of 77 (5%) males had no PSA results documented • 1 of 77 (1%) males were overdue for PSA testing <u>Breast Cancer Screening</u> • 2 of 5 females met criteria for breast cancer screening • 2 of 2 (100%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 83 females, the date of the last mammogram, and explanations for any lack of testing: • 62 of 83 (75%) females completed breast cancer screening in 2011 or 2012 • 5 of 83 (6%) females did not complete screenings due to the inability to position • 6 of 83 (7%) females did not have current breast cancer screenings • 10 of 83 (12%) females did not have current screenings due to refusal, inability to cooperate, or discontinuation by the PCP	

#	Provision	Assessment of Status	Compliance
		Cervical Cancer Screening • 5 of 5 females met criteria for cervical cancer screening • 4 of 5 (80%) females completed cervical cancer screening within three years A list of females age 18 and older was provided. The list included the names of 91 females, the date of the last pap smear, and explanations for lack of testing: • 41 of 91 (45%) females completed cervical cancer screening in 2012/2011 • 25 of 91 (27%) females completed cervical cancer screening between 2009 and 2010 • 10 of 91 (11%) females completed cervical cancer screening prior to 2009 • 14 of 91 (15%) females had no documentation of cervical cancer screening • 1 of 91 (1%) females was a new admission Colorectal Cancer Screening • 6 of 10 individuals met criteria for colorectal cancer screening • 4 of 6 (67%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 129 individuals: • 56 of 129 (43%) individuals had completed colonoscopies • 49 of 129 (38%) individuals had not completed colonoscopies, but were in the process of being scheduled. • 14 of 129 (11%) individuals were listed as "will not do" secondary to increased risk • 10 of 129 (8%) individuals did not complete colonoscopies due to poor preps or lack of cooperation Additional Discussion A preventive care audit tool was developed. The medical compliance nurse completed the audit at the time of the annual assessment and provided feedback to the primary providers. The providers expressed that this information was helpful and they reported frequent communication with the medical compliance nurse regarding this and other compliance issues. Compliance with colorectal cancer and cervical cancer improved. For those individuals who did not complete screenings, the annual assessments did not include any discussion of the rational for not completing the screenings. The importance of prevention was highlighted in the case of Individual #341 who was diagnosed with invasive colorectal cancer. This individual had negative fecal occult blood testing. Based on guidelines that have been the standard for many years, this individual qualified for completion of a	

#	Provision	Assessment of Status	Compliance
		colonoscopy 11 years ago, but the procedure was never done. Although right sided colon cancers are more difficult to detect due to the location, sensitivity of the colonoscopy is dependent on many factors. Endoscopists request additional studies if unable to visualize the entire colon. The importance of prevention was again highlighted in the cases of five individuals who, through colonoscopy, were found to have adenomatous colon polyps. It will be important for these individuals to receive the appropriate follow-up. The facility included these individuals in its document submission listing individuals with malignancies. The monitoring team recommends that the medical providers thoroughly document the discussion to discontinue or not complete required screenings. This documentation should include a risk/benefit assessment as well as the discussion with the individual/LAR and the IDT. **Disease Management** The facility implemented numerous clinical guidelines based on state issued clinical protocols. The monitoring team reviewed records and facility documents to assess overall care provided to individuals in many areas. Data derived from record audits and the facility reports are summarized below. <u>Diabetes Mellitus</u> One record was reviewed for compliance with standards set by the American Diabetes Association: (1) glycemic control (HbA1c<7), (2) monitoring for diabetic nephropathy (3) annual eye examinations, and (4) administration of yearly influenza vaccination: • 1 of 1 (100%) individuals had adequate glycemic control • 1 of 1 (100%) individuals had urine microalbumin documented • 1 of 1 (100%) individuals had documentation of eye examination • 1 of 1 (100%) individuals had documentation of influenza administration <u>Pneumonia</u> The facility reported 13 episodes of pneumonia for 2012. Eight of the 13 (62%) were classified as aspiration events. The remainder was classified as bacterial pneumonia. Each of the cases of pneumonia was reviewed by the Pneumonia Review Committee. The monitoring team attended this meeting. A checklist was implemented to facilitate the reviews. Clinical information, including chest roentgenograms, lab data, and history was reviewed. A determination was then made about the type of pneumonia that occurred. This process represented a significant improvement over the process that was in place during the previous review. During the February 2012 review, it was reported that J-tubes were not used at SASSLC.	

#	Provision	Assessment of Status	Compliance
		The medical director revised the aspiration guidelines to reflect consideration of small bowel feedings for individuals with gastric tubes and recurrent aspiration. Nonetheless, the monitoring team did not find documentation by physicians that reflected this approach. If the changes were considered, but decisions were made to adopt another approach, records should have at least documented the rational. The management of pneumonia and aspiration of Individual #5 and Individual #157 is discussed in the case examples below. <u>Osteoporosis</u> • 2 of 10 individuals were diagnosed with osteoporosis • 2 of 2 (100%) individuals received treatment with Vitamin D and/or calcium • 0 of 2 (0%) individuals received additional pharmacologic therapy • 0 of 2 (0%) individuals had documentation of BMD A list of 63 individuals with the diagnosis of osteoporosis or osteopenia was provided. For those 44 (70%) individuals with a diagnosis of osteoporosis: • 35 of 44 (80%) individuals received calcium and vitamin D supplementation • 12 of 44 (27%) individuals received additional pharmacologic therapy • 10 of 44 (23%) individuals did not receive any treatment • 22 of 44 (50%) individuals completed DEXA scans between 2010 and 2012 • 3 of 44 (7%) individuals completed DEXA scans between 2008 and 2010 • 19 of 44 (43%) individuals completed DEXA scans prior to 2008 For those 18 (26%) individuals with osteopenia: • 16 of 18 (89%) individuals received calcium and Vitamin D • 3 of 18 (17%) individuals received additional pharmacologic therapy • 4 of 18 (22%) individuals received no treatment • 9 of 18 (50%) individuals completed DEXA between 2010 and 2012 • 7 of 18 (29%) individuals completed DEXA between 2008 and 2010 • 2 of 18 (18%) individuals completed DEXA scans prior to 2008 Record reviews identified several individuals who were at risk for osteoporosis, but did not complete bone mineral density testing. Individuals diagnosed with osteoporosis, who did not receive adequate treatment, were also identified. The decision not to treat was often based on a history of esophageal disorders. It appeared that no consideration was given to treatment modalities, which were not contraindicated for use in individuals who had gastrointestinal issues, such as esophagitis. The facility's self-	

#	Provision	Assessment of Status	Compliance
		assessment noted individuals who were at risk for osteoporosis due to AED therapy. The use of a single risk factor will result in the failure to detect individuals who are at high risk for osteoporosis due to other reasons. The facility's clinical guidelines provided a detailed list of risk factors that should have been considered. The results of the facility's osteoporosis audit, conducted in April 2012, also indicated that additional work was needed in the management of osteoporosis. In addition: • Individual #256 was at risk for osteoporosis, but had no documentation of a BMD. • Individual #67 was at high risk for osteoporosis due to chronic long term AED treatment, but had no BMD documented. • Individual #60 was diagnosed with osteoporosis, received calcium and vitamin D, but had no DEXA documented in records. **Case Examples** Individual #341 • This elderly individual had a history of cerebellar atrophy, refractory seizure disorder, breast cancer, recurrent pneumonia, and hypothyroidism. • Immunizations, vision, and hearing screenings were appropriately provided. • The individual had refractory seizure disorder and required a VNS implantation. The last neurology appointment was in June 2011. At that time, the individual was started on Vimpat to improve seizure control. Numerous seizures were documented, but the individual has had no further follow-up in neurology clinic. The QMSs completed by the PCP provided contradictory accounts related to the number of seizures. • There was no documented BMD, although the individual was at risk due to long term treatment with multiple AEDs. • The individual required transfer to an acute care facility in March 2012 due to a change in mental status and a history of abdominal pain. There was no medical assessment completed prior to the transfer. Upon return, post hospital notes documented the diagnosis of UTI, anemia, and heme positive stools. The guardian refused colonoscopy during the hospitalization. The individual was hospitalized again in April 2012 and was found to have invasive adenocarcinoma of the colon. The medical status at the time of discovery precluded surgical resection. The individual was receiving hospice services at the time of the onsite review. o This individual never had a colonoscopy and qualified for that, based on her age, 11 years ago. Fecal occult blood testing was documented as negative in August 2011. The annual assessment did not provide any discussion related to risks, benefits, and the decision not to refer for a colonoscopy.	

#	Provision	Assessment of Status	Compliance
		Individual #5 • On 3/30/12, nursing notes documented follow-up of abdominal pain. The individual complained of abdominal pain and had a distended abdomen. A physician's order was obtained to administer an antacid. There was no follow-up medical evaluation. Approximately seven hours later, nursing documented that the individual had a hard distended abdomen. The physician was contacted and requested transfer to the emergency department for evaluation. The individual was admitted, diagnosed with a sigmoid volvulus, and underwent a colectomy. There was no medical evaluation documented prior to hospital transfer. Post-hospital assessments were documented. • Upon return the facility on 5/31/12, the individual had a PEG tube and was to receive nothing by mouth. The PCP documented that a MBSS would be obtained prior to re-starting oral intake. The speech and language pathologist conducted a bedside trial of feeding the same day, but noted that the physician should consider a MBSS because aspiration was noted on previous studies. Follow-up trials were also noted and the SLP made similar recommendations to obtain a MBSS. On 6/11/12, multiple episodes of emesis were documented and a "loose congested cough" was documented. The individual was transferred to the hospital and diagnosed with a small bowel obstruction. IPN entries documented that the LAR for the individual attended a 30-day admission meeting and requested that the individual receive nothing by mouth without prior notification of the LAR. • The records provide no clear explanation or documentation why this individual, with a history of aspiration and a vague or unequivocal MBSS during hospitalization, was allowed to have oral intake. Individual #157 • This individual had a history of recurrent pneumonia, epilepsy, osteoporosis, constipation, and other problems. Nutrition was provided enterally through a gastric tube. On 6/24/12, nursing documented that the individual was tachycardic. The physician was notified, labs were scheduled for the next morning, and antibiotics started for a presumptive UTI. There was no documentation of a medical assessment or the lab results. Over a period of several days, nursing documented treatment for a UTI and antibiotics continued. The urinalysis showed no evidence of a UTI and a culture was not performed by the lab since it was not indicated. A trial of oral feedings also began in late June 2012. On 6/27/12, there was documentation of fluctuating vital signs with O2 sats dropping to 88%. On 7/9/12, the individual was noted to be in respiratory distress. The MD was notified and requested transfer to the	

#	Provision	Assessment of Status	Compliance
		emergency department. The individual was diagnosed with aspiration pneumonia and experienced a clinical deterioration. The family elected to withhold mechanical ventilation and a DNR was implemented. • This individual was treated at the facility in September 2011 for pneumonia, which was stated to be bacterial. The records reviewed did not document a plan by the physician related to the management of pneumonia. There was no discussion related to the trial of oral feedings or results of a swallow study or risk of aspiration. • There were other problems identified with the care provided to this individual. The individual had a diagnosis of osteoporosis and was treated with vitamin D. The last DEXA was done in 2001. Although treated with two AEDs, the individual was not followed in neurology clinic. The last neurology assessment was in 2009 at which time a CT of the head was recommended. Follow-up did not occur. Individual #89 • This individual experienced abdominal pain with emesis. Symptoms were intermittent over a period of several hours. A PRN antacid was provided. Vital signs taken with the onset of symptoms were normal. The nursing abdominal exam was documented as benign, but there was no follow-up abdominal exam or vital signs and the physician was not notified. Approximately 18 hours after the onset of symptoms, the individual appeared pale and clammy and had another episode of emesis. The physician was then notified. There was no documentation of a physician assessment prior to transfer. The individual was diagnosed with a gangrenous ruptured appendix. Following return to SALLSC, post-hospital documentation was noted. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 141 individuals. The following data regarding AED use were summarized from the list provided: • 20 of 141 (14%) individuals received 0 AEDs • 61 of 141 (43%) individuals received 1 AED • 31 of 141 (32%) individuals received 2 AEDs • 19 of 141 (13%) individuals received 3 AEDs • 7 of 141 (5%) individuals received 4 AEDs • 2 of 141 (1%) individuals received 5 AEDs The number of individuals seen in the on-campus clinic and by the epileptologist is summarized in the table below. The on-campus clinic was conducted by a general	

#	Provision	Assessment of Status	Compliance
		neurologist consultant to SASSLC once or twice per month. Some individuals with refractory seizures or those who had VNSs were followed by an epileptologist at the University of Texas Health Sciences Center San Antonio. The numbers below reflect on-campus and off-campus visits for the general neurologist. Neurology Appointments 2012 Neurologist / Epileptologist Jan -- 5 Feb 4 1 Mar 4 0 Apr 5 5 May 19 3 June 8 5 Total 40 19 The total number of appointments was not adequate given the number of individuals with the diagnosis of seizure disorder who actually received medications. The average number of visits per month was six for the neurologist and three for the epileptologist. The facility supported 141 individuals with a diagnosis of seizure disorder. One hundred twenty-one individuals received AEDs with 59 of 121 (49%) receiving two or more drugs. The facility reported that 14 (10%) individuals had refractory seizure disorder and 11 (8%) had undergone VNS implantation. Individuals with a psychiatric diagnosis in addition to seizure disorder were seen in the SASSLC neuropsychiatry clinic. The monitoring team requested neurology consultation notes for 10 individuals. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the 10 records in addition to the five records included in the record sample: • 9 of 15 (60%) individuals were seen at least twice over the past 12 months • 9 of 15 (60%) individuals had documentation of the seizure description • 13 of 15 (87%) individuals had documentation of current medications for seizures and dosages • 10 of 15 (67%) individuals had documentation of recent blood levels of antiepileptic medications • 12 of 15 (80%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 12 of 15 (80%) individuals had documentation of recommendations for medications • 0 of 15 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc.	

#	Provision	Assessment of Status	Compliance
		The facility revised the template used for SASSLC neurology clinic notes. The template included vital signs, MOSES/DISCUS evaluations, labs, and medications. Although the templates included the MOSES and DISCUS scores, there was very little information related to side effect monitoring. Furthermore, the notes almost never included any information on the findings of a neurological examination. The majority of SASSLC clinic notes reviewed provided no specific follow-up dates. The health sciences clinic notes did not appear to be the actual notes for treatment, but appeared to be aftercare summaries provided to patients. These summaries did include a significant amount of information, such as seizure classification, medications, vital signs, and aftercare instruction. The recommendations for medication changes were quite detailed. The following are additional examples of information noted in the record sample and clinic consultations submitted. • Individual #94 was evaluated at the UT Medicine neurology clinic in April 2012. The individual was to return in two months for follow-up. There was no documented follow-up. • Individual #60 was treated with multiple AEDs. The last documented neurology evaluation was in 2006. • Individual #157 was treated with multiple AEDs. The last neurology evaluation was in 2009. • Individual #250 was seen in the SASSLC neurology clinic on 1/31/12 due to seizures and progressive generalized weakness. A CT of the cervical spine was pending. The follow-up appointment on 5/15/12 did not report the results of the CT, but recommended that Dilantin be discontinued due to unpredictable levels. The weakness was reported to improve, however, neither visit documented an exam by the neurologist regarding the determination of any focal findings or weakness. There was no specific follow-up recommended. The medical director will need to address outstanding needs for services and determine why some individuals have not had appropriate follow-up. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included 15 individuals with Level III DNRs meaning that no resuscitative measures were to be performed. The dates of implementation ranged from 2004 to 2012. One new DNR was implemented since the last onsite review and 13 DNRs were rescinded. The monitoring team requested the notes and orders for DNRs that were rescinded. The	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>documents of 13 individuals were reviewed. Seven of the individuals had no documentation by the primary care physician of the discussion with family regarding the change in DNR status. In some instances, the medical compliance nurse documented that she contacted the family to discuss the change in the DNR status, but there was no documentation that the PCP participated in the discussion. The reason for the change in status was generally due to the fact that the DNR was not consistent with current state policy.

The primary provider has an obligation to discuss a change in status, such as rescinding a DNR, with the family/LAR. The monitoring team has recommended in previous reviews and continues to recommend that the facility review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy.</td><td></td></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td><u>Medical Reviews</u>
An external medical reviewer, from a sister SSLC, conducted Round 5 of the external medical reviews in March 2012. Internal audits were completed in April 2012. State guidelines required that a sample of records be examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were eight 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.

Scheduling issues and problems with sample sizes resulted in an audit that did not meet state office requirements. The medical director reported that 9 records were audited instead of the required 14. The data provided are summarized in the tables below:

<table><tr><td></td><td>Essential Elements</td><td>Non-Essential Elements</td></tr><tr><td>Round 2</td><td>81</td><td>74</td></tr><tr><td>Round 3</td><td>88</td><td>72</td></tr><tr><td>Round 5</td><td>80 (90)*</td><td>63 (96)</td></tr><tr><td></td><td></td><td></td></tr></table>* ( ) Internal audit scores

<table><tr><td colspan="3">Medical Management Audits</td></tr><tr><td>Diabetes</td><td>Osteoporosis</td><td>Pneumonia</td></tr><tr><td>0</td><td>60</td><td>86</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Compliance scores for Round 5 were lower than previous rounds. There was also a marked variation in the results of the internal and external audits. The medical director reported that this was attributed to process issues, including the sample size and the reviewer's lack of familiarity with the audit process. Even so, completion of internal audits a month after the external audits would likely produce different scores if corrective actions had been initiated in a timely manner. The compliance by question graph for the external audit did not provide any scores for several important areas and there was no explanation for the lack of data. One record for each condition was assessed for the medical management audits. The zero score for the diabetes audit was due to the individual being incorrectly diagnosed with diabetes. The scores for osteoporosis and diabetes were based on the review of a single record for each condition. The QA nurse developed corrective action plans for the deficiencies identified in the external and internal audits. Follow-up reports showed resolution of nearly all deficiencies. These documents did not include the dates that the follow-ups were completed. Achieving substantial compliance in this provision will require state office to address several issues with the medical reviews: • The medical management audits were developed to assess clinical outcomes, however, the current indicators focused on processes and not outcomes. The audits should assess both. • The procedure for completing internal and external audits must be reviewed. Inter-rater reliability cannot be established once the results of the first audit are known. • The staff completing the audits should receive training on the process. • The sample size will need to be adjusted for the external reviews because audits were completed twice a year instead of quarterly. The 14-record requirement was adequate for the quarterly reviews, but this will need to be doubled if reviews are conducted only twice a year. The sample size for the medical management audits will also need to be re-considered. A single record review cannot assess the facility's overall management of a specific disease. • Graphs, charts, corrective action plans, and other data should be dated or provide some indication of the timelines. • The aggregate data should be used to determine if systemic issues contribute to low compliance scores. Corrective actions targeted deficiencies of individual providers. When compliance scores are repeatedly low in a particular area, causes for the lack of compliance should be explored. This analysis requires a	

#	Provision	Assessment of Status	Compliance
		review of the facility's aggregate longitudinal data. <u>Mortality Management at SASSLC</u> Five deaths had occurred at SASSLC in 2012. At the time of the compliance review, all death reviews were completed. There were three deaths since the last review. Information for those deaths is summarized below: • The average age of death was 54 years with an age range of 48 to 59 years. • The causes of death were: (1) dementia (2) anoxic encephalopathy, recurrent pneumonia, sepsis, and (3) acute cardiac arrest, sepsis, acute respiratory and renal failure. • No autopsies were performed. • One individual died during hospitalization. The other two individuals were receiving hospice services. The monitoring team met with the medical director, medical compliance nurse, and QA nurse to discuss mortality management at SASSLC. The administrative reviews generated several recommendations based on the recommendations of the Clinical Death Review Committee. The majority of the corrective actions implemented had not been completed because all of the deaths had occurred in recent months. The QA nurse provided dates that the corrective actions were due. Facility staff were unaware of other recommendations listed in the administrative review and reported that the decision to include these recommendations occurred outside of the committee meeting. For one review, the recommendations appeared to be a cut and paste of comments and observations from the nursing review. These comments did not translate into actual recommendations. Moreover, inaccuracies were identified in the reviews and the meeting minutes. The facility did not conduct any type of meeting in which all parties involved in the mortality management process met to review recommendations and the status of the recommendations. There was no analysis of longitudinal data to determine if there were trends, patterns, or systemic issues. Several of the deaths for 2012 involved individuals with a history of pneumonia or recurrent pneumonia. The manner in which the administrative reviews were completed, coupled with the inaccuracy of the reviews and the report that staff were not aware of all recommendations included in the reviews, indicated that mortality management was not given the attention necessary to result in an effective system. The finding that key committee members, who were responsible for implementation of corrective actions, were not aware of the recommendations documented in the administrative reviews speaks to the need to re-assess this process.	

#	Provision	Assessment of Status	Compliance
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 medical department made good progress in the development of a medical quality program. The Medical Continuous Quality Improvement Program Committee was developed. Members included the medical director, chief nurse executive, director of habilitation therapy, medical compliance nurse, dietician, QA nurse, infection control nurse, and the hospital liaison nurse. The committee met monthly to review and analyze data on the selected indicators. The indicators reviewed included a mix of structural, process, and outcome indicators, such as fractures, pressure ulcers, repeat hospitalizations, weight loss, diabetes management, aspiration pneumonia, urinary tract infections, and clinic appointments. The committee conducted four meetings, three of which covered actual review of data. Minutes were recorded and included information related to the discussion of the individuals. For example, for those individuals who experienced weight loss, the minutes documented the actions taken to address the weight loss. The monitoring team recommends that this information include pertinent lab data, and diagnostic work-ups. The time frame for follow-up should also be specified. The medical department maintained several databases with information related to preventive screenings, osteoporosis, and seizure disorders. As part of the overall quality efforts, the quality program policy should define how these data are to be utilized, how often they are reviewed, and how the medical staff will receive feedback on the data. The end goal of data collection and analysis is to have a positive impact on health care services. Data analysis should, therefore, be an ongoing process and not just part of the preparation for compliance reviews. The committee will also need to expand the indicators reviewed. The state-issued guidelines provided important indicators that should be considered for inclusion in the medical quality program. For example, the facility implemented a policy on bowel management and, therefore, indicators related to bowel management should be included in the quality program. The monitoring team discussed this with the medical director and medical compliance nurse. Other guidelines, such as osteoporosis should also be considered for review. Indicators for osteoporosis and diabetes would require less frequent review, perhaps quarterly, unless the data indicated a more frequent review was necessary. In addition to establishing a medical quality program, the medical department moved forward with other initiatives to assess quality. An audit was completed for osteoporosis management. The indicators and compliance data from the osteoporosis audit are summarized in the table below.	Noncompliance

#	Provision	Assessment of Status	Compliance

Osteoporosis Diagnosis and Treatment 4/20/12	
Metric	Overall scores (%)
Wrong Dx on APL	15
No Dx on APL	19
Wrong Indication	44
No Indication	4
No Treatment With No Reason	16

Compliance with the clinical guidelines varied among providers. Spreadsheets with treatment regimens, sorted by providers, were submitted for two providers. While this was a good effort in reviewing the facility's management of osteoporosis, this audit focused primarily on processes and documentation. A number of metrics assessing the quality of osteoporosis management should be considered including:

- Appropriate identification of risk factors, mitigation of risks, and implementation of plans to address risks
- Investigation of secondary causes of osteoporosis
- Appropriate completion of bone mineral density testing and re-testing
- Implementation of dietary modifications
- Implementation of exercise regimens when appropriate
- Pharmacologic therapy
- Risk assessment after fracture

The metrics used in this audit provided little information on the facility's overall management of osteoporosis and those at significant risk for loss of bone density. The audit reviewed those individuals who completed DEXA scans. Others qualified for bone mineral density testing and did not have it completed. The monitoring team identified individuals who had a diagnosis of osteoporosis/osteopenia, but did not receive adequate treatment. The management of osteoporosis is discussed in section L1.

In moving forward with this provision, the medical director should expand the set of indicators, as previously discussed. It will be important to achieve a good mix of process and outcome indicators. Beyond this, the facility will need to ensure that the data are periodically analyzed and trended. When trends are not favorable, an appropriate performance improvement methodology should be utilized to ensure remediation is achieved.

This provision remains in noncompliance. The monitoring teams believes that expansion of the set of indicators and refining the methods for review, analysis, implementation, and follow-up will result in the framework for an adequate medical quality program. The

#	Provision	Assessment of Status	Compliance
		development of such a program will assist the facility in monitoring and improving the services delivered.	
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.	State office issued a series of clinical guidelines and protocols on enteral feeding, aspiration risk reduction, constipation/bowel management, seizure management, urinary tract infections, osteoporosis, diabetes mellitus, and anticoagulation. Several of the state-issued clinical guidelines were multidisciplinary and provided guidance to physicians, nurses, and direct care professionals. Realization of the full impact of the guidelines will require participation by all of these disciplines. The monitoring team did learn of some efforts, such as the iLearn module, that provided information to the direct care professionals on detection and reporting of clinical indicators related to aspiration. The facility did not present an overarching strategy for achieving this goal. The medical department developed guidelines for aspiration pneumonia, anaphylaxis, treatment of clostridium difficile, bowel management, diabetes, osteoporosis, seizure management, and urinary tract infections. The facility's medical service policy provided guidance on the general provision of medical care. SASSLC did not appear to utilize all of the clinical guidelines issued by state office. The monitoring team reviewed state-issued guidelines on anticoagulation and diabetes mellitus at other SSLCs. Additionally, there were detailed narratives and guidance provided for PCPs, nurses and direct care professionals for several areas, including seizure management, aspiration risk reduction, and enteral feedings. SASSLC did not include the more recent state guidelines, such as anticoagulation (3/12/12) and diabetes mellitus (1/18/12) in its policy and procedure manual. The anticoagulation guidelines needed to be localized at SASSLC. The localized diabetes guidelines should have been reviewed to determine consistency with state protocols. The medical director will need to ensure that SASSLC has implemented all guidelines issued by state office. Record reviews indicated several areas in which there was a lack of compliance with the clinical guidelines. The failure to complete appropriate BMD and provide adequate treatment was one example. The lack of plans to address individuals with recurrent pneumonia in accordance with clinical guidelines was another. The facility's aspiration guidelines were updated to include management of recurrent pneumonia. Physicians received inservice on this important revision after the onsite review. During discussions with the medical staff, providers indicated that the medical compliance nurse was extremely valuable to the staff in helping them to understand why they needed to take certain actions.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The medical provider/medical director meetings appeared to have been discontinued since the last compliance review. Historically, these meetings included discussions on guideline and protocol implementation. There was no compelling evidence that the medical staff received adequate information on the newly issued and updated policies, procedures, and guidelines. This provision was found to be in noncompliance due to the lack of implementation of all state issued guidelines. The medical director will need ensure that all state guidelines and protocols are localized and implemented. The medical staff should receive inservicing on policies, procedures, guidelines, and updates in a timely manner. New employees should be required to review this information during the orientation process. Collaboration should occur between medical, nursing, and residential services to ensure that all disciplines have received training and have successfully implemented the state issued multidisciplinary clinical guidelines.	

Recommendations:

1. The medical director should follow-through on reliving the caseloads of the PCPs since the hiring of the nurse practitioner (L1).
2. The medical director must ensure that all members of the medical staff have current CPR certification and meet all requirements of the Texas Board of Medical Examiners for continuous medical education (L1).
3. The medical director should work with the PCPs in streamlining the content of the AMAs and providing better plans for medical management. (L1).
4. Quarterly Medical Summaries should be completed by the primary care physicians in accordance with state issued medical policy (L1).
5. The Preventive Care Flow Sheets should be signed and initialed when updated by providers. These documents should be updated at least on a quarterly basis (L1).
6. 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).
7. The medical director should work with consulting neurologists to ensure that clinic notes contain key data related to seizure management. Recommendations for additional testing and medication management should be specific as should timelines for follow-up appointments (L1).
8. The facility must provide better access to neurological services. The use of a community neurologist is acceptable for those individuals who do not have refractory seizures (L1).

9. All individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation (L1).

10. The primary provider should discuss a change in status, such as rescinding a DNR, with the family/LAR. The facility must continue to review the list of individuals with DNRs and for every individual ensure that the long term DNRs are clinically justified and fulfill all requirements of state policy (L1).

11. The medical director should draft an algorithm related to the management of recurrent aspiration syndromes providing more detail on the various treatment modalities and diagnostics (L1)

12. The medical director should review the clinical guidelines for the management of osteoporosis with the medical staff ensuring that adequate information is provided on acceptable treatments for individuals with esophageal disorders. (L1).

13. The medical director should ensure that all individuals have a through risk assessment completed for osteoporosis. Moreover, it should be determined why compliance with the osteoporosis clinical guidelines was so low (L1).

14. State office will need to take several actions in order to achieve substantial compliance with the requirement to complete external facility reviews. Those recommendations are listed in the body of the report (L2).

15. The facility needs to re-assess the current mortality management at SASSLC:
    a. A through medical review should be completed by an outside physician. Recommendations should be made for any deficiencies that are identified.
    b. Committee members should meet periodically to review the status of recommendations.
    c. The facility should conduct a periodic analysis of the longitudinal data looking for patterns, trends, and opportunities for improvement (L2).

16. The medical director should continue to expand the set of indicators reviewed as part of the medical quality program. Indictors should be selected from, but not limited to, all of the state issued clinical guidelines as one means of assessing compliance with the guidelines (L3).

17. The facility must demonstrate that indicator data are collected, analyzed, and trended. When trends are not favorable, an appropriate performance improvement methodology must be utilized to ensure remediation is achieved (L3).

18. Several action should occur to move towards substantial compliance for Provision L4:
    a. The medical director must ensure that all state issued guidelines are localized and implemented.
    b. The medical director must ensure that medical providers receive timely transfer of information regarding clinical guidelines.
    c. All forms, protocols, and guidelines should include an issue or revision date (L4)

19. The facility director/designee must ensure that all disciplines have received training on the state issued multidisciplinary clinical protocols and have successfully implemented the protocols (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 Chart o Map of SASSLC o DADS State Supported Living Center Policy: Nursing Services (5/11/11) o DADS State Supported Living Center Policy: Guidelines for Comprehensive Nursing Assessment (July 2010) and Comprehensive Nursing Assessment form (June 2010) o Alphabetical list of individuals with current 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 Nursing Department Staff Deployment Guide o 8/23/12 Skin Integrity Committee (power point presentation) o Analysis of UTIs o Evidence of PPE Training 2/1/12 – 8/23/12 o Infection Control Monthly Rounds 2/1/12 – 8/23/12 o Hand Hygiene Surveillance Monitoring 2/1/12 – 8/23/12 o Housekeeping Log for Terminal Cleaning 2/1/12 – 8/23/12 o Employee Health Surveillance Forms 2/1/12 – 8/23/12 o SASSLC Infection Data 2/1/12-8/23/12 o Status of approval of IC.01 The Infection Control Program, ID.01 Scabies Protocol, SP.05 Respiratory Hygiene o Skin Integrity Committee meeting minutes 6/23/12 – 8/23/12 o Code Blue/Medical Emergency Reports 5/12 o Curriculum for NEO session - "Observing and Reporting Clinical Indicators" o SASSLC Self-Assessment: updated 8/7/12 o SASSLC Meeting Schedule updated 8/22/12, updated o Records and MARs/TARs of: • Individual #303, Individual #252, Individual #255, Individual #284, Individual #217, Individual #92, Individual #341, Individual #199, Individual #267, Individual #178, Individual #302, Individual #250, Individual #288, Individual #135, Individual #293, Individual #286, Individual #204, Individual #23, Individual #313, Individual #4, Individual #113 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive, Marla Lanni, RN o Acting Nursing Operations Officer, Tina Rivera, RN o Quality Assurance Nurse, Minerva Maldonado, RN o Program Compliance Nurse, Robert Zertuche, RN o Infection Control Nurse, Sam Lee, RN o Nurse Educator, Joe Gomez, RN

	o Hospital Liaison, Gayindria Collier, RN o Nurse Manager, Lola Faulkner, RN o Nurse Manager, Kim Godfredson, RN o Nurse Manager, Juliet, RN o Informal interviews with 8 direct care nurses (LVNs and RNs) <u>Observations Conducted</u>: o Visited individuals residing on all units o Medication administration on selected units o Enteral feedings on selected units o 8/20/12 Nurse Case Managers Meeting o 8/21/12 ISP for Individual #281 o 8/22/12 Integrated Health Care Planning Meeting o 8/22/12 Medication Variance Committee Meeting o 8/23/12 Skin Integrity Committee Meeting o 8/23/12 Nurse Operations Meeting
	Facility Self-Assessment: SASSLC submitted its self-assessment, which was updated on 8/7/12. Since the prior review, SASSLC had implemented the new style self-assessment that was being used at other SSLCs. As recommended by the monitoring team's prior report, the Chief Nurse Executive (CNE), Center Lead for section M, reviewed, 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 the suggestions and recommendations made within the narrative and at the end of the section of the report. As a result, the CNE completely overhauled what was presented the last time and ensured that the self-assessment process resulted in a much more comprehensive, meaningful, and accurate portrayal of the activities and outcomes for each provision item. The most important next step for the CNE is that she makes sure that the self-assessment includes everything that the monitoring team looks at by provision item. This can be done by going through the monitoring team's report and also by reviewing the notes that were taken during the CNE's meeting with the monitoring team when all topics pertaining to section M were reviewed and discussed at length. For example, during the monitoring team's meeting with the CNE, the outline of the monitoring report for section M was reviewed, and it was reaffirmed that it will continue to be important for the self-assessment to line up with the topics in the monitoring team's reports. Of note, even though more work was needed, the monitoring team wanted to acknowledge the efforts of the CNE to successfully move the self-assessment process forward. The facility rated itself as being in noncompliance with all provisions of section M. The monitoring team agreed with all of these ratings.

	Summary of Monitor's Assessment: The monitoring team was pleased to report that under the leadership of the CNE, the Nursing Department made progress across all provisions of section M. There were significant improvements in nurses' time and attendance at work, increased accountability, and decreased unscheduled absences. This positively affected nursing care and morale among colleagues. There were also improvements in the timeliness of nursing assessments. This came about when the CNE articulated and enforced the expectation that all individuals served by the facility should and would receive nursing services in accordance with standard of care, the facility's policies and procedures, and the provisions of the Settlement Agreement and Health Care Guidelines. Systems were developed and implemented, and performance improved to 100% compliance. Other specific areas of nursing care, which were deficient in the prior review, were re-established with expectations for quality processes and procedures that were articulated, agreed upon, and, currently, in the early stages of implementation. For example, the Skin Integrity Committee, led by the acting NOO, was re-conceptualized and re-implemented. The education and training of facility nurses was extended from the classroom to the bedside, such that individuals would directly benefit from the implementation of the nurses' competency-based training program. The Nursing Department continued to maintain good working relationships with other departments, most notably the quality assurance and pharmacy departments. This had been, and continued to be, a very positive finding. For example, despite the sometimes challenging and sensitive nature of the QA Nurse's assignments, which usually resulted in a number of findings and recommendations for the Nursing Department, the CNE and her leadership team remained open to the QA Nurse's findings, welcomed her recommendations, and took actions that benefitted the individuals and their receipt of improved health care services. Notwithstanding these positive findings, the results of the facility's self-assessments, audits, monitoring tools, etc. continued to reveal problems across the provisions of section M. These findings were consistent with the findings of the monitoring team. Notably, however, the CNE and her leadership team were aware of these problems and were up to the task of improving the delivery of nursing care at the facility and ensuring that SASSLC's nursing practices comported with standards of care, the Settlement Agreement, and the Health Care Guidelines.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Since the prior review, SASSLC reported a number of actions were taken to achieve substantial compliance with this provision item. For example: • Nursing leadership staff members distributed the monitoring team's report to all nurses and held "brainstorming" meetings to review the monitoring team's findings and recommendations, • The CNE met with other clinical departments, such as medical, pharmacy, habilitation, and psychology, to discuss and solve specific clinical issues that were identified as barriers to progress, the infection control program and hospital liaison duties were realigned with the standards and expectations of the state's and the facility's policies and procedures, the Settlement Agreement, and the Health Care Guidelines, and • Regularly scheduled compliance meetings were initiated for the purpose of monitoring key nursing staff members' progress toward completing tasks that were focused on achieving the ultimate outcomes of substantial compliance with the provisions of section M and the delivery of quality care. According to the facility's self-assessment, "this provision is not in compliance due to the results of the monitoring tools showing that nursing is not addressing all areas of nursing care documentation, [and] furthermore not all hospital liaison duties [and] requirements are being met." For example, over the past six months, the results of the monitoring tool audits revealed that the nursing care for individuals who suffered acute injury and/or illness widely varied and ranged from low scores of 37% to 100% compliance with no trend toward improvement. In addition, the results of the audits of nursing documentation revealed an average compliance score of 62% and monthly scores that ranged from 47% to 73% compliance, which failed to meet the requirements of the Settlement Agreement and Health Care Guidelines. The monitoring team agreed with the facility's finding of noncompliance for this provision item, but based its own rating on SASSLC's consistent failure to demonstrate the adequacy of nurses' assessment, reporting, documenting, planning, communicating, monitoring, and evaluating significant changes in individuals' health status. During the conduct of the monitoring review, all presentation books and all documents submitted by the facility were closely examined, all residential areas were visited, daily observations of nursing care were made, 18 nurses were interviewed, and 21 individuals' records were reviewed.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Staffing, Structure, and Supervision Since the prior review, the CNE, with assistance from other members of the nursing leadership team, completed analyses of the department's current deployment of staff members, staff minimums, and staff ratios by residential unit and in accordance with acuity of health needs and risks. The CNE used the results of the analyses to develop and maintain a "Nursing Department Staff Deployment Guide," which referenced the minimum and preferred levels of nurses assigned to SASSLC's eight homes across all three shifts. Based upon data and upon the evidence of where, when, and what level of nursing staff members were needed across the facility in order to best meet the health needs of the individuals, the CNE changed the status quo deployment of nurses from top to bottom, and she created a "float pool" of nurses who volunteered to float, were clinically savvy, and on record with excellent time/attendance. As of the review, the float pool was not completely staffed, but it was clearly on its way toward realization. Another area where the CNE, along with the very capable assistance of the facility's work-force administrator, made remarkable progress was in reducing the frequent tardiness of a number of nurses in the department. Reportedly, there was a serious problem with nurses who came to work more than seven minutes late on many days of the month. As of 6/1/12, this problem was rectified, and as of the review, nurses time and attendance records were markedly improved and they continued to be held accountable to the time and attendance requirements of their positions. Notwithstanding these positive findings, a review of the organizational chart of the Nursing Department and the data submitted by the facility for Document #I.11.a-f revealed that, over the past six months, the vacant positions in the Nursing Department had increased from five to nine vacancies. During the monitoring team's interview with the CNE, it was also reported that the Nurse Operations Officer (NOO) was on leave, and the Nurse Educator resigned several weeks prior to the review. In addition, during the week that the monitoring team was onsite, the Infection Control Nurse resigned. These three positions were critical to the facility and of utmost importance to the leadership, management, and operations of the Nursing Department. The next step for the CNE and her leadership team was to ensure that these positions were properly covered during certain nurses' leave and/or filled with capable and competent nurses who demonstrated that they were eager to carry out the roles/responsibilities of these positions.	

#	Provision	Assessment of Status	Compliance
		Recordkeeping and Documentation As noted in the prior review, all individuals' records were organized in a unified form/format. The format of nurses' notes was mostly in the desired SOAP (Subjective and Objective (data), Analysis, and Plan) format, which was consistent with the state's standardized protocol. However, consistent with the facility's self-assessment and as noted in all prior reviews, there continued to be significant problems with nurses' documentation. Of note, the problems with nurses' documentation potentially and actually undermined many of the Nursing Department's initiatives to meet the provisions of the Settlement Agreement. For example, a review of the individuals' records revealed that the Nursing Department's education initiative to improve the delivery of nursing care at the individual's bedside was repeatedly set back by nurses' failure to document what they had done to identify, monitor, and intervene on behalf of the individual to address their health care problems. In addition, it was unclear to the monitoring team why many of the problems with documentation and recordkeeping continued to exasperate and delay progress toward compliance with this provision item. For example, as noted during all prior reviews, a number of nurses' signatures, and especially their credentials, continued to be illegible, nurses' notes failed to have the time of the entry documented on the note, which made it difficult, if not impossible, to know when critically important nursing assessments and interventions were delivered, nurses' notes, usually written by the same few nurses, were documented on the margins of the IPNs rather than new IPNs making it difficult to read and comprehend their assessments and plans, and despite the nature of the individuals' afflictions, many nurses continued to document the same oblique references to their planned interventions, such as "Follow-up PRN," and "Will continue to monitor." During the review of the 21 sample individuals' records, other problems were noted. • Although all 21 individuals had one or more high health risks, over half failed to have a Risk Action Plan filed in their records, • Three individuals had ISPs that were not current, and one individual failed to have an ISP filed in his record, • Several individuals' growth/weight records were missing entries for their monthly weights, and although several individuals had dieticians' recommendations and/or physicians' orders for weekly weights, none of the individuals' growth/weight records or their Medication Administration Records (MARs) referenced these data, and • Although several individuals' nursing assessments indicated that they had problems with pain and pain management, there were only two individuals and a total of three FLACC scales filed in the records reviewed by the monitoring team.	

#	Provision	Assessment of Status	Compliance
		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." During the prior review, not one of the records of the sample individuals who were hospitalized had 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. However, since the prior review, the CNE reported that she "removed barriers for [the Hospital Liaison]," fully supported the implementation of this important role/responsibility, and "afforded [the Hospital Liaison] more opportunities to see the individuals at the hospital." According to the Hospital Liaison, since the prior review, he/she increased visits to hospitals, and it was his/her goal to "go [to the hospital] every day" of the individual's hospitalization. As noted during the prior review, the NOO continued to be the Hospital Liaison's designated back-up staff member. During the period of 3/1/12 – 8/24/12, 11 of the 21 individuals selected for in-depth review were hospitalized one or more times for treatment of significant changes in their health. The 11 individuals suffered a total of 21 hospitalizations that averaged five days length-of-stay and ranged from an overnight stay to almost three weeks in the hospital. Although the Hospital Liaison and CNE clearly reported that they followed the state's and the facility's policy directives, the provisions of the Settlement Agreement, and Health Care Guidelines, which called for regular contact with the individuals' tertiary care providers throughout their hospitalizations, a review of the individuals' records revealed that two-thirds (65%) of the individuals' hospitalizations referenced that they were visited one or fewer times by the Hospital Liaison and/or the NOO during their hospitalization. Another 10% of the individuals' hospitalizations referenced only two visits, and the remainder referenced three visits by the Hospital Liaison and/or NOO during the individuals' hospitalizations. The pattern that emerged and appeared to explain some of the failed visits/contacts was that there seemed to be no plan in place to ensure that that the status of hospitalized individuals would be ascertained over weekends, holidays, and/or when the Hospital Liaison was not on-duty. Thus, as noted during the prior review, the individuals' records continued to reveal that some tertiary care providers were unaware of individuals' relevant health information, such as their	

#	Provision	Assessment of Status	Compliance
		current medication regimens, and some SASSLC physicians, nurses, and other clinical professionals were not consistently apprised of the course of individuals' hospital care, test results, medical specialists' recommendations, estimated discharge dates and needs for services upon discharge. For example, on a Friday afternoon, Individual #313 was found lying on the floor and unresponsive. He was hospitalized over the weekend for treatment of syncope and sinus bradycardia. According to Individual #313's physician, when he returned to SASSLC, he had "no labs with his paperwork from [the hospital]." Thus, Individual #313's physician noted that he/she would "request labs from [hospital]" to help inform his/her medical care planning process. There was no evidence of follow-up to the physician's request or that this important information was obtained. Of note, the Hospital Liaison visits and reports that were completed and filed in the individuals' records were thorough assessments of the individual's status, comprehensive reviews of the hospitals' records, and thoughtful interviews with individuals' tertiary care providers, which were promptly communicated to the individuals' interdisciplinary team members. Nonetheless, the review of the hospitalized individuals' records failed to reveal that adequate procedures were in place to ensure that they were consistently seen and evaluated by the Hospital Liaison during their hospitalization. These findings, which were again unexpected, continued to suggest that the serious concerns for the health and safety of hospitalized individuals that were raised during the prior review remained unresolved. It would seem appropriate for the CNE and the Hospital Liaison to conduct an analysis of the hospitalization data, including frequency of hospitalization, number of individuals hospitalized, lengths-of-stay, etc., to help identify what, if any, barriers continue to prevent the Hospital Liaison from completely and successfully carrying out his/her role/responsibility, as articulated by the state's and the facility's policies and procedures. The QA department and/or the QA nurses might be called upon to assist with this activity. A particularly important area to clarify would be the plan for visiting and/or contacting tertiary care providers on behalf of individuals who were hospitalized on the weekends, holidays, and/or when the Hospital Liaison was not on-duty. The challenge that lies ahead for the Hospital Liaison, once he/she establishes an effective program of monitoring and overseeing hospitalized individuals, would be to investigate and identify possible interventions to reduce the frequency of individuals' hospitalization and the likelihood that individuals would suffer frequent re-hospitalization(s).	

#	Provision	Assessment of Status	Compliance
		Wound/Skin Integrity 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 CNE's 8/20/12 oral presentation for section M, she reported that the skin integrity program had been reestablished under new leadership. As reported, on 6/25/12, there was a meeting that was held to reintroduce the reestablished Skin Integrity Committee members and discuss the focus, mission, goals, and schedule of the committee. On 7/23/12, the first meeting of the committee occurred and individuals with "skin concerns" were reviewed. In addition, plans to conduct and complete training of direct care staff members on skin checks and skin care guidelines were developed. On 8/23/12, the monitoring team attended the Skin Integrity Committee meeting, which was well attended and represented by all disciplines and was nothing short of excellent. The committee presented its systems and processes for tracking, trending, and reporting alterations in skin integrity and reported on the outcomes of its facility side baseline skin assessment. Although SASSLC reported that the results of the past six months of their monitoring revealed an average of only 65% compliance with the provisions of the Settlement Agreement and Health Care Guidelines that pertained to skin integrity, the roll out of the skin integrity program over the next six months holds promise for improving the facility's compliance with identifying and addressing issues, patterns, and trends in individuals' who suffered alteration in skin integrity and increasing their likelihood of positive health outcomes. Infirmary According to SASSLC's document submission, "SASSLC does not have an on-campus infirmary." However, during the prior review, it was apparent that there were a number of individuals, referred to as "boarders," who were regularly transferred to/from 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. As noted during the prior review, unit 673 continued to be used as a place where sick and/or injured individuals were cared for on a time-limited basis. For example,	

#	Provision	Assessment of Status	Compliance
		Individual #267, who resided on unit 668 and was hospitalized on two occasions for treatment of pneumonia, was a temporary resident on unit 673 as a result of his need for close monitoring due to "low [blood] oxygen saturation levels." During the prior review, it was noted that 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 (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. As of the current review, however, there was evidence of ongoing analyses of the physicians' orders and rationales for the transfers to/from unit 673, examinations of the individuals' lengths-of-stay, and monitoring of the timelines of individuals who were temporarily admitted to unit 673 for enhanced medical monitoring. In addition, at the time of the review, the CNE received approval to implement the recently drafted facility policy entitled, "Transfers for Medically Enhanced Supervision" and the newly developed "Home to Home Transfer Check List." This policy defined and laid down the rules for safely transferring individuals to/from unit 673, and the check-list helped ensure that individuals' records, equipment, medications, etc. would be available and accessible to them in a timely manner and not disrupted by their transfer to/from unit 673. Over the next six months, it will be important for SASSLC to closely watch the implementation, effectiveness, and outcomes of this new policy and procedure. <u>Infection Control</u> According to the facility's self-assessment, since the prior review, the infection control surveillance and tracking systems were reviewed to ensure that "appropriate transmission-based management interventions [were] in place," and the facility's compliance monitoring scores related to infection control were averaging 84%. In addition, it was reported that the facility's infection control program had taken the "single most important intervention to prevent disease transmission, hand-washing, to a new level." A review of the Infection Control Committee meeting minutes revealed that the Infection Control Nurse brought the findings of the prior monitoring report to the committee's attention, however, there was no evidence that the committee developed a comprehensive corrective action plan to fix the systemic problems, which were not likely to be easily addressed by creating a new form or another log. Thus, contrary to the facility's self-assessments, audit scores, and document submission, the review revealed that there continued to be a number of serious problems, many of which were previously identified, in the facility's implementation of its infection prevention and control	

#	Provision	Assessment of Status	Compliance
		program. First, the Infection Control Nurse reported to the monitoring team that all facility policies related to infection prevention and control were abandoned and, instead, only the "Infection Control Reference Manual for SSLCs" was in effect at SASSLC. Curiously, although SASSLC's document submission referenced that there were four infection prevention and control policies that were developed over the past six months and pending approval, upon follow-up by the monitoring team, it was reported that, as of the review, there were none that were drafted, pending approval, and/or approved. The state-issued reference manual was indeed a good resource, which was an outcome of the state's successful endeavor to standardize the SSLCs' approach to infection prevention and control. But, it was not the intention of the Texas SSLC's Infection Prevention and Control Committee that facilities should, or would, abandon their policies and procedures and replace them with the reference manual. Rather, the Infection Control Reference Manual was developed as a source of information to help guide and direct the facility's development and implementation of policies and procedures. For example, the reference manual's one-page description of the procedure and key points of "Isolation of Potentially Infectious Individuals" properly directed the reader to "...notify the Provider or Infection Control Practitioner immediately for instructions." It did not, and would not, provide specific directions and guidance for staff members on how to care for and treat a potentially infectious individual who resided at SASSLC. Second, according to the infection control documents submitted to the monitoring team in Document #X.21.a-d, the Infection Control Nurse reported that he/she conducted monthly monitoring and the Infection Control Committee analyzed the data collected vis a vis monitoring tools, but no written procedures existed for the monitoring function of the facility's infection prevention and control program. In light of the lack of written procedures, the monitoring team attempted to obtain additional information on this subject during an interview with the Infection Control Nurse and CNE, but no additional information was provided. However, since the prior review there appeared to be 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. These data were requested for the period of 2/1/12 – 8/23/12.	

#	Provision	Assessment of Status	Compliance
		Consistent with the prior review, an examination of these data continued to reveal many serious problems. For example: • There were environment of care inspections conducted on five units. Two of the five units, unit 672 and 671, which were reviewed on 5/18/12 and 6/25/12, respectively, had serious and pervasive problems, such as malodorous conditions, feces and shredded fabric in the floor of the bathroom stalls, soiled clothing and towels on the floor, overfilled sharps containers, damaged and heavily stained furnishings, broken and missing tiles in the shower stalls, black mold/mildew covered the straps of the shower chairs and lined the shower stalls, soiled and dirty refrigerators, and violations of the CDC recommendations for preventing risks of cross-contamination. On 6/27/12, the Infection Control Nurse presented these serious problems to the facility's Safety Committee. During the monitoring team's onsite follow-up tour of these areas, there was no evidence that these serious health and safety hazards had been addressed and corrected. Rather, they had persisted, worsened, and created a health hazard for the individuals who resided on these units. • There was evidence that hundreds of "Hand Hygiene Surveillance" forms were completed during the period of 2/1/12 – 8/23/12. A review of these forms revealed that only 23 forms had one or more responses indicative of problems with employees' performance of hand washing. These problems were usually related to the employee's failure to adhere to proper protocol when drying his/her hands and turning off the faucets. Although this surveillance activity occurred hundreds of times and the forms were dutifully turned in to the Infection Control Nurse, there was no evidence of the Infection Control Nurse's analysis of these data and/or specific interventions implemented to ensure that the problems that were revealed during the hand hygiene surveillance of these 23 employees were corrected. • Despite the well-documented occurrences of infections, contagious illnesses, and uses of the isolation room at the facility, there was evidence of a total of only eight cleanings of the isolation room during the period of 2/1/12 – 8/23/12. Of note, seven of the eight entries in the Housekeeping Department's "Environmental Sanitation Checklist," which noted that the isolation room was cleaned/disinfected, were written in the space intended for the signature of the housekeeper on duty and, sometimes, over the signature of the housekeeper, appearing as though the notations for cleaning/disinfecting the isolation room were made after the fact. • There were no data submitted to provide evidence of surveillance, tracking, and monitoring of the infections suffered by individual residents. Regrettably, this appeared to be the facility's response to the monitoring team's prior report, which found infection prevention and control data to be in disarray and not properly recorded and maintained in a database.	

#	Provision	Assessment of Status	Compliance
		• There were only six reports of employee health matters that pertained to infection prevention and control during the period of 2/1/12 – 8/23/12. As noted during the prior review, it was not clear what, if anything, was being done to address employee health matters, vis a vis infection prevention and control, at SASSLC. Thus, the review of the six "Employee Health Surveillance Forms" revealed that some reports were incomplete, some indicated that the employee(s) failed to notify the Infection Control Nurse when their symptoms started, and at least one form, which indicated that several individuals suffered elevated temperatures after an employee was diagnosed with the flu, failed to indicated what, if any, follow-up steps were taken by the Infection Control Nurse, in accordance with the state's Infection Control Reference Manual for SSLCs. The findings noted above continued to indicate that the concerning decline in the infection prevention and control program that was noted six months ago had not been adequately addressed or corrected. Thus, the impact of this decline continued to be 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: • Over the past six months, two individuals were diagnosed with scabies. One of the individuals, Individual #178, was diagnosed and treated for scabies twice during the two-month period of 6/3/12 – 8/2/12. Although Individual #178's mother complained, "Scabies keeps getting passed around," there was no evidence that the Infection Control Nurse was active or involved in addressing Individual #178's mother's concern or engaging in appropriate activities to address the contagious skin infections suffered by the individuals, including, but not limited to reducing the likelihood of transmission and re-infection(s). • On 6/8/12, after weeks of diarrhea, Individual #113 was diagnosed with blastocystis hominis, an intestinal parasite. Several days later, the Infection Control Nurse noted the individual's diagnosis in his record, but failed to meet with the individual because he was "not available for assessment." The Infection Control Nurse left some posters pertaining to post-transmission prevention and hand hygiene "for staff" on Individual #113's unit and apparently instructed staff members to "report clinical indicators to nursing and/or medical staff." However, there was no evidence of an explanation of what "clinical indicators" were relevant to report, no evidence of any further attempts to see the individual, and no evidence that specific information pertaining to the type and scope of the individual's infection was provided to staff members, or the individual, to allay their possible fear, anxiety, and misconceptions surrounding Individual #113's diagnosis. • On 5/22/12, Individual #288 was hospitalized for treatment of c.difficile colitis	

#	Provision	Assessment of Status	Compliance
		and urinary tract infection. When Individual #288 returned to SASSLC, her physician recommended that the Infection Control nurse review Individual #288's prior history of c.difficile. The extent of the Infection Control Nurse's review of Individual #288's infection history was limited to one sentence - "Historically she was c.diff + by lab report of June 20, 2011." There was no information provided regarding the nature of Individual #288's treatment, her response to and the effectiveness of her treatment, how long she suffered the infection, whether or not isolation was implemented, etc. <u>Emergency Response</u> A review of the state of medical emergency equipment at SASSLC revealed many improvements upon the serious problems noted during the prior reviews. For example, medical emergency equipment, which was regularly checked, was available and accessible to staff members. In addition, there was evidence that nurses responded to most, if not all, drills, and several drills included participants from the habilitation and dental departments. Notwithstanding these improvements, Training Specialists continued to reference the need to "inservice [clinical professionals] regarding their responsibilities during emergency drills." For example, on 7/31/12, the drill failed, because the OT/PT personnel, nurse, and contract employee failed to respond to the emergency drill, the emergency equipment was not brought to the scene, and staff members were not knowledgeable of the location and use of emergency equipment. The plans of action to address these problems were usually delegated to department heads to address and resolve. However, given the persistence of these problems, it appeared that the facility administration must set the tone and reaffirm the expectations of the state's and facility's policy, which required "...all staff members who provided direct services to individuals received emergency response training [and] demonstrate competence in emergency response." Indeed, clinical professionals have an obligation to participate and model the conduct they expect of and often delegate to direct care staff members. <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 of the Integrated Progress Notes (IPNs) must include all information regarding the status of the problem, actions taken, and response(s) to treatment at least every day to ensure that treatment is appropriate and recovery underway until such time as the problem is resolved. In addition, the 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.	

#	Provision	Assessment of Status	Compliance
		Across the 21 sample individuals reviewed, there was evidence that their physicians usually responded to nurses' notifications of significant changes in their health status and needs and/or when the individuals needed to be seen by their doctor. However, as noted in prior reviews, it was the direct care staff members who continued to be the first responders and reporters of health care problems and concerns to the LVNs. Thus, there continued to be a heavy reliance upon the direct care staff members to readily identify problems, and on the LVNs to promptly respond to the direct care staff member's report, review the individual and situation, and report their findings to RNs for assessment, monitoring, and referral to the physician. A review of 21 sample individuals' records showed that the facility failed to ensure that its nurses consistently identified, implemented, and documented their interventions to address individuals' health care problems and changes in health status, and/or conducted at least daily follow-up until resolution of the significant changes in individuals' health status occurred. This problem manifested itself in different ways, such as the failure of nurses to consistently and completely document their assessments to help ensure that accurate information was relayed to the treating physicians and/or the nurse practitioner. Oftentimes, important information, such as the onset and duration of the problem, aggravating and alleviating factors, and accompanying signs and symptoms were not documented. As a result, proper diagnosis and treatment of individuals' significant changes in health status were at risk of delay. For example, Individual #113's physician noted that he was "Status post gastroenteritis [but] no one on the dorm knows if he's eating?" Absent any other information or relevant history, Individual #113's physician prescribed, "Monitor eating and pooping (sic)." Across all records reviewed, there were many other examples of nurses who failed to ensure proper and complete follow-up to significant changes in individuals' health status. The following examples represented the seriousness of this problem at SASSLC. • On 8/11/12, Individual #217's physician noted that she had upper airway congestion after suffering an episode of vomiting. Her physician ordered vital sign measurements every four hours and chest percussion three times a day for five days. Notwithstanding the significant change in Individual #271's health status, there was no evidence that the vital sign checks and chest percussions were carried out as ordered. • On 8/13/12, Individual #255 fell, suffered a laceration above his right eye, and required emergency medical treatment, which included sutures. Despite his significant change in health status and his nurse's report that "Neuro checks will be done," there was no evidence that Individual #255 was monitored and assessed in accordance with the head injury protocol.	

#	Provision	Assessment of Status	Compliance
		• On 6/27/12, at 7:30 pm, Individual #92's nurse was informed that he was diaphoretic, clammy, and stating that he did not feel well. Individual #92's condition deteriorated such that he was gasping for air. His physician ordered his transfer to the emergency room, but he refused to go. Thus, his physician ordered close monitoring and vital sign measurements every two hours until his physician saw him the next morning. Notwithstanding the significant changes in Individual #92's health status, there was no evidence that his vital signs were obtained and monitored as ordered.	
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.	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 and the Post-Hospital/ER/LTAC 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. In addition, a review of the state's guidelines for completing the quarterly/annual comprehensive nursing assessments revealed that they clearly required the comprehensive nursing assessments to be completed prior to and in anticipation of the individuals' annual and quarterly ISP meetings. Thus, making it imperative that the Nursing and QDDPs/ISP Coordination Departments closely coordinate, communicate, and collaborate with each other. Of note, since the prior monitoring review, 11 of the SASSLC RNs completed phase two of the RN physical assessment course, which continued to help improve their knowledge and training in identifying and evaluating variance in health status indicators. Also, SASSLC recently distributed the state's protocols for nurses to help them in their performance of assessment, documentation, and reporting to physicians and other clinical professionals their findings related to several, frequently occurring health problems, such as vomiting, infection, constipation, seizures, etc. Nonetheless, documentation by exception, as implemented by SASSLC nurses, continued to have significant problems that set back many of the CNE and her nursing leadership team's efforts to obtain substantial compliance with the provisions of section M. The presentation book for section M showed evidence of numerous, ongoing activities to address the delinquencies in nursing assessments and ensure that all individuals who resided at SASSLC received standard of care with respect to timeliness of their nursing assessments. Over the past six months, the CNE and QA Nurse spent many hours working with nurses and nurse case managers to achieve their goal of 100% compliance with timeliness of annual and quarterly nursing assessments. On 7/18/12, the Nursing	Noncompliance

#	Provision	Assessment of Status	Compliance
		Department reported that they achieved their goal of 100% compliance with the expectation that nursing assessments would be completed on time. On 8/5/12, the Nursing Department reported that all nursing assessments continued to be completed on time. This was no small task and the result of much hard work and stick-to-itiveness by nursing leadership who remained unflappable in the face of short-term missteps and supremely confident that they would find a way forward. Without a doubt, the Nursing Department's successful approaches to ensuring timeliness of nursing assessments bolstered their confidence and resolve to improve the content and quality of nursing assessments. According to the Nursing Department's QA data analyses, over the past six months, the results of the departmental and QA audits of the content of annual and quarterly nursing assessments varied by unit and ranged from 60% to 98% compliance with the requirements of the Settlement Agreement and Health Care Guidelines. At the time of the review, the Nursing Department was developing and refining its plan to improve the content and quality of the nursing assessments. The review of 21 sample individuals' records revealed that nursing assessments were indeed timely, however, with respect to content, they continued to fail to meet the provisions of the Settlement Agreement and Health Care Guidelines. As a result, a rating of noncompliance was given to this provision item. Across the sample of individuals reviewed, nursing assessments had many of the deficiencies described below. Of note, these deficient practices were also found during prior reviews: • Current active problem lists were incomplete and not up-to-date. • The majority of nursing assessments failed to show meaningful reviews of individuals' response to and effectiveness of all of their medications and treatments. Individual #252 was a good example of this problem. o It should be noted, however, that there were several nursing assessments, such as Individual #250's assessment, where his nurse very thoughtfully and completely evaluated his response to his medications and treatments. • When significant weight changes were revealed in the individuals' records, there were no corresponding evaluations of the nature and impact of the changes on the individuals' health status in their assessments. This problem was most egregious when an individual suffered significant, abrupt, and/or unplanned weight loss and his/her nurses failed to take assertive actions. • Tertiary care reviews were incomplete. • Individuals' significant histories of chronic and acute conditions, including, but not limited to, respiratory illnesses and infections, heart disease, skin	

#	Provision	Assessment of Status	Compliance
		breakdown, and medication side effects were not completely identified and evaluated. • Nursing assessments that indicated that individuals had pain management problems failed to reference complete evaluations of the location, intensity, onset, duration, quality, etc. of the individuals' pain, and what alleviated and/or aggravated their pain. • Individuals' persistent, recurring problems, such as alteration in skin integrity, infection, vomiting, diarrhea, dehydration, constipation, insomnia, etc., were usually noted by their nurses in the nursing assessments, but frequently the nature and extent of these problems were not accurately portrayed and not adequately evaluated, diagnosed, or addressed vis a vis care plan(s). • Lists of nursing problems/diagnoses were incomplete and, occasionally, referenced problems/diagnoses that were not identified or revealed during the comprehensive assessment or elsewhere in the individuals' records. In addition, it was not uncommon to find lists of nursing problems/diagnoses carried over from one nursing assessment to the next regardless of changes in the individuals' health problems, needs, and risks. • Nursing summaries continued to need improvement. In general, they continued to be difficult to read and understand the main points, run-on lists of orders, order changes, discrete events, lab test results, etc., which always left the reader wondering how all of the various health events, treatments, interventions, risk reduction activities, etc. impacted the individual. The following examples from this sample indicated the seriousness of this problem at SASSLC. • From 3/29/12 to 6/29/12, the day when Individual #4's quarterly nursing assessment was completed, her record notes indicated that she fell 11 times before her fall on 6/23/12, when she was found on the floor with a laceration to the back of her head. It was exceedingly unclear how Individual #4's nurse concluded in her quarterly nursing assessment that Individual #4 had "one fall this quarter and received 8 staples [to the back of her head]." Absent a complete and accurate nursing assessment, there were no interventions developed to reduce Individual #4's risk of falls and help protect and prevent her from suffering additional injuries. • Over the past several months, Individual #92 suffered frequent episodes of vomiting and diarrhea, such that his physician ordered tests to rule out the presence of intestinal infection, ova and parasites, and gastrointestinal bleeding. Despite Individual #92's significant health needs and risks, his nursing assessment failed to reference them as part of his gastrointestinal history and/or current status and failed to include them as part of his nursing	

#	Provision	Assessment of Status	Compliance
		problems/diagnoses. • Individual #284 was seven months post decannulation of her tracheostomy, and, as of the review, her stoma was still not closed. However, Individual #284's nursing assessment failed to reference her unique condition and erroneously indicated that there were no abnormal findings of her neck/throat.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	According to the Health Care Guidelines and DADS Nursing Services Policy and Procedures, based upon an assessment, a written nursing care plan should be completed, reviewed by the RN on a quarterly basis and as needed, and updated as to ensure that the plan addressed the current health needs of the individual at all times. The nursing interventions put forward in these plans should reference individual-specific, personalized activities and strategies designed to achieve individuals' desired goals, objectives, and outcomes within a specified timeline of implementation of 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 managers 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 Officer 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. During the review, the monitoring team attended a meeting with the RN case managers and requested that they list the barriers that continued to prevent them from focusing on their main tasks. Only three of the 15 RN case managers responded to the request and submitted their lists to the monitoring team. Albeit limited participation, the three RN case managers' lists referenced many of the same barriers. The top three barriers were the almost constant change in processes, scheduled and last minute unscheduled meetings, and carrying out direct care nursing duties. These barriers must be addressed by facility administration, as well as the Nursing Department, in order to achieve substantial compliance with the provisions of section M. According to the facility's presentation book for section M3, since the prior review, the Nursing Department adopted a system of assessing the quality of 100% of all annual/quarterly HMPs. The single criterion used to assess the quality of the HMPs was	Noncompliance

#	Provision	Assessment of Status	Compliance
		that they must adequately "address each individual's health care needs." According to the Program Compliance Nurse's analysis of RN case managers' compliance with the single criterion, the quality of HMPs increased from 31% meeting the criterion in May 2012 to 70% meeting the criterion in June 2012. This was a significant accomplishment that was achieved in short order. Time will tell whether or not health care planning will continue to improve and meet the criterion of adequately addressing individuals' health needs. Over the next six months, with the expected roll out of the state's integrated health care planning process, this aspect of the delivery of nursing supports and services will be ripe for continued improvement and compliance with the provisions of the Settlement Agreement and Health Care Guidelines. Currently, the monitoring review of 21 individuals' records revealed that all 21 individuals failed to have specific, individualized nursing interventions developed to address all of their health care needs, including their needs associated with their health risks. As a result, a rating of noncompliance was given to this provision item. However, it should be noted that there were improvements in certain ACPs for some individuals. For example, there were obvious attempts made to make certain that the ACPs for Individual #303 were more complete, accurate, individualized, and appropriate. Some general comments regarding the 21 sample individuals' care plans are below. Of note, all of the findings were consistent with the findings from the prior reviews. • The generic, stock, mini-plans with various dates and time frames, some of which were reviewed at least quarterly, many of which were not, continued to be the pattern of health care planning at SASSLC. o A number of the interventions put forward in the stock care plans were not consistent with the state's health and nursing care protocols. • Almost identical HMPs were used to address health problems regardless of the individual's co-morbid conditions and/or the precursors, nature, scope, and intensity of the problem. • Almost half of the 21 sample individuals were diagnosed with poor oral hygiene. And, at least one individual's oral hygiene was so poor that she suffered multiple caries and heavy bleeding upon brushing her teeth. However, several individuals failed to have a HMP to address oral hygiene needs. • Some individuals HMPs referenced that the implementation date occurred a year before the individuals' baseline data were collected and examined. Of note, these HMPs were signed and dated as "reviewed" by their nurses, which raised question regarding the veracity of the review process. • Not one of the 21 individuals records contained plans that addressed all of the current health needs of the individuals at all times.	

#	Provision	Assessment of Status	Compliance
		• There were many examples of when the implementation of care plan interventions was not appropriate to meet the individuals' needs. For example, a number of individuals had HMPs to address their osteoporosis and risk of fractures. However, the interventions referenced by these plans, such as immobilization, controlling bleeding, treating for shock, etc., would, and should, only be implemented during an actual episode of an acute fracture. Examples of problems in the HMPs and ACPs of specific individuals are presented below: • Individual #284 was a 66-year-old woman with many health needs and risks. She had only two HMPs filed in her record, one related to her seizure disorder and the other related to her periodontal disease. As of the review, there were no planned interventions to address her risk of aspiration, immobility related to her right above the knee amputation, spastic right hemiparesis, and scoliosis, osteopenia, dyslipidemia, constipation, risk related to infection at the site of her slowly closing stoma, and acute folliculitis of her right stump. • Over the past several months, Individual #302 suffered weight loss, increased dyskinesia, eye infection, sinusitis, cluster of seizures, PEG tube placement, and physician-ordered NPO status due to his high risk of aspiration. Neither his "revised" constipation HMP nor his "revised" weight/under HMP were truly and completely modified and individualized to reflect his NPO status. Thus, these plans placed Individual #302 at serious risk of harm, and, if implemented, could result in life-threatening outcomes. • On or about 7/5/12, Individual #23's dietician noted that his RN case manager reported that he suffered weight loss and weighed only 82.5 pounds. At this time, although Individual #23's dietician recommended, "Additional weight loss was not advisable," there were no planned interventions to address Individual #23's weight loss and prevent further decline other than adding one can of nutritional supplement to Individual #23's meals. Thus, several days later, when Individual #23 was found to have a critically low sodium level, his physician ordered his immediate transfer to the emergency room for hydration because he/she "suspected added fluids [were] not being done." Of note, one week later, the physician wrote, "I am told [Individual #23] has 20-pound weight loss since March. I was unaware it was this severe." As of the review, Individual #23 was hospitalized, and his most current weight, as recorded in his record on 8/1/12, was 77 pounds.	

#	Provision	Assessment of Status	Compliance
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.	Of the six provisions of section M, M4 has the broadest scope. This provision item clearly ties assessment and reporting protocols to outcomes, and it requires rigorous implementation to achieve substantial compliance. More specifically, this provision item demands that each component of the nursing process is in place and put into practice, such that the health needs of the individuals served by the facility are met. This means that, when properly implemented, the assessment and reporting protocols should produce results, that is, expected outcomes. Expected outcomes will depend on the individual and his/her situation, and they may include maintaining or attaining health or achieving end of life goals. The facility's self-assessment indicated that, since the prior monitoring review, SASSLC continued to ensure that all new employees were attending the "Observing and Reporting Clinical Indicators" course, and nurses were completing their annual competency evaluations. In addition, in the spirit of embracing the state's mandated protocol training and implementation, the Nursing Department distributed 18 health assessment and reporting protocol cards to all of its nurses. In March 2012, the Nursing Department designed and implemented a systematic method to conduct nurses' training and develop their skills while on-the-job, or, in the words of the CNE, while "at the bedside." At the time of the review, this training program was underway and soon to be under the leadership of the newly hired Nurse Educator. Notwithstanding these positive findings, the facility reported that, based upon the results of their self-assessment, this provision item was in noncompliance due to the need for additional monitoring in the area of improving compliance with nurses' implementation of the assessment and reporting protocols. The monitoring team was in agreement with the self-rating of noncompliance due to the findings of numerous problems in the implementation of the nursing assessment and reporting protocols specifically developed by the state (and some developed by the facility) to improve nursing practice and ensure consistent application of the nursing process. Since the prior review, under the leadership of the CNE, the Nursing Department made progress in all provisions of section M. This was accomplished during a tumultuous six-month period of time when, for example, vacancies in the department were increased, the Nurse Educator resigned, the NOO was on extended leave, and newly hired nurses were asked to step up and accept the responsibility and challenges of leadership positions in the department. Although the CNE agreed that the past six months were challenging times, she added that they were also exciting and productive, and many accomplishments were achieved. The CNE was correct. There were significant improvements in the following areas: • culture of the Nursing Department and acceptance of change,	Noncompliance

#	Provision	Assessment of Status	Compliance
		• performance and accountability of nursing leadership, • time and attendance, • deployment of nurses across the facility to meet the health and behavioral needs of individuals, • teaching and learning opportunities for nurses, and • delivery of standard of care with respect to timeliness of assessments. With the addition of a new Nurse Educator, the CNE will undoubtedly improve upon the baseline of performance, which she and her leadership team successfully established at SASSLC. The CNE, acting NOO, and Nurse Managers continued to meet on a weekly basis. During these meetings, staffing issues, policies and procedures, nurses' education and training topics, plans of correction, and other management matters were discussed. In addition, meetings of nursing leadership included some discussion of the department's progress toward implementing the steps of their strategic plan to meet the provisions of section M. As such, the Nurse Managers were completely aware of the department's priorities and 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. Notwithstanding these positive findings, it was clear that there was more work to be done to build a stable and competent Nursing Department. Since the prior review, the newly hired Medically Fragile Unit Nurse Manager was appointed to the position of acting NOO. She quickly became integral to the department's endeavor to build up the Nursing Department and ensure that the state's and the facility's nursing policies, procedures, and protocols were properly implemented. For example, over the past several weeks, the acting NOO sought to improve the Nursing Department's relationships with other departments, reinforce the expectation for nurses to apply their clinical knowledge and skills during daily activities, and tighten up the process of cross-training nurses to units other than their home base. The NOO was also assigned the responsibility of rolling out the facility's skin integrity processes and chairing the Skin Integrity Committee, which were well on their way toward full implementation (see section M1 for more information). The acting NOO summarized her observations of the Nursing Department's progress over the past six months when she stated, "[The nurses] work ethic and their willingness to engage has changed a lot and for the better [and] they were no longer wayward or unsupported [by nursing leadership]." The Nursing Department also continued to have three unit Nurse Managers, two of whom were long-standing employees, that supervised the direct care nurses across the	

#	Provision	Assessment of Status	Compliance
		facility. They were the front-line nursing leadership staff members that were critically important to the success, or failure, of the implementation of assessment and reporting protocols, plans, and processes to achieve compliance with the provisions of the Settlement Agreement and Health Care Guidelines. Although the three Nurse Managers unanimously reported that, over the past six months, they had observed improvements and positive changes in the Nursing Department, they also consistently reported that there was indeed "a ways to go." The Nurse Managers expressed much appreciation for and observed many positive outcomes from their attendance at the state's physical assessment and documentation training course, and they were looking forward to the Mosby Physical Exam Course, which was soon to be released. According to the Nurse Managers, two of the most frustrating and difficult parts of their job were (1) implementing the assessment and reporting protocols in the face of constant changes in processes, policies, and procedures, and (2) managing the nurses during times of communication breakdown and failure from both within and outside the Nursing Department. During the monitoring team's observations on the units, the failure to ensure implementation of the assessment and reporting protocols was noted. Less than half of the nurses who were observed had the state's protocols on laminated cards on their person and/or in their workstations. In addition, there was no evidence in either the IPNs, comprehensive assessments, or HMPs that the protocols were consistently and/or correctly used to guide and direct nursing interventions during episodes of acute changes in health, ensure that adequate and appropriate nursing assessments and monitoring of health status changes were completely carried out, and trigger the parameters and time frames for the reporting of signs and symptoms of significant changes in health to the individuals' physician and/or other clinical professionals, as indicated. For multiple individuals, their records revealed the following: • Many individuals who were sedated for procedures failed to have evidence of implementation of the protocol developed to address pretreatment and post-sedation/anesthesia. Thus, there were significant lapses in close monitoring of individuals who were recovering from various medical procedures. • Individuals who suffered frequent episodes of nausea, vomiting, and diarrhea failed to have evidence of implementation of the protocols developed to address these problems. Thus, individuals suffered complications, such as dehydration and fluid/electrolyte imbalance. • Individuals who suffered episodes of constipation failed to have evidence of implementation of the protocol developed to address this problem. Thus, these individuals suffered repeated use of ineffective interventions, delayed treatment, and heightened risks of impaction and obstruction.	

#	Provision	Assessment of Status	Compliance
		• Several individuals who suffered head injuries were not assessed or monitored, in accordance with the head injury protocol. This was especially significant for individuals who suffered more than minor head injuries and were not closely and completely assessed and monitored, as indicated by the protocol. • There were uniform failures to implement the SOAP documentation protocol. Thus, there were numerous occasions when there was no evidence that significant changes in individuals' health status were adequately assessed, acted upon, and monitored until resolution. Although it was apparent to the monitoring team that adherence to the protocols was a work in progress, it was not apparent what actions the Nursing Department planned to take, apart from developing and completing addition monitoring tools, to help ensure that their nurses would consistently implement the nursing protocols. Since the prior review, the Program Compliance Nurse and the Quality Assurance Nurse continued to provide the Nursing Department with high quality, 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 all 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 Quality Assurance Departments focused on improving the timeliness of nursing assessments and the content of health care plans. Through this process they were able to identify nurses who needed more educations and coaching and individuals who benefitted from the timely development and implementation of strategies to address significant changes in their health status and needs. Thus, through the combined efforts of nursing leadership, quality oversight, and compliance monitoring, along with the hard work of nurse case managers, compliance with standard of care pertaining to timeliness of nursing assessments achieved and maintained 100% compliance for two months running. The Program Compliance Nurse and the QA Nurse continued to move SASSLC's monitoring and quality oversight program forward, away from an emphasis on process, and 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 it continued to be a model for other facilities.	

#	Provision	Assessment of Status	Compliance
		As noted in the prior review, the QA Nurse continued to conduct Quality Improvement Death Reviews of Nursing Services. Since the prior review, the QA Nurse completed three such reviews. 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) timeliness of nursing assessments, especially when individuals suffered untoward health outcomes, such as unplanned weight loss, (2) individualization of health care plans, (3) health information provided to IDTs to ensure that the members were adequately informed and knowledgeable of significant changes in individuals' health needs and risks to ensure the development of plans to meet their needs, follow through with nursing interventions to ensure that preventative measures were taken, (4) timeliness of nurses' notifications of physicians of significant changes in individuals' health status, and (5) 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 corrective actions were developed to respond to the recommendations referenced in the individuals' death reviews.	
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 almost two years 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 action plan, since the prior monitoring review, nurses attended and participated in the state's risk assessment and planning training program and the State Office Nursing Coordinator's training on the new integrated health care planning process. The facility's self-assessment indicated that over the past six months, there was a focus on reviewing education record and data, which included the training records of RN case managers and the past six months meeting minutes of the Skin Integrity Committee and the infection control and environment of care data maintained by the Infection Control Nurse. Thus, according to the self-assessment, this provision was rated, "not in compliance at this time as further training and evaluation is needed in the area of At Risk." The monitoring team was in agreement with the facility's finding of noncompliance, however, its finding was based upon observations during an annual ISP meeting and reviews of 21 sample individuals' records that revealed that the facility failed to develop and implement a reasonable system of assessing, documenting, reviewing, and revising, as appropriate, the health and behavioral risks of individuals served by the facility. One of the most direct ways that the Nursing Department would improve its performance and compliance with the risk assessment and risk planning processes would be through improving nurses' assessment and documentation of individuals'	Noncompliance

#	Provision	Assessment of Status	Compliance
		indicators of risk, ensuring that interventions to adequately address and reduce individuals' health risks were incorporated into individuals' health care plans, and helping nurses understand and assume the role of the individual's health advocate during the ISP/ISPA processes. During the conduct of the review, the monitoring team attended an annual ISP meeting, which was the first meeting where the latest iteration of the state's new risk assessment and planning process was demonstrated. The ISP meeting was held on behalf of Individual #281. The QDDP who chaired the meeting appeared to know the individual and his mother, who was present, very well. The QDDP was versed in the ISP process and ensured that all participants had the information that they needed to help them knowledgeably discuss and develop an annual plan of care for Individual #281. In addition, prior to the start of the meeting, the QDDP listed Individual #281's strengths and preferences on a poster on the wall. Although the QDDP started the meeting by stating that the individual's strengths and preferences would be incorporated throughout the discussion and development of his plan, this failed to occur. Over the course of the meeting, many aspects of Individual #281's life – his injuries, incidents, medical problems, behavioral problems, dental care, diet, health and behavior risks, relationships, leisure activities, restrictions, and living options – were reviewed and action steps were planned, but the process, which ultimately concluded with a "review of the list" of Individual #281's preferences and strengths, was almost entirely focused on Individual #281's caregivers and the plan for their activities over the next year versus a focus on Individual #281 as a total person, with desires and interests. Thus, the process was not person centered, and new opportunities for Individual #281 to develop personal relationships, increase control over his life, and develop the skills/abilities he needed to achieve his desired goals were not explored. The discussion of Individual #281's health and health risks was interspersed throughout the meeting, but the review and assignment of health risks was placed at the very end and segregated from the team's review and discussion of other relevant aspects of Individual #281's life. All clinical professionals who provided services to Individual #281 attended the ISP meeting, and although there were some occasions when the QDDP needed to prod and probe team members to offer their expertise and provide information, opinions, and recommendations to the team, there were other occasions when the clinical professionals, such as the dentist, dietician, and physician, provided the team with concise summaries of Individual #281's status and progress over the past year In addition, they offered their informed opinions and recommendations for planned interventions that would be implemented over the next year to achieve particular goals.	

#	Provision	Assessment of Status	Compliance
		Thus, the ISP meeting, which took almost three hours to complete, referenced many bits and pieces of what could conceivably become part of a risk action plan and integrated health care plan, but it was unclear how the QDDP and RN case manager would develop these plans based upon the lengthy, and sometimes confusing, discussion of problems versus risks, trigger sheet versus no trigger sheet, and action steps versus planned interventions. The RN case manager who participated in the ISP meeting was knowledgeable of Individual #281's health needs, but he/she failed to offer information about whether or not Individual #281 had progressed toward achieving his health goals with the implementation of the planned interventions in place over the past year. In addition, there were several missed opportunities for the RN case manager to help the QDDP pull together the discussion of Individual #281's health and behavioral needs and risks. For example, during the discussion of Individual #281's scratching behavior and possible need for a body suit, the RN case manager missed the opportunity to raise the likelihood that Individual #281 was scratching because he itched because his skin was dry from his daily use of Dial soap and Hibiclens. Thus, the implementation of a planned intervention, such as daily use of skin moisturizer may have supplanted the discussion of how to achieve authorization for the use of a restraint/body suit. 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 team members, including clinical professionals, receive adequate and appropriate training to ensure that they are aware of the expectations for their participation in the risk assessment and planning processes that falls within their scope of practice. 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, more than half failed to have current risk assessments and as many failed to have a risk action plan filed in their records. Also, a review of the 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' health status and needs occurred. Therefore, this provision item was rated as being in noncompliance. Examples included the following: • Over the past six months, Individual #4 fell over 13 times, and on one occasion, she suffered a serious head injury. Although her IDT met to review her serious injury, the only recommendations that resulted from the meeting were that Individual #4 would be checked every 15 minutes, she would not be allowed to	

#	Provision	Assessment of Status	Compliance
		ride in the van, and that staff were to "monitor" her when she was off the home. It was unclear how any of these aforementioned restrictions would help to reduce the likelihood that Individual #4 would suffer additional falls and injuries, especially since many of her falls occurred in the presence of direct care staff members and/or when she was "just checked" by direct care staff members. Of note, as of the review, her risk assessment related to "falls" was blank, and her risk assessment related to fractures was "low." • Over the past several months, Individual #302 suffered a number of significant changes in his health. He was transferred to unit 673 for medical monitoring and, ultimately, he underwent an esophagogastroduodenoscopy and PEG tube placement. Notwithstanding the many and significant changes in Individual #302's health problems and risks, as of the review, his 2/8/12 risk assessment was not revised to accurately portray his needs. • In June 2012, Individual #204 suffered two fractures and underwent open reduction and internal fixation of her left elbow. There were no ISPAs filed in Individual #204's record and no evidence that her team met to review her serious injuries. In addition, there was no evidence that Individual #204's 1/18/12 risk assessment was reviewed. Thus, Individual #204's level of risk for fractures remained low, as did her risk of pain. Of note, Individual #204's type of fracture was known to be very painful.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	According to the facility's self-assessment, since the prior review, medication reconciliation was reinstituted and monitored by the Medication Variance Committee for identification of patterns and trends in variance. In addition, training sessions were held for nurses to help improve their accuracy when transcribing medication orders to the medication administration records (MARs). Also, in response to a medication error, a root cause analysis (RCA) was performed and the Nursing and Pharmacy Departments conducted a re-enactment of the error to identify factors associated with the error to identify and provide the necessary supervision and training to minimize medication errors. These activities were improvements and stood in stark contrast to the activities of the prior review, which included the surreptitious discontinuation of the facility's medication reconciliation program. Notwithstanding these positive findings, this provision item was rated as being in noncompliance because there continued to be problems in nurses' safe administration of medications, in accordance with standards of practice and problems in nurses' documentation of medication administration records across 16 of the 21 individuals reviewed. Observations of medication administration on various units across the facility revealed	Noncompliance

#	Provision	Assessment of Status	Compliance
		numerous problems with nurses' practices and a significant pattern of failure to comply with basic standards of practice and the Health Care Guidelines. The names and numbers of the units are not given below in order to help the facility address these facility-wide practices rather than focus solely on specific units and nurses. • Nurses did not consistently wash and/or sanitize their hands prior to pouring medications and/or between contacts with individuals. • When 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. • Nurses did not review or properly reference the individuals' MARs during the assembling and administration of medications. • 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 7/1/12 – 8/23/12, revealed that 16 individuals had missing entries in their MARs/TARs, which indicated potential medication errors in the administration of seizure medications, cardiac medications, psychotropic medications, laxatives, calcium/vitamin D, drops, skin treatments, breathing treatments, enteral feedings/fluids, etc. that were not captured by or represented as potential errors in the facility's medication variance database. This was a significant increase from the prior review when only four individuals had missing entries in their MARs/TARS. Also, the review of the 7/1/12 – 8/23/12 MARs/TARS for all 21 individuals revealed that, although all individuals had an order for sunscreen to be applied prior to and during the time that they were outdoors, not one individual's record revealed that sunscreen was used at anytime during the 54-day period of predominantly sunny weather. Notwithstanding the problems noted above, as noted in the prior review, a review of the results of the facility's self-monitoring of medication administration and documentation revealed that problems almost never occurred and nurses' received scores of 95-100% during observations of their administrations of medications. 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	

#	Provision	Assessment of Status	Compliance
		observations of medication administration took place across different units, days, and times, and involved several different nurses. Since the prior monitoring review, the Medication Variance Committee continued to meet on a monthly basis. The monitoring team attended the 8/22/12 meeting during which, old and new business was discussed and medication error reports were presented. During the Committee's review of medication error reports for July 2012, it was revealed that the numbers of reported medication errors dramatically increased from a low of 25 errors reported during 11/11-1/12 to a high of 554 errors reported during 5/12-7/12. Coincidentally, during the above-mentioned period of dramatic increase in reported medication errors, the facility's system medication reconciliation was reinstituted and a pharmacy technician, who counted and reconciled medications upon delivery from the pharmacy, was hired. During the Medication Variance Committee meeting, the following initiatives were put forward for consideration and approval by the Committee: • When the Nurse Managers' investigations of the overages/shortages of medications reveal reasonable explanations for the overage/shortage, such as the individual was in the hospital, out on pass, etc., and concludes that no medication error occurred, these data should be incorporated into the calculation of a reconciliation rate and included in the Medication Variance Trend Report. • Begin systematically reviewing the Medication Administration Observation Reports and report the findings of the review to the committee. • Consider including some trend data in the reports to the Medication Variance Committee. • Spot-check the pharmacy technician's counts of medications delivered to the facility. • Add a review of the components of a physician's order to the nurses' New Employee Orientation. As of the monitoring review, the above initiatives were pending further review by the committee.	

Recommendations:

1. Facility senior management's continued support of the CNE's strategic plan to effectively utilize the nurses in leadership and management positions to achieve substantial compliance with the provisions of section M (M1-M6).

2. Continue to bring administrative and clinical supports to bear on the facility's nursing education and infection control and management programs and processes to ensure that they fully develop into functioning programs/departments (M1- M6).

3. Consider developing focused, real-time interventions to address the pandemic problem of nurses' documentation, or the lack thereof (M1-M6).

4. Continue to work with the Nurse Hospital Liaison to ensure that the expectations of the position are clearly communicated and that barriers to the performance of her job duties are removed (M1).

5. Consider ways to reward nurses' positive performance (M1–M6).

6. Consider ways to remove or diminish the barriers to the RN case managers' ability to focus on their main tasks (M2, M3, M5).

7. Develop ways to help all nurses understand how they should be using the standardized nursing protocols during their daily routines. (M1–M6).

8. Continue to work on ensuring that nurses consistently document health care problems and changes in health status, adequately intervene, notify the physician(s) in a timely manner, and appropriately record follow-up to problems once identified (M1, M4).

9. Ensure that nursing assessments are complete and comprehensive and conducted upon significant change in individuals' health status and risks (M1, M2, M5).

10. The facility should consider providing RN case managers with additional training and support to ensure the successful implementation of the integrated health care planning process (M3).

11. Consider developing additional strategies to continue to improve the collaboration and cooperation between the Nursing and Habilitation Departments, and especially with the PNMT RN, to improve the coordination of individuals' health care (M1-M6).

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 #009.2: Medical Care, 4/19/12 o SASSLC Self-Assessment for Section N o SASSLC Action Plan Provision N o SASSLC Provision Action Information o SASSLC Organizational Charts o Presentation Book for Section N o SASSLC Pharmacy Services, 9/26/11 o SASSLC Quarterly Drug Regimen Reviews, 6/1/12 o SASSLC Adverse Drug Reactions, 9/1/12 o SASSLC Pharmacy and Therapeutics Committee, 12/1/10 o SASSLC Drug Utilization Evaluation Policy, 1/1/12 o Pharmacy and Therapeutics Committee Meeting Minutes, 2/15/12, 5/29/12, 8/21/12 o Medication Variance Review Committee Meeting Notes, 2/15/12, 3/28/12, 4/25/12, 5/30/12 o Polypharmacy Committee Meeting Minutes, 6/22/12, 7/10/12 o SASH Pharmacy Intervention Reports, 2012 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Do Not Crush • Quetiapine o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #245 Individual #282, Individual #148, Individual #336, Individual #111 Individual #315, Individual #42, Individual #3, Individual #284, Individual #88, Individual #270, Individual #196, Individual #291, Individual #295, Individual #11, Individual #205, Individual #230, Individual #96, Individual #215 Individual #188, Individual #127, Individual #302, Individual #129, Individual #12, Individual #160, Individual #168, Individual #330, Individual #194, Individual #339, Individual #171 o MOSES and/or DISCUS Evaluations for the following individuals • Individual #285, Individual #303, Individual #125, Individual #270, Individual #97, Individual #146, Individual #15, Individual #150, Individual #344, Individual #195, Individual #155, Individual #89, Individual #316, Individual #252, Individual #82, Individual #174, Individual #259, Individual #135, Individual #283, Individual #244, Individual #332, Individual #5, Individual #67, Individual #113 Individual #256,

	Individual #304, Individual #60, Individual #341, Individual #89, Individual #157, Individual #201, Individual #9, Individual #42 Interviews and Meetings Held: o Sharon Tramonte, PharmD, Clinical Pharmacist o Nicole Cupples, PharmD, Clinical Pharmacist o Carmen Mascarenhas, MD, Medical Director o Marla Lanni, RN, JD, Chief Nurse Executive o Joann Smith, RN, Medical Compliance Nurse o Liesl Schott, MD, Primary Care Physician o Yenni Michel, DO, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Nurse Practitioner o Mandy Pena, RN, QA Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o ISP for Individual #281
	Facility Self-Assessment: SASSLC submitted three documents as part of the self-assessment process: self-assessment, action plan, and the provision action information. For each of the provision items, the lead clinical pharmacist listed the activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. This was an overall improvement in the self-assessment process. It is important that the facility understand how the monitoring team determines the compliance rating. This can be accomplished by reviewing the report and the various items discussed. Moreover, it will be essential for the self-assessment to include everything that the monitoring team evaluates. The facility rated itself in substantial compliance with provision items N2, N5, and N7. For provision items N1, N3, N4, N6, and N8, the facility rated itself in noncompliance. The facility remained in substantial compliance with provisions N4 and N5. Substantial compliance was also achieved for provision N7. The monitoring team found the facility in noncompliance with provisions N1, N3, and N6. The facility did not maintain substantial compliance for provision N2.

	Summary of Monitor's Assessment: Over the past two years, there was progress in the provision of pharmacy services and safe medication practices. During previous reviews, the monitoring team recommended that the pharmacy department be under the supervision of the medical director. This was based on the fact that many of the activities of the pharmacy department were tightly interwoven with the medical department and would benefit from the guidance of the medical director. The supervision of the pharmacy department was moved from the CNE to the facility director. The medical director, however, continued to have very little involvement in the activities of the pharmacy department because there was no established supervisory relationship. Thus, the pharmacy department, which expanded to include a second clinical pharmacist and a pharmacy technician, had very little clinical oversight for the many activities for which it was responsible. The result was a six-month period in which progress in some areas was overshadowed by a paucity of movement in other areas and significant regression in others. The pharmacist at the State Hospital increased documentation of communication with SASSLC staff, but the communication occurred largely with the nursing staff. Less than 20 percent of the communication transpired with the medical staff. The implementation of prospective lab reviews was not addressed because the facility was awaiting further guidance from state office. There was also a failure to outline the management of drug interactions. Documentation revealed several interactions that should have been discussed with the physicians, but were not. The facility did not meet the requirements to complete Quarterly Drug Regimen Reviews in a timely manner. Data reported by the facility, at the end of August 2010, indicated that more than 21% of the individuals did not have current QDRRs. During the February 2012 review, the monitoring team noted that the timelines were narrowly met for completion of many QDRRs and a cautionary statement regarding this requirement was issued. While the overall quality of the QDRRs was adequate, the facility did not maintain substantial compliance due to the significant number of QDRRs that were not completed. The monitoring for metabolic risks associated with the new generation psychotropic agents was clearly noted in all QDRRs reviewed. A Polypharmacy Oversight Committee was formed just prior to the onsite review. This area will continue to need additional work. The clinical pharmacist reported that the facility did not maintain substantial compliance in provision N4. This was based on the failure to maintain QA documents related to the pharmacy's follow-up on recommendations. The monitoring team noted, through record reviews, that physicians responded to the recommendations of the clinical pharmacist with appropriate actions and orders resulting in a continued rating of substantial compliance. The psychiatrists continued to complete the MOSES and DISCUS evaluations in a timely manner and scores were being reported on the neurology consults. The facility maintained substantial compliance in this area as well. SASSLC did not have an adequate system for detecting, reporting, and monitoring adverse drug reactions. The system was never formally implemented by outlining the program and its requirements. This resulted

	in a series of failures that had the potential to adversely affect the care provided to individuals. Moreover, staff did not receive the appropriate training on detection and reporting of ADRs. The monitoring team surfaced many of these issues over the past two years, but sufficient attention was not devoted to remediation of the deficiencies. Two Drug Utilizations Evaluations were completed. Both were done in a timely manner and presented to the Pharmacy and Therapeutics Committee. Corrective action plans were implemented for identified deficiencies and follow-up was documented. The facility moved to substantial compliance in this area. Progress was noted in the medication variance system based on the re-institution of minimal reconciliation. Continued work was needed to further define the etiologies of the returned medications. Until that occurs, the extent of medication variances at SASSLC will remain largely unknown.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing 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.	Medication orders for the facility continued to be filled by the pharmacy department of the San Antonio State Hospital. Orders were faxed directly from SASSLC to the 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. In February 2012, the State Hospital implemented a new method for documentation of interventions with the intent of ensuring adequate follow-up of interventions and maintenance of documentation. The monitoring team reviewed the documents submitted, which included all interventions recorded since the last onsite review, and the facility's intervention data. The State Hospital's process change resulted in improved documentation of interventions. The average number of interventions per month increased from 16 in the last reporting period, to 78. Notwithstanding the increased documentation of interventions, communication with the facility medical staff remained relatively low. Only 17.5% of the interventions reported occurred with the medical staff. This represented an average of 13.7 interventions per month for a facility with five prescribers. The primary providers indicated, during interviews with the monitoring team, that they received frequent calls from the pharmacy staff. Resolution of interventions also improved since the last onsite review, but remained challenging. The facility's data indicated that 64% of the interventions had documented resolutions. The notes extracts captured several types of issues related to medication orders, such as incomplete orders, allergies, side effects, missing indications, drug doses, and drug interactions. The majority of the interventions were order clarifications that were discussed with the nursing staff. Incomplete orders and missing indications were frequently noted. There were also several interventions related to medication allergies and drug interactions.	Noncompliance

		Based on the documentation, it appeared that, for most drug interactions, the pharmacist called the unit. The nurse subsequently contacted the medical provider for clarification and relayed the clarification and/or approval to the pharmacist. More severe interactions appeared to have warranted direct contact of the physician. On 6/7/12, the pharmacist documented a discussion with a physician regarding two major drug interactions. The pharmacist documented that the physician was aware and would decrease the drug dose. There was no evidence that the physician was provided any written information in the form of a drug monograph for these major drug interactions nor was there any documentation that the dose reduction actually occurred. The facility did not have a process to guide the management of drug interactions. During the February 2012 review, this was discussed and the monitoring team made a specific recommendation to clarify the management of drug-drug interactions by outlining the actions required by all disciplines for each level of drug interaction. These requirements were never codified in policy and procedure. The monitoring team also recommended that the medical director review and analyze intervention data to determine the presence of trends or patterns related to physician practices. The clinical pharmacist reported that this information was provided to the medical director on a monthly basis. Email correspondence to the medical director in mid-July 2012 indicated that the practice had not started, but would begin. The medical director must be aware of the prescribing patterns of the medical staff and any irregularities that occur, so that corrective action can occur. Problems with physician orders also surfaced as part of the medication variance system. The inservice conducted in April 2012, by the clinical pharmacist with the staff on the essential components of medication orders and the facility's approved abbreviation list, was an example of an educational activity that should help to remediate these deficiencies. 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 lead clinical pharmacist reported that no additional work was done in this area due to the ongoing work in state office related to the intelligent alerts pilot. The implementation of this WORx module was scheduled to occur in the near future. Successful implementation of the intelligent alerts at SASSLC will require a great deal of collaboration with the State Hospital. The facility director/designee and state pharmacy lead will need to maintain an active and integral role in this process.	

		The monitoring team found this provision to remain in noncompliance due to the following reasons: • There was relatively little documentation of communication between the pharmacists and the medical providers. • There was no clearly defined process for the management of drug interactions. • The requirement to review the need for laboratory testing had not been implemented.	
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.	Forty QDRRs were reviewed to determine if the facility remained in substantial compliance with this provision item. The QDRRs were thorough and commented on many clinically relevant issues. Each review contained a table that listed pertinent lab values and the dates of the studies. With some exceptions, all values were usually documented. Normal ranges were included in the table. In addition to lab values, the pharmacist 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 weight were noted in most reviews, when appropriate. The comments section included statements on the use of psychotropic medications, seizures, metabolic risk, and the risk of osteoporosis. This was good information and the medical staff commented that it was helpful. The monitoring team did find some QDRRs that lacked recommendations or failed to take all treatment options into consideration. The following are a few examples: • Individual #67, 5/17/12: The clinical pharmacist noted that the individual was at high risk for osteoporosis, but a DEXA was not done "given the risk of GERD and GI bleeding, the individual was not a candidate for anti-resorptive therapy." Comments, such as this were not uncommon. In the management of osteoporosis, consideration should be given to newer classes of medications that are not contraindicated in the presence of diagnoses, such as GERD. • Individual #157, 4/30/12: The individual had a diagnosis of osteoporosis and was treated with vitamin D. There was no other therapy and no DEXA scan was completed. The last DEXA was in 2001. There was no recommendation for a repeat DEXA. • Individual #60, 5/25/12: The individual was treated with a loop diuretic. The last set of electrolytes was documented in November 2011. There were no recommendations to repeat a BMP. The use of diuretics required periodic monitoring of electrolytes as required by the lab matrix. While there were no major issues related to the content of the QDRRs, there were serious problems with the completion of the reviews. The monitoring team requested the dates of completion for all QDRRs. The data submitted showed that at the time of submission in late August 2010, quarterly QDRRs were due, but not completed for 57 individuals. This	Noncompliance

		represented 21% of the individuals living at SASSLC. Moreover, document reviews revealed that for numerous QDRRs, the date of the review differed from the date that the clinical pharmacist finalized the review with a signature. The differences in some instances were noted to be 14 to 30 days. Delays of nearly 80 days were noted for a few reviews. The information included in the QDRRs was, therefore, not transferred to the primary providers and psychiatrists in a timely manner. For Individual #157, 5/27/12, the pharmacist signed the QDRR on 8/19/12. The same dates applied to the QDRR completed for Individual #60. The facility developed a procedure related to the completion of QDRRs in June 2012. The procedure provided guidance on the content of the reviews as well as the timelines for completion of QDRRs. The policy required completion of quarterly QDRRs. A quarterly requirement offered a great deal of latitude in the timelines for completion. This was not consistent with the guidelines issued by state office, which provided more precise timelines for completion. Additionally, the QDRR policy was not consistent with the facility's medical policy, which also included specific timelines for completion of the reviews. The requirement to complete QDRRs on a quarterly (90 day) basis is a fundamental requirement of this provision item. The facility's self-reported data, and document and record reviews demonstrated a significant lack of compliance with this basic requirement. Thus, the facility did not maintain substantial compliance for this provision item.	
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	The five elements required for this provision item were all monitored in the QDRR. Oversight for most was also provided by additional methods and/or committees as described below. <u>Stat and Emergency Medication and Benzodiazepine Use</u> The use of stat medications and benzodiazepines was documented in the QDRRs. For each use, there was a comment related to the indication and the effectiveness of the medication. Facility data showed an overall decrease in the use of benzodiazepines for psychiatric indications. The use of PRN meds is discussed further in section J. <u>Polypharmacy</u> Polypharmacy was addressed in every QDRR reviewed. The pharmacist consistently made recommendations for reduction of polypharmacy as warranted. The facility implemented a Polypharmacy Oversight Committee in June 2012. Three meetings had occurred. The monitoring team attended the meeting during the week of the review. This was the third meeting, but only the second meeting where cases were reviewed. Generally, the participants of this meeting were not prepared, which diminished the effectiveness of the process. Additional work is needed to improve the value of this committee. This is discussed in detail in section J, too.	Noncompliance

	use of new generation antipsychotic medications.	<u>Anticholinergic Monitoring</u> Each of the QDRRs commented on the anticholinergic burden associated with drug use. The risk was stratified as low, medium, or high. The report indicated what signs and symptoms could be seen as a result of the anticholinergic burden. The results of the MOSES and DISCUS evaluations were included and could be cross-referenced. There were no specific recommendations to decrease the anticholinergic burden, but recommendations were frequently noted regarding minimizing polypharmacy and discontinuing unnecessary medications. <u>Monitoring Metabolic and Endocrine Risk</u> The facility monitored individuals for the metabolic risk through the QDRRs. The laboratory matrix included several monitoring parameters, including glucose, HbAlc1, weight, lipid panels, and blood pressure. The QDRR reports consistently included a section/statement related to metabolic risk that provided comments on the relevant parameters. The quetiapine DUE completed in August 2012 showed high compliance rates with laboratory monitoring based on the facility's lab matrix. The facility also collected data on the percentages of individuals who were at risk for development of metabolic syndrome. The exact classification criteria were not known, however, 28.4%, 56%, and 15% were classified as low medium and high, respectively. This provision remains in noncompliance due to the need to develop a more robust system for the review of psychotropic polypharmacy.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Medical providers responded to the recommendations of prospective and retrospective pharmacy reviews. Substantial compliance for this provision item should be determined based on the provider's responses to both prospective and retrospective reviews. Based on the documentation provided, the providers accepted the recommendations made by the pharmacists during the retrospective reviews (QDRRs). For the records included in the record sample, there was evidence that when most providers accepted the recommendations of the pharmacist, there were follow-up actions, such as ordering of labs, changing medication doses, etc. The clinical pharmacist determined that this provision was no longer in substantial compliance due to a lack of QA efforts. While the monitoring team believes that there should be follow-up by the clinical pharmacists and some data elements should be collected, the compliance rating is determined by the actions of the prescribers. Based on the documentation provided, the providers accepted the recommendations made by the pharmacists during the retrospective reviews (QDRRs) and took appropriate actions. Explanations were provided on the QDRR report when the recommendation was not accepted. Therefore, this provision remains in substantial compliance.	Substantial Compliance

		In order for the facility to maintain substantial compliance with this provision item, there must be evidence that the medical staff continue to accept and implement the recommendations of the clinical pharmacists. The medical staff should clearly note in the IPN an explanation when recommendations are not accepted. The clinical pharmacists should conduct follow-up in an ongoing manner to ensure that this occurs.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	A sample of the most recent MOSES and DISCUS evaluations submitted by the facility in addition to the most recent evaluations included in the active records of the record sample was reviewed. The findings are summarized below: Thirty-four MOSES evaluations were reviewed for timeliness and completion: • 34 of 34 (100%) were signed and dated by the prescriber • 22 of 34 (65%) documented no action necessary • 12 of 34 (35%) documented actions taken, such as drug changes and monitoring Thirty-one DISCUS evaluations were reviewed for timelines and completion: • 31 of 31 (100%) were signed and dated by the prescriber • 29 of 31 (94%) indicated no TD • 2 of 31 (6%) indicated the presence of TD The MOSES and DISCUS evaluations assessed were completed by the psychiatrists. The physician reviews were timely and through. Explanations or a plan of action was documented when indicated based on the findings of the examiner. The clinical pharmacist reported that the facility's policy was undergoing revision. An email dated 7/9/12 from the clinical pharmacist informed staff that a decision was made to complete the MOSES and DISCUS every quarter for all individuals who were seen in psychiatry clinic and for all individuals who received Reglan. The email did not specify changes for physician review. Although these rating instruments served as a valuable source of information, record reviews did not reveal any documentation, on the part of the primary provider providers, of discussion of this relevant information. There were a few MOSES evaluations completed by the PCPs. The facility recently revised the neurology clinic template to include the results of the most recent MOSES and DISCUS evaluations for review by the neurologist. The monitoring team has and continues to recommend that the primary care providers review this information. This provision item remains in substantial compliance. In order to maintain substantial compliance, the facility must continue to demonstrate that these evaluations are thoroughly completed in a timely manner. Moreover, the information must be utilized in	Substantial Compliance

		clinical decision-making. In order for this to occur, the data must be reviewed by the primary providers in addition to being reviewed by the psychiatrists and neurologists.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The facility reported adverse drug reactions, but had not developed a formal process for the facility's ADR monitoring and reporting system. The clinical pharmacist maintained an ADR summary log. It included information, such as the suspected drug, reaction, outcome, P&T report date, ADR confirmation, and identifying staff. The log recorded 26 ADRs for the months of February 2012 through June 2012, however, data related to report dates and confirmation were incomplete. Seventy-six percent of the ADRs documented in the summary log were related to either the use of psychotropics or AEDs. The monitoring team attended the Pharmacy and Therapeutics Committee meeting during the onsite review. Twelve ADRs were presented during the meeting. The dates of occurrence ranged from September 2011 to June 2012. The clinical pharmacist reported that these ADRs were discussed with the primary providers. A new ADR report form was utilized, but it did not require the PCP's signature. Almost all of the ADRs discussed should have been presented and reviewed by the Pharmacy and Therapeutics Committee during the May 2012 meeting. This information did not appear to be adequately communicated to all necessary staff. It was clear that, for one individual, the treating psychiatrist administered a stat psychotropic agent without the knowledge of the previous report of a suspected ADR related to psychotropic agents. Thus, the failure to administer this system in the appropriate manner had the ability to adversely impact the care provided to the individuals living at the facility. The majority of the ADRs reported were identified through the QDRRs. Fifty-one percent of ADRs were identified through the QDRRs, 22% through the clinical services meetings, and 21% through the MOSES evaluations. Two percent of the reports originated in the clinics. The clinical pharmacist reported that physicians were reporting ADRs through the clinical services meeting and this was an improvement. The goal of the ADR system is to assist in achieving positive outcomes through a bevy of intermediate benefits. Overall, SASSLC did not maintain an adequate ADR monitoring and reporting system. Over the past two years, the monitoring team recommended the development of a procedure to guide this process. The lack of a formally developed process resulted in a series of failures in this important system: • There were no guidelines regarding the reporting of ADRs to the P&T Committee, which resulted in a failure to report ADRs for up to six months. The lack of the appropriate P&T Committee review precluded the necessary critical analysis of the ADR data to determine the development of patterns or trends. • The ADR reporting form was changed with no discussion or approval by the P&T	Noncompliance

		Committee. This form lacked several essential items including a review by the treating physician. • Staff were not trained on the recognition and reporting of ADRs and the facility's ADR system. The pharmacy policy and procedure manual received following the onsite review included a new ADR policy with an implementation date of 9/1/12. The monitoring team highly recommends that the medical director, facility director and lead clinical pharmacist review the content of the current policy taking note of specific features of an ADR-monitoring and reporting system as noted in previous reports: • All ADRs should be reported to the designated multidisciplinary committee such as the Pharmacy and Therapeutics Committee. This committee should be charged with reviewing ADR data, analyzing the data for patterns or trends, and developing preventive and corrective actions. The committee should also receive follow-up on the status of the corrective actions. • The findings of the ADR monitoring and reporting system should be incorporated into the facility's quality program and medical quality program. The medical staff should receive appropriate information and feedback. There should be continuous monitoring of individual and aggregate data. Opportunities for educational efforts to train on prevention of ADRs should be identified. The daily clinical meeting provides a good forum for such education activities. • 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 discipline-specific training on the recognition of ADRs and the facility's reporting process. Documentation of this training should be maintained • A risk threshold for completion of an intense case analysis should be developed. This provision remains in noncompliance based on the deficiencies previously outlined.	
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	The facility's DUE policy required completion of one DUE each quarter. The facility maintained a DUE calendar and the P&T Committee meeting minutes of 5/29/12 documented discussion of possible future DUEs. Since the last review, SASSLC completed DUEs on crushing medications and quetiapine. Summaries of the information presented in the DUE reports are presented below. The Do Not Crush DUE was completed in May 2012 and presented at the P&T Committee meeting. The objective of the review was to determine if medications that should not be crushed were being crushed before administration. All individuals living at the facility were included in the analysis. Nurses that typically administered the meds were queried regarding administration practices. The clinical pharmacist reviewed all medication	Substantial Compliance

	assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	profiles. The DUE identified problems related to the crushing of medications. This resulted in the development of a corrective action plan. Several of the action steps had occurred at the time of the onsite review. Many others were in progress or scheduled to be started. The P&T agenda included follow-up on the DUE action plan. It appeared that some of the efforts, such as the clinical pharmacist discussing the topic with the nursing staff, occurred just prior to the onsite review. Other actions were scheduled to start over the next few months. The Quetiapine DUE was completed in August 2012 and presented during the August 2012 P&T Committee meeting, which the monitoring team attended. The objective of the evaluation was to determine what indications quetiapine was being used for at SASSLC, to review dosing levels and to determine if monitoring was being consistently done. Twenty-three individuals received quetiapine and all were reviewed. In addition to the review of indications and dose, the DUE assessed compliance with monitoring for blood pressure, weight, CBCs, CMP/HbA1c, annual lipids, prolactin levels, EKGs, eye exams, and EPS. The evaluation did not identify any issues with indications and dosages used at the facility. Overall, compliance with the monitoring parameters was good. The facility identified problems in the areas of monitoring for orthostatic blood pressure changes, EKG monitoring, and yearly eye exams. During the P&T Committee meeting, the clinical pharmacist pointed out that the development of cataracts was observed in association with quetiapine treatment in animal studies. It should be noted that the drug manufacturer clearly notes in the package insert "lens changes have also been observed in adults, children, and adolescents during long-term Seroquel treatment, but a causal relationship to Seroquel use has not been established. Nevertheless, the possibility of lenticular changes cannot be excluded at this time. Therefore, examination of the lens by methods adequate to detect cataract formation, such as slit lamp exam or other appropriately sensitive methods, is recommended at initiation of treatment or shortly thereafter, and at 6-month intervals during chronic treatment." The monitoring team also noted that the requirement for obtaining orthostatic blood pressures was removed from the lab matrix and replaced with monitoring of blood pressure and heart rate. Quetiapine may induce orthostatic blood pressure and the rationale for removing the term from the lab matrix was not clear. These two issues illustrate the importance of defining the correct standards for monitoring. The recommendations of the drug manufacturers must be considered in this process. Overall, the DUEs were well done and provided good information. Physicians did not	

<table>
<tr>
<td></td>
<td></td>
<td>participate in the P&T Committee and were, therefore, not present for the DUE discussion. The medical staff received the DUE information during the morning daily clinical meeting. It would appear that the amount of information conveyed during that morning meeting would be limited given the many topics that must be covered each day. Given the importance of the P&T Committee and the many responsibilities that flow through the committee, the monitoring team recommends and expects greater participation by the medical staff.

While the monitoring team finds this provision to be in substantial compliance, the facility must continue to address several issues:
• Physicians should participate in the quarterly P&T Committee meetings. There should be at least one member of the medical staff, other than the medical director, with active participation.
• Action plans developed through the DUE process should have reasonable timelines for completion of action steps. There should be oversight of these plans by the medical director and/or facility director to ensure that timelines are appropriate.</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 and some progress was noted with regards to the reporting of medication errors and corrective actions implemented. The medication data provided to the monitoring team are summarized in the tables below.

<table>
<tr><th colspan="8">Medication Variances 2012</th></tr>
<tr><th>Jan</th><th>Feb</th><th>Mar</th><th>Apr</th><th>May</th><th>June</th><th>July</th><th>Total</th></tr>
<tr><td>10</td><td>51</td><td>161</td><td>152</td><td>175</td><td>166</td><td>213</td><td>928</td></tr>
</table>

The Medication Variance Committee that was implemented in October 2011 continued to meet, although it appeared that meetings did not occur every month. The monitoring team attended this meeting during the week of the review. Medication data for the month of July 2012 and the trend report were reviewed. Omissions accounted for 732 (79%) of the variances reported in 2012. Problems related to order writing represented four percent of the variances. Omissions were, for the most part, the number of medications retuned to the pharmacy without an explanation. That is, the excess/shortage form did not explain why the medication was returned to the pharmacy. P&T minutes documented the lack of explanations over a period of several months. The minutes for 5/30/12 documented that the lead clinical pharmacist “can only assume that medications were not administered.” While the nurse managers may have had some ideas related to the cause of the returned medications, there were no data presented on the reconciliation of the returned medications. As a result of this, the facility did not have a clear indication of the extent of the medication variances.

Notwithstanding a lack of appropriate reconciliation, there were some improvements in</td>
<td>Noncompliance</td>
</tr>
</table>

		the medication variance system. Reporting for all disciplines was improved. Prescribing errors accounted for five percent of variances. Twenty percent of the variances reported were dispensing errors. Staff at SASSLC received additional training related to order writing. Several of the dispensing errors were considered robot errors. This ongoing problem will need to be addressed with the State Hospital. In response to a medication error in which the individual received another individual's medication, a Root Cause Analysis was conducted. A team consisting of the CNE, clinical pharmacist, QA nurse and direct care staff reviewed the events utilizing standard RCA methodology. This was a positive finding because it demonstrated a relatively quick and appropriate response to a potentially serious problem. The result was analysis of the problem via critical thinking that resulted in the determination of a root cause and implementation of corrective actions. The facility will need to take several actions to move towards substantial compliance: • The facility must reconcile the medications that are returned to gain better knowledge of the extent of the problems that exist within the facility. That is, there should be a clear understanding if the medications returned represent likely errors of omission or if there are explanations for the return of the medication such as hospitalization, refusal, or leave of absence from the facility. • The Medication Variance Committee must provide a report to the pharmacy and Therapeutics Committee. The monitoring team noted that there was no presentation of medication error data during the P&T Committee meeting and the minutes of the 5/29/12 meeting also documented that there was no report of the medication variance data to the committee. As documented in several P&T minutes, the status of medication variances was unknown due to the lack of clear explanation related to the returned medications. This provision, therefore, remains in noncompliance.	

Recommendations:

1. The facility will need to take a number of steps in order to move towards compliance with Provision N1. The monitoring team offers the following recommendations for consideration:
    a. The documentation of communication with prescribers should be improved. The outcomes of the interventions should be documented.
    b. There should be clear documentation of the prescriber who is contacted and the time of contact.
    c. The procedure for management of drug interactions should be clearly delineated. Pharmacists and prescribers should all be aware of this process. Severe drug interactions should require direct communication with the prescriber and written information should be provided in the form of the drug monographs.
    d. The lead clinical pharmacist should assimilate information on the interventions and provide to the medical director for review.

e. The lead clinical pharmacist will need to collaborate with the medical director and State Hospital when the intelligent alert module is released so that the facility can develop a relevant list of drugs for monitoring based on state guidelines.
f. The facility will need to work closely with the State Hospital during implementation of the intelligent alerts. The monitoring team recommends that the facility director or a designee along with the state pharmacy coordinator take an active role in this process.

2. The facility must provide greater oversight for the QDRR procedure given this is a fundamental regulatory requirement. The lack of compliance was not noted in the self-assessment or any other of the facility's compliance reports (N2).

3. The lead clinical pharmacist should review the QDRR policy and ensure that it is consistent with the requirements of the Settlement Agreement, Health Care Guidelines, and state guidelines. The various forms utilized should be included as attachments to the policy (N2).

4. The clinical pharmacists should follow-up on the most critical recommendations before the next quarterly QDRR and data regarding these audits should be maintained (N4).

5. The primary care physicians should review the information included in the MOSES and DISCUS evaluations and utilize the information in clinical decision making. Consideration should be given to including this information in the annual and quarterly assessments (N5).

6. The facility should take multiple actions with regards to the ADR reporting and monitoring system:
   a. The ADR policy should specify how the reporting form is completed.
   b. ADRs should be reviewed by the primary provider, clinical pharmacist, and medical director. All three should be required to sign the ADR reporting form.
   c. The form should indicate who initiated it.
   d. The facility must ensure that all medical providers, pharmacists, nurses, 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
   e. Additional recommendations are contained in the body of report (N6).

7. The medical staff should become more actively involved in the DUE process. They should have the opportunity to fully engage in the DUE discussions. The facility's DUE policy should clarify the requirements for development of the DUE calendar by the Pharmacy and Therapeutics Committee (N7).

8. The nursing department should continue the work on medication reconciliation such that medications retuned to the pharmacy are differentiated from true potential errors of omission (N8).

9. The facility must ensure that appropriate reconciliation of all liquid medications is being completed and documentation is being maintained in a format that can be retrieved and reviewed (N8).

10. The medical, nursing and pharmacy departments should continue their collaborative efforts to ensure that proactive steps occur to improve medication practices at the facility (N8).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC client list o Admissions list o PNMT Staff list and Curriculum Vitae o Staff PNMT Continuing Education documentation o Section O Presentation Book and Self-Assessment o Settlement Agreement Cross-Reference with ICFMR Standards Section O-Physical Nutritional Management o Guidelines for Therapist Monitoring Frequency o SSLC Policy 012.2 Physical Nutritional Management (4/23/12) o PNMT Assessment template o Other PNM assessment templates submitted o HOBE template o PNMT Meeting documentation (2/23/12 to 8/23/12) o Individuals with PNM Needs (7/16/12) o Dining Plan Template o Adaptive Equipment Database (7/19/12) o Habilitation Therapies Trend Reports and Audits submitted o Universal Compliance Monitoring tool templates and instructions o Completed Physical Management Observation Forms (5/12) o Universal Compliance Monitoring Forms submitted (5/12 and 8/12) o Completed Meal Observation Forms submitted (5/12) o Monitoring Forms tracking log o Fall Evaluation/Investigation Form template o PNMT Thresholds for Intervention o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Curriculum for Gait Belt training (5/5/12) o Pneumonia Committee Meeting Notes submitted o Hospitalizations for the Past Year o Summary List of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o List of Individuals with Aspiration and/or Pneumonia o List of Pneumonias in the Past Year

	o Individuals with Pain o Individuals with Choking Incidents and related documentation (Individual #171 o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months o Individuals Having Falls Past 12 Months (7/10/12) o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o Skin Information from January 2012 – July 2012 o Individuals with Fractures Past 12 Months 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 Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o List of Individuals with MBSS (7/20/12) o PNM Maintenance Log o ISP Draft, Annual Integrated Risk Rating Form, and APEN for Individual #281 o Competency Training documentation for Individual #149 o PNMT Assessments, Risk Assessments, Action Plans and ISPs/ISPAs: • Individual #152, Individual #176, Individual #248, Individual #302, Individual #47, Individual #23, Individual #333, and Individual #149 o APEN Evaluations: • Individual #259, Individual #189, Individual #40, Individual #165, Individual #157, Individual #36, Individual #164, Individual #284, Individual #167, and Individual #281, and Individual #217. 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206.

	o PNMP section in Individual Notebooks for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206. o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MA, CCC-SLP o Patricia Delgado, RN o Edward Harris, DPT o Joanna Ramert-VanHoove, OTR o Allison Block Trammell, MA, CCC-SLP o Roberta Washburn, MBA, RD, LD o PNMP Coordinators o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas, dining rooms, day programs (on and off-site) o PNMT meeting o Meeting with PNMT members o PNM Competency Check-offs conducted by the PNMPCs o ISP meeting for Individual #281
	Facility Self-Assessment: SASSLC applied a new model for the self-assessment format for this review. Margaret Delgado-Gaitan, MA, CCC/SLP, the Habilitation Therapies Director, outlined specific assessment activities, some of which were based on previous reports by the monitoring team. She attempted to quantify each and presented findings in the self-assessment report as well as supporting documentation that demonstrated specific accomplishments or steps. The Presentation Book provided a sample of documents to illustrate some of the elements assessed and an analysis of the findings, accomplishments, and work products. While the existing audit tool was referenced in O3, these were not heavily relied on for self-assessment. This was a positive step. While some elements may be valuable in assessing compliance with this provision, others clearly were not and, as such, this tool may be revised to better reflect what is meaningful. The most important next step for Ms. Delgado-Gaitan is to minimally revise the existing audit tool for

	section O. A revised/new version of this tool may be used in addition to the other indicators identified by Ms. Delgado-Gaitan. The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. An action plan to address identified issues can illustrate how Ms. Delgado-Gaitan would intend to proceed toward continued progress toward compliance. This was discussed at length and hopefully will be helpful to her as she moves forward over the next six months. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the clinicians and Ms. Delgado-Gaitan and believes that the facility was continuing to proceed in the right direction. She is highly commended for her leadership, direction and support to the speech staff through this process. Careful review of this monitoring report will provide additional insight into essential measures for self-assessment. The facility self-rated itself as noncompliant with all four items of O (O1 through O8). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: There was a clear progress in this area since the previous review. Many of the recommendations and suggestions made during discussion at that time were either addressed or in the process of being addressed. Margaret Delgado-Gaitan, MA, CCC-SLP, Director of Habilitation Therapies was a strong leader and continued to build a stable and cohesive staff. She appeared to understand the essential elements required for substantial compliance for sections O, P, and R and continued to seek ways to improve the supports and services provided by the department. She continued also to refine the elements of the self-assessment process and many of these were very good, putting the department on the right track. Discussion onsite and the information in this report should be useful to her. There was a fully constituted PNMT, including a full time nurse. The PNMT generally met weekly and attendance, with alternates, was good. A meeting observed during this visit showed significant improvement since the last review. There was, however, no clear leader or facilitator of these meetings and this should be considered as they move forward. The nurse sat "separate" from the group with her back to them much of the time, documenting information on the computer. A system to remedy this was needed in order to permit all team members to contribute fully is needed. Documentation had been reviewed and revised to be more concise and streamlined. Further modifications may be needed to increase organization and ease of tracking and follow-up. They had added clinical indicators, such as hospitalizations, choking, and fractures for automatic review to determine if further assessment and action were indicated. Follow-up of all individuals discussed would be prudent to ensure

	that issues are effectively resolved, and remain so, over time. During the meeting observed by the monitoring team, it was noted that the discussions conducted were thorough. The PNMT had recently reinitiated IDT member participation in their meetings. There had been some confusion over the necessity of this and the process was still unclear. The participation by the team members present on this date was vital to the process, so continuing this is important. It would be critical, however, that the PNMT was respectful of the time and focus of discussion involving the other IDT members to ensure that it was meaningful and productive for all. The PNMT could conduct additional informal brainstorming and problem-solving sessions if needed. This is just one of the many advantages to having a strong and competent team leader to facilitate the meetings. There continued to be some concerns related to mealtimes and position and alignment, though both areas were improved. Some ongoing issues were noted and included: • Food textures related to food service preparation, particularly fruits and vegetables. • Liquid consistencies related to the viscosities of the premixed liquids versus those manually prepared. The clinicians should take care with their recommendations to ensure that the individual's needs were appropriately met. Some of the premixed liquids were much thinner and may be an issue for those who require a much thicker consistency. • Implementation strategies related to level of independence and required verbal and physical prompts. • A need for consistent mealtime or dining room supervisors on duty in each home throughout the meal. • Positioning and alignment in wheelchairs and alternates, such as recliners continued to be problematic. The recliners are difficult to maintain appropriate alignment and support, particularly for activities and participation, and these should be evaluated carefully. Other options to these should be considered, too. • Evaluation was also needed for the blue geri-chairs. There are many custom and commercial products available that would likely better meet the needs of the individuals who currently used these. The newer products are also designed to provide excellent alignment and support, yet ensure ease of mobility for participation in small group settings. Observation of one aspect of NEO training was observed and noted to be excellent. This was conducted by the PNMPCs. There was excellent content and instructional methods. Some additional suggestions were made at that time to further enhance this important staff training. The implementation of true competency-based training continued to be lacking. This training must outline criteria for performance of skills with check-offs of return demonstration. Another area of focus needs to be on the clarification of non-foundational individual-specific training required. Follow-up monitoring of staff should be considered at a specified interval(s) to ensure that continued competency is ongoing and that compliance is consistent once staff are placed into their assignments in the homes.

#	Provision	Assessment of Status	Compliance
01	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 were Patricia Delgado, RN, Edward Harris, DPT, Joanna Ramert-VanHoove, OTR, Allison Block Trammell, MA, CCC-SLP, and Roberta Washburn, MBA, RD, LD. There was no physician core team member, though in some cases, the PCP attended. Ms. Delgado was the only full time dedicated team member as the others each had other caseload responsibilities. Each of these team members were assigned to the PNMT during the previous review. The PNMT had recently resumed including other IDT members, such as the QDDP and psychologist, in their meetings on an as needed basis. There was some confusion as to the role of the nurse case manager with the PNMT and the monitoring team requested clarification of direction provided from state office regarding this issue. Emails received indicated that, for PNMT business, such as completing an assessment or discussing routine matters, additional PNMT members would not be expected to attend. It was reported that, as necessary, other IDT members may be requested to attend or, in some cases, it may be more appropriate for the PNMT to instead attend an IDT meeting to formulate a plan. In that case, it would become part of the ISP and IHCP. Continuing Education Continuing education was documented for each of the core members of the team in the last six months and included the following. Some were attended by one or more core team members: • Wheelchair, Seating Mobility and Positioning (three hours) • Managing Dysphagia (one hour) • The Elderly: Nutritional Needs, Challenges, Screening and Solutions Webinar (one hour) • TSHA 2012 Annual Convention (10 hours) This level of continuing education was adequate. It is critical that this team continue to achieve and maintain the highest possible knowledge and expertise in the area of PNM. Consideration of continued PNM-related continuing education opportunities for all team members, in addition to the state-sponsored conferences/webinars, should be a priority. Cross-training in areas traditionally viewed as pertaining to a specific discipline would also be highly useful to enhance team building and the transdisciplinary approach. Qualifications of Core Team Members Background and experience for these team members was reported in previous reviews. Each had multiple years of experience with individuals with developmental disabilities and PNM. Current licenses to practice in the State of Texas were verified for all team members.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>
<u>PNMT Meeting Frequency and Membership Attendance</u>
There were, generally, one time weekly meetings held from 2/23/12 through 7/17/12; 22 listed in total. This frequency was appropriate. Attendance during that period was:

RN: 100%
PT: 100%
OT: 100% with alternate
SLP: 100 % with alternate
RD: 100% with alternate, though several were via teleconference

<u>Role of the PNMT: Facility PNMT Policy</u>
The state PNMT process was outlined in a policy that described the referral process and PNMT member responsibilities. Appropriate referrals included individuals at high risk who were not stable and/or for whom the IDT required assistance in the development of an intervention plan to address PNM concerns. This included the IDT, of which the PCP was a member, and self-referrals by the PNMT based on review of key clinical indicators. There was no other local operational policy.

SASSLC PNMT Thresholds for Intervention had been developed and implemented on 5/17/12. This document listed a variety of health risk areas and outlined specific conditions to be tracked routinely. At designated thresholds, the PNMT included the individual on the agenda for discussion to determine if actions or interventions were needed and then, at additional thresholds, automatic actions were taken by the PNMT including assessment.
<table>
<tr><th>Risk Area</th><th>PNMT Tracking</th><th>PNMT Discussion</th><th>PNMT Automatic Action</th></tr>
<tr><td>Aspiration</td><td>• Aspiration Pneumonia
• Emesis</td><td>• 1 episode of aspiration pneumonia
• 3 episodes of emesis in 1 month
• MBS study</td><td>• 2 episodes of aspiration pneumonia in 1 year
• 3 episodes of emesis in 1 month for any two months in a year</td></tr>
<tr><td>Falls</td><td>Falls</td><td></td><td>• 3 falls in a month</td></tr>
<tr><td>Skin Integrity</td><td>Decubitus</td><td></td><td>• 2 Stage II wounds in 12 months
• Delayed healing
• Any Stage III or IV</td></tr>
<tr><td>Fractures</td><td>Fractures</td><td></td><td>• Fracture of a long bone</td></tr>
<tr><td>Choking</td><td>Choking Incidents</td><td>• 1 choking incident</td><td>• 2 or more choking incidents in 1 year</td></tr>
<tr><td>Weight</td><td>Individuals monitored for weight loss</td><td></td><td>• Continued undesired weight loss totaling ≥10% for 3 months</td></tr>
<tr><td>Respiratory</td><td>Hospital visits</td><td></td><td>• 2 respiratory-related hospital visits in 6 months</td></tr>
</table>
</td><td></td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td></td><td></td><td>• 2 non-aspiration pneumonia episodes in 6 months</td></tr>
<tr><td>Bowel Obstruction</td><td>Hospital visits</td><td>• 1 hospitalization</td><td>2 hospital visits for bowel obstruction in 1 year</td></tr>
<tr><td>Dehydration</td><td>Hospital visits</td><td></td><td>• 2 hospital visits for dehydration in 6 months</td></tr>
<tr><td>GI</td><td>Hospital visits</td><td>• 1 hospitalization for GI bleed or other GI issue
• Consideration of g-tube placement</td><td>• New g-tube placement</td></tr>
</table>

It was reported in the section O Presentation Book that, based on these guidelines, it was determined that 15 individuals were identified who met criteria, yet only six of these had been assessed by the PNMT (40%) through 7/20/12. By report, assessments had been initiated for three others as of 8/7/12. The team planned to evaluate the others, as well. In addition, the PNMT was to review thresholds on a monthly basis. While improved, the documentation continued to be somewhat disjointed and difficult to follow. Continued improvements with this will permit the team to ensure that all individuals are included with consistent follow-up.</td><td></td></tr>
<tr><td>O2</td><td>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</td><td><u>PNMT Referral Process</u>
Though the Thresholds for Intervention were developed, these were guidelines for PNMT tracking, and guidelines for actions taken by the team (via self-referral). It did not provide any guidance or guidelines for the IDTs to make the decision to refer to the PNMT.

The SASSLC PNMT developed a PNMT Action Plan (in conjunction with the IDT) that outlined responsibilities and actions from the PNMT assessment, rather than integrating these into a revised IDT Action Plan (which they may want to consider in the future). It is likely that there was already an existing plan for risk issues not addressed by the PNMT and this would prevent there being multiple plans.

As with the other plan, the QDDP would be responsible for ensuring that all aspects of the plan were implemented appropriately and in a timely manner. This information is a key element to the effective provision of services by the PNMT and should be tracked and analyzed. Actions outlined in the plan were reviewed at the PNMT meetings and follow-up/outcomes were documented for each. In the case that an individual was hospitalized, the PNMT RN completed a post-hospitalization assessment of status to ensure that the individual’s needs were clearly identified and met.</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>problems to identify the causes of such problems.</td><td>Comprehensive PNMT assessments submitted were completed as follows:

<table>
<tr><td>Name</td><td>Date of Referral</td><td>Assessment Date</td></tr>
<tr><td>Individual #311</td><td>Not documented</td><td>2/9/12</td></tr>
<tr><td>Individual #149</td><td>2/29/12</td><td>undated</td></tr>
<tr><td>Individual #176</td><td>4/19/12</td><td>5/19/12</td></tr>
<tr><td>Individual #23</td><td>7/26/12</td><td>8/17/12</td></tr>
<tr><td>Individual #47</td><td>7/26/12</td><td>8/16/12</td></tr>
<tr><td>Individual #152</td><td>4/19/12</td><td>5/24/12</td></tr>
<tr><td>Individual #248</td><td>6/21/12</td><td>7/19/12</td></tr>
<tr><td>Individual #302</td><td>7/26/12</td><td>8/9/12</td></tr>
</table>

83% (5/6) of the assessments with referral and assessment dates were completed in one month or less. This was a reasonable timeframe for completion. With identified needs, there should be a sense of urgency to complete the assessment and implement appropriate interventions to address the identified needs. As described above, there were a number of individuals who had not yet received a PNMT assessment despite the identification of need. While the new system implemented on 4/16/12 should assist them in better tracking, it is critical that these assessments be completed in a timely manner. These individuals were identified as having significant need for supports and services to mitigate identified PNM health concerns.

<u>PNMT Assessment and Review</u>
Six of the eight most current assessments were noted to generally be of a similar format. Only three of these appeared to be completed, signed, and dated by the team members. The assessment for Individual #152 was signed, but was lacking a monitoring plan and criteria for discharge, review, or reassessment. The others were lacking measurable outcomes, a monitoring plan, criteria for discharge from the PNMT, and criteria for further review (Individual #23 and Individual #47). Individual risk levels at the time of the assessment and rationale were included in each, though it was not clear if these were developed by the PNMT, the IDT, or a collaboration. Most of the documentation in the assessment appeared to be from extensive record review and included respiratory and GI concerns as well as surgeries, hospitalizations, and consults.

There were brief clinical assessments in the following areas: nursing physical assessment, diet history, skin integrity, eating problems with an oral motor assessment, and positioning and mobility status. Other areas briefly addressed were behavioral challenges and communication.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		While health and medical history were necessary to gain perspective on the individual's current status, it was critical that a hands-on assessment of current status be documented by all team members. The information presented should be analyzed to identify correlations, antecedents, and other relationships. The most extensive aspect of these assessments was the medication review, pertinent laboratory results for drug therapy monitoring, and related comments from the record provided by Sharon Tramonte, Pharm D. The analysis of findings, however, did not consistently reflect use of the majority of the data presented, and the comments there did not necessarily provide a rationale for the recommendations made (Individual #302, Individual #152, and Individual #23). In the case of Individual #47, a full PNMT assessment was conducted, but the brief analysis was limited to her falls only. While this was the reason for referral, there were no comments as to the data reported in other areas of PNM. Since she met the threshold for action by the PNMT, it would be expected that PNMT would use all the information gathered. If there were no remarkable findings, this should have been clearly stated. The PNMT did not consistently document any judgment as to the accuracy of the risk levels in the assessment. Much of the assessment was not reader-friendly, with many abbreviations, shorthand symbols, use of a significant amount of professional jargon, and incomplete sentences. In the case of Individual #152, an eight-page report was written and the analysis section did not consist of any clinical reasoning to explain why he was presenting with persistent aspiration pneumonia and infection secondary to impaired skin integrity and what interventions and supports were needed to mitigate these concerns. Rather only vague and general statements were presented, such as: • Oral hygiene needed to be improved. • Required total assistance for all needs. • PNMP needed continuous updates for various reasons. The recommendations listed were limited to: • PNMP updated to not put pillows under each shoulder, may place a pillow under forearm, set air mattress to 5, and change large boots to small boots. • Change choking risk from medium to low due to no oral intake. • Request dental consult for directions on how to implement oral hygiene. There was no rationale in the analysis to justify these very limited actions. The dental consult should have been completed so that interventions could be implemented. The analysis should capture the PNMT's opinions/rationale for the necessary actions required to address the issues defined. The analysis of findings was weak in these reports and did little to present the clinical reasoning used to identify and interpret the primary issues and to select specific interventions and supports.	

#	Provision	Assessment of Status	Compliance
		Finally, the clinical indicators were not defined, such as established thresholds, baselines, or clinical criteria. The Action Plan for this element indicated that a prompt had been added to the analysis section of the PNMT evaluation as of 4/13/12. It would appear that this was ineffective and/or not actually implemented. This will require immediate attention because an appropriate analysis is critical to the design of effective supports and services by the PNMT. An audit tool was designed, but not yet implemented. A PNMT meeting was observed by the monitoring team. A significant amount of information was discussed that did not appear to require other IDT members and it was of concern that it was not good use of their time, particularly in the case of the physician. The system of documentation by the PNMT, however, was an improvement since the previous review. Again, while the PNMT is commended for its efforts and dedication to complete and accurate documentation, the monitoring team challenges them to evaluate the current system to identify ways to streamline the process and documentation. <u>Risk Assessment</u> Risk rating tools and/or action plans were submitted for the 12 of 17 individuals (71%) in the sample for whom individual records were requested (though both documents were not available for Individual #138, Individual #206, Individual #215, Individual #302, and Individual #241). The risk assessment in Individual #176's individual record was actually Individual #217's. These tools were to be completed by the IDT at the time of the annual ISP with routine review after hospitalizations or other changes in status. An action plan was developed to manage or mitigate identified risks. There were a number of inconsistencies in the risk ratings for a number of individuals. Though improved since the previous review, there was no rationale provided for a particular rating in some cases and ratings were often inconsistent with clinical indicators. Some examples are below. • Individual #114 was identified at medium risk for aspiration, but the rationale merely indicated that he had been hospitalized for aspiration pneumonia. It did not address other related issues that would impact his risk for additional occurrences. He was identified at low risk for cardiac disease. The rationale was limited to that he did not have a diagnosis of cardiac concerns and did not take related medications. There was no discussion of any potential factors, such as family history, for example, that may predispose him to this condition. • Individual #241 was identified at low risk in 13 of 22 indicators. There was no rationale provided for any. He was listed at medium risk for seizures and osteoporosis. • Individual #302 was listed at high risk for dental concerns, yet no rationale was	

#	Provision	Assessment of Status	Compliance
		documented. He was listed at medium risk for gastrointestinal concerns, which was increased since 2/8/11 when he was considered low. The rationale was only that he had a history of GERD and took a GERD-related medication. He was listed at medium risk for osteoporosis and high risk for falls, yet only at low risk for fractures. There were additional potential inconsistencies with regard to risk assessment and actual occurrences of health issues. There were five individuals who were listed with an unplanned weight loss of 10% or greater over a six month period, yet at least three were identified as low risk for weight issues (Individual #150, Individual #122, and Individual #23). There were 27 individuals (10% of the census) with a BMI under 20, which suggested that they were on the low end of their weight ranges and four of those were considered to be underweight with a BMI of 18 or below (Individual #171, Individual #110, Individual #138, and Individual #302). With any additional weight loss, these individuals potentially would be at greater risk for related health concerns and diligent monitoring was required to ensure weight stability or to promote weight gain. Eighteen of them, however, were considered to be at low risk for weight concerns. Individual #138 was not included in the list submitted, though had a BMI of 15.1, significantly underweight. There were 19 individuals with BMIs greater than 30, in the obese range, three over 40 (morbidly obese). Five of these individuals were identified only at low risk with regard to weight. One of these, Individual #152, had a BMI of 44.1. Seven others were listed at medium risk. Individual #302 was identified with a fecal impaction in the last 12 months, yet he was considered at only medium risk for GI concerns and constipation/bowel obstruction. There were eight individuals listed with Stage I, II, and/or III decubitus/pressure ulcers, four of whom had more than one incidence in the last seven months. Individual #325 was listed at low risk for skin integrity and four others were listed at medium risk, despite multiple incidences (Individual #215).	
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	<u>PNMP Format and Content</u> It was reported that 250 individuals at SASSLC had identified PNM needs and, as such, should be provided PNMPs (91% of the census). Only 161 PNMPs were submitted, however. Comments below relate only to the PNMPs submitted for the individuals in the sample (17). Improvements in the format and content were noted. Continued improvements in the implementation of the plans were also observed. • PNMPs for 16 of 17 individuals in the sample (94%) were current within the last 12 months. The PNMP for Individual #122 was expired on 6/22/11. His was not included in the review of PNMP content that follows. • PNMPs for 16 of 16 individuals in the sample (100%) were of the same format	Noncompliance

#	Provision	Assessment of Status	Compliance
	and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	and consistent with the most current state-established format that included risk levels, triggers, and outcomes. • PNMPs for 16 of 16 individuals in the sample (100%) included a list of risk areas, including the actual risk level of high, medium, or low. Each of those listing the risk areas also provided a brief rationale. • In 12 of 16 PNMPs (75%), photographs of positioning were included, though four of these individuals were identified as independent with mobility and positioning. Individual #270 was listed with a gait belt and rollator walker, but there were no pictures of these being used with him. There were no pictures with the PNMP for Individual #302, though he had a wheelchair, gait belt, shower chair and walker. The others showed pictures of the individual in their wheelchairs only and did not picture any other adaptive mobility or positioning equipment. The photographs were generally large and easy to see. For that reason, only color copies should be made available for staff reference in all locations. • In 16 of 16 PNMPs (100%), positioning was addressed. • In 2 of 13 PNMPs (15%) for individuals who used a wheelchair as their primary mobility, some positioning instructions for the wheelchair were included, though this was generally very minimal. • In 16 of 16 PNMPs (100%), the type of transfer was clearly described or there was a statement indicating that the individual was able to transfer without assistance. • In 0 of 16 PNMPs (0%), the PNMP had a distinct heading for bathing instructions. In 13 PNMPs, the bathing equipment was listed under adaptive equipment, but no other instructions regarding use or positioning. There were only two individuals with any instructions related to bathing. Most stated that no special instructions were needed. • In 5 of 16 (31%) of the PNMPs, toileting-related instructions were provided, included under activities of daily living. • In 16 of 16 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning or the individual was listed as independent. • In 16 of 16 PNMPs (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • There were 4 of 16 individuals who had feeding tubes. The PNMPs indicated nothing by mouth as indicated for these individuals (100%). • In 3 of 16 PNMPs (19%), dining position for meals or enteral nutrition was provided via photographs. The three individuals were pictured receiving enteral nutrition. There were no photographs provided for Individual #302. Full view pictures of mealtime positioning were provided in Dining Plans for six individuals. • 13 of 13 individuals who ate orally (100%) had Dining Plans current within the	

#	Provision	Assessment of Status	Compliance
		last 12 months contained in the individual record or book. The Dining Plan for Individual #122 was submitted, though a PNMP was not. • In 11 of 12 PNMPs (92%) for individuals who ate orally, diet orders for food texture were included. The diet texture for Individual #114 was stated as solid, which was not a standard texture category. • In 12 of 12 PNMPs for individuals who received liquids orally (100%), the liquid consistency was clearly identified. In some cases liquids were described as regular or thin, so the terminology was inconsistent. • In 12 of the 12 PNMPs for individuals who ate orally (100%), dining equipment was specified in the dining equipment section or that the individual uses regular dinnerware or utensils. In the case of Individual #241, no utensils were specified. • In 16 of 16 PNMPs (10%), a heading for medication administration was included in the plan. This included medication texture, liquid consistency, positioning. There was a reference to the dining equipment section for the appropriate adaptive equipment. This was one of the most complete sections of the plan. The clinicians may want to consider identifying the specific adaptive equipment in this section and state that none was needed in the case that this was indicated. • In 16 of 16 PNMPs (100%), a heading for oral hygiene was included in the plan, though this section addressed positioning only. • 16 of 16 PNMPs (100%) included information related to communication. A reference was made to the communication plan when there was one. This description was limited to expressive communication only in most cases. A plan for auditing the PNMPs had not yet been implemented to ensure that all content areas were included and to ensure consistency of content. A target date of 9/1/12 was established in the action plan for this provision. <u>Integration of the PNMPs in the ISPs/ISPAs</u> There were 17 ISPs submitted for the 17 individuals included in the sample selected by the monitoring team. Only 13 of those were current within the last 12 months and signature sheets were included for only nine of those. ISP meeting attendance by the following team members was as follows for the current ISPs included in the sample for whom signature sheets were present in the individual record, though there were generally other team members in attendance (also see section F above): • Medical: 11% (1/9) • Psychiatry: 0% (0/9) • Nursing: 67% (6/9) • RD: 11% (1/9) • Physical Therapy: 44% (4/9) • Communication: 33% (3/9)	

#	Provision	Assessment of Status	Compliance
		• Occupational Therapy: 22% (2/9) • PNMPC: 11% (1/9) • Psychology: 78% (7/9) • Dental: 0% (0/9) It is not 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 cannot be reviewed and revised in a comprehensive manner by the IDTs. The Physical Nutritional Management Plan was referenced in 11 of the 12 current ISPs (92%). The sections varied as well as the content, though the newer format ISPs stated specifically that the IDT had reviewed the PNMP and that it continued to be appropriate. It would be important to address any changes needed in the plan per the assessments completed. In no cases were specific strategies included and none listed any required changes identified. These statements, however, did not reflect a substantial discussion and review of the efficacy of the strategies included in the plan. This did, however, reflect a considerable improvement in this area since the previous review by the monitoring team. Training for QDDPs had been conducted to address this issue, with an annual and quarterly review of the PNMP documented in each document. The self-assessment indicated that integration of the PNMPs reviewed for a sample of individuals with ISPs held from February 2012 to June 2012, was at 71%. While the monitoring team noted that the PNMP was referenced in most of the ISPs reviewed, this was not an indication of the integration expected. The current tool for self-assessment did not clearly identify the criteria for this element. The standard should be identified to ensure consistency across ISPs and to assist the QDDPs in meeting this standard in their facilitation of ISP meetings and subsequent documentation of PNMP review and approval.	
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	<u>PNMP Implementation</u> PNMPs and Dining Plans were developed by the therapy clinicians with variable input by other IDT members. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input were limited. There was little evidence of ISPAs for required changes in the PNMPs. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve IDT involvement in the development of the plans. Dining Plans were available in the dining areas. Generally, the PNMP was located in the	Noncompliance

#	Provision	Assessment of Status	Compliance
	during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	individual notebook in the back of an individual's wheelchair, if he or she had one, or was to be readily available nearby. Wheelchair positioning instructions were generally not individual-specific in the PNMPs. 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 NEO and in individual-specific training provided by the therapists and PNMPCs. Observations There was clear improvement related to mealtimes in the homes observed by the monitoring team. There were only a few notable concerns related to implementation are presented below: • Individual #79: Her thighs were angled down and her feet were not well supported. The photograph with her PNMP showed a solid foot rests, though her current wheelchair had separate footrests. There were two different DPs in her individual notebook • Individual #340 and Individual #241 were served pureed spinach for the chopped spinach they were prescribed. By report, food service indicated that they could not prepare chopped spinach, so individuals on any modified diet were served pureed spinach. • There were no adjustable height stools for staff in order to sit eye level with individuals. Staff sat in regular dining chairs, which made it difficult for them to sit in good alignment and also took up a lot of room in an already crowded dining room. These should be considered for all dining rooms, particularly for those with individuals who require physical assistance and verbal and physical prompts throughout the meal. This would allow all staff to be seated, comfortably, and in good alignment throughout the meal. • Individual #235: There was no dining plan available. The monitoring team had to request it. • In most of the dining rooms, there lacked a manager or supervisor who provided oversight and direction to the direct support staff. This role was generally filled by the PNMPCs. While this was a reasonable approach for gaining compliance with the dining plans, the responsibility for this should now be assigned to a dining room supervisor. This will ensure that the homes take ownership for compliance. The PNMPCs could then provide more in the way of monitoring and staff training. Dining room supervisors would require specialized training to ensure that they understand their roles and responsibilities and to gain further knowledge and skills related to the implementation of dining plans and PNMPs. Though also improved, positioning and alignment remained to be a problem area as before because staff attention to detail was lacking. There were many examples of this, though none were serious. It was noted that some of the less complex wheelchairs were	

#	Provision	Assessment of Status	Compliance
		in poor condition and did not provide adequate support and alignment. A number of individuals were seated in geri-chairs that did not provide appropriate support and alignment. Individuals with these types of seating system should become a focus for assessment, modifications, and/or new systems as needed. Cleanliness appeared to be an issue. • Individual #239: He was observed sitting in a recliner in the sensory area of DC. The seatbelt was attached across his abdomen. One staff had started the transfer with a mechanical list by herself, and then a second staff moved to help as required. Individual #239 (and several others) were wearing huge boots intended for protection, but that were also very heavy, possible placing significant stress on the hips and knees while sitting. Their legs were torqued awkwardly due to difficulty positioning and supporting these boots. A different product should be considered. • Individual #30: He was seated in an old-style Inva-Care chair. Numerous others were noted in Home 671. These individuals should be evaluated for more individualized seating that could incorporate both custom and commercial components for improved support and alignment. • Individual #79: Her thighs were angled down and her feet were not well supported in her wheelchair. The photograph with her PNMP showed solid foot rests, though her current wheelchair had separate footrests. There were two different DPs in her individual notebook. • Individual #248: The pictures in his PNMP were not dated. He was observed slumped down in his wheelchair with his head below the headrest and his legs extended at least six inches beyond the edge of the seat. After comment by the monitoring team, staff tried to reposition him, though this was not successful. They reported that they frequently had this problem. • Individual #328: She was slumped down in the recliner in the sensory area of DC. Her head was forward on her arms. Staff continued to present activities without attempting to reposition her. Her face was not visible, essentially buried on her arms and the armrest and she could not see the activity. • Individual #151: He was to wear elbow pads on both elbows per his PNMP, though only the right one was on. It was not actually positioned on his elbow, but down on his forearm. His elbow was resting on this wheelchair tray. • Individual #41: He was to wear a sling for a shoulder injury, but his arm was not fully in the sling and it provided no support at all to the arm. The majority of staff struggled to verbalize the rationale for the strategies in the plans and to answer questions related to individual health risks, but as usual, there were some others who demonstrated excellence with regard to this.	

#	Provision	Assessment of Status	Compliance
		The self-assessment indicated that there were no facility-wide issues identified from the trend analysis of the monitoring data conducted. There was an indication of negative trends in various homes that required action to correct. See O6 below for further comments related to PNM monitoring. Choking/Aspiration Events There was one choking incident since the previous review (Individual #171, 3/23/12). The SLP was notified within an hour and documented that he could not be evaluated at that time (due to the need for chest x-rays) and ordered a downgrade to pureed foods. The SLP completed a follow-up assessment at lunch on 3/35/12, after the weekend. The findings were not significantly different than in previous assessments. A MBSS was completed on 4/5/12 with a diagnosis of moderate oropharyngeal dysphagia. Recommendations included pureed foods and honey-thick liquids. The liquid consistency was a significant change from his previous diet order and it was of concern that this need had not been identified until he experienced an additional choking incident on a food item. He had experienced choking incidents in 2003, 2005, 2010, and this one in 2012. He also had a severe coughing episode in 2009. While modifications to his dining plan were made after those events, there was no evidence of a MBSS until after the event this year. There was no evidence of a referral for a PNMT assessment. While the response to this 3/23/12 choking episode was prompt, it was of concern to the monitoring team that he had not been fully evaluated by the PNMT prior to that time. At the 3/29/12 PNMT meeting, Individual #301 was reported to have had a choking incident and Individual #250 had an aspiration event. These were not included in the list provided to the monitoring team. Individual #250 was admitted to the hospital several days later. There was no evidence of any further follow-up for these three individuals by the PNMT in the meeting documentation submitted.	
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.	PNMP Implementation PNMPs and Dining Plans were developed by the therapy clinicians with variable input by other IDT members. Attendance by PNM-related professionals at the ISP meetings was limited and, as such, discussion and input were limited. There was little evidence of ISPAs for required changes in the PNMPs. Continued efforts to increase attendance at the ISPs and ISPAs, and continued participation of other team members in this process, should improve 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. Wheelchair positioning instructions were generally not individual-specific in the PNMPs. General practice guidelines with regard to transfers,	Noncompliance

#	Provision	Assessment of Status	Compliance
		position and alignment of the pelvis, and consistent use of foot rests and seat belts were taught in NEO and in individual-specific training provided by the therapists and PNMPCs. Observations There was clear improvement related to mealtimes in the homes observed by the monitoring team. There were only a few notable concerns related to implementation are presented below: • Individual #79: Her thighs were angled down and her feet were not well supported. The photograph with her PNMP showed a solid foot rests, though her current wheelchair had separate footrests. There were two different DPs in her individual notebook • Individual #340 and Individual #241 were served pureed spinach for the chopped spinach they were prescribed. By report, food service indicated that they could not prepare chopped spinach, so individuals on any modified diet were served pureed spinach. • There were no adjustable height stools for staff in order to sit eye level with individuals. Staff sat in regular dining chairs, which made it difficult for them to sit in good alignment and also took up a lot of room in an already crowded dining room. These should be considered for all dining rooms, particularly for those with individuals who require physical assistance and verbal and physical prompts throughout the meal. This would allow all staff to be seated, comfortably, and in good alignment throughout the meal. • Individual #235: There was no dining plan available. The monitoring team had to request it. • In most of the dining rooms, there lacked a manager or supervisor who provided oversight and direction to the direct support staff. This role was generally filled by the PNMPCs. While this was a reasonable approach for gaining compliance with the dining plans, the responsibility for this should now be assigned to a dining room supervisor. This will ensure that the homes take ownership for compliance. The PNMPCs could then provide more in the way of monitoring and staff training. Dining room supervisors would require specialized training to ensure that they understand their roles and responsibilities and to gain further knowledge and skills related to the implementation of dining plans and PNMPs. Though also improved, positioning and alignment remained to be a problem area as before because staff attention to detail was lacking. There were many examples of this, though none were serious. It was noted that some of the less complex wheelchairs were in poor condition and did not provide adequate support and alignment. A number of individuals were seated in geri-chairs that did not provide appropriate support and alignment. Individuals with these types of seating system should become a focus for	

#	Provision	Assessment of Status	Compliance
		assessment, modifications, and/or new systems as needed. Cleanliness appeared to be an issue. • Individual #239: He was observed sitting in a recliner in the sensory area of DC. The seatbelt was attached across his abdomen. One staff had started the transfer with a mechanical list by herself, and then a second staff moved to help as required. Individual #239 (and several others) was wearing huge boots intended for protection, but that were also very heavy, possible placing significant stress on the hips and knees while sitting. Their legs were torqued awkwardly due to difficulty positioning and supporting these boots. A different product should be considered. • Individual #30: He was seated in an old-style Inva-Care chair. Numerous others were noted in Home 671. These individuals should be evaluated for more individualized seating that could incorporate both custom and commercial components for improved support and alignment. • Individual #79: Her thighs were angled down and her feet were not well supported in her wheelchair. The photograph with her PNMP showed solid foot rests, though her current wheelchair had separate footrests. There were two different DPs in her individual notebook. • Individual #248: The pictures in his PNMP were not dated. He was observed slumped down in his wheelchair with his head below the headrest and his legs extended at least six inches beyond the edge of the seat. After comment by the monitoring team, staff tried to reposition him, though this was not successful. They reported that they frequently had this problem. • Individual #328: She was slumped down in the recliner in the sensory area of DC. Her head was forward on her arms. Staff continued to present activities without attempting to reposition her. Her face was not visible, essentially buried on her arms and the armrest and she could not see the activity. • Individual #151: He was to wear elbow pads on both elbows per his PNMP, though only the right one was on. It was not actually positioned on his elbow, but down on his forearm. His elbow was resting on this wheelchair tray. • Individual #41: He was to wear a sling for a shoulder injury, but his arm was not fully in the sling and it provided no support at all to the arm. The majority of staff struggled to verbalize the rationale for the strategies in the plans and to answer questions related to individual health risks, but as usual, there were some others who demonstrated excellence with regard to this. The self-assessment indicated that there were no facility-wide issues identified from the trend analysis of the monitoring data conducted. There was an indication of negative trends in various homes that required action to correct. See O6 below for further	

#	Provision	Assessment of Status	Compliance
		comments related to PNM monitoring. Choking/Aspiration Events There was one choking incident since the previous review (Individual #171, 3/23/12). The SLP was notified within an hour and documented that he could not be evaluated at that time (due to the need for chest x-rays) and ordered a downgrade to pureed foods. The SLP completed a follow-up assessment at lunch on 3/35/12, after the weekend. The findings were not significantly different than in previous assessments. A MBSS was completed on 4/5/12 with a diagnosis of moderate oropharyngeal dysphagia. Recommendations included pureed foods and honey-thick liquids. The liquid consistency was a significant change from his previous diet order and it was of concern that this need had not been identified until he experienced an additional choking incident on a food item. He had experienced choking incidents in 2003, 2005, 2010, and this one in 2012. He also had a severe coughing episode in 2009. While modifications to his dining plan were made after those events, there was no evidence of a MBSS until after the event this year. There was no evidence of a referral for a PNMT assessment. While the response to this 3/23/12 choking episode was prompt, it was of concern to the monitoring team that he had not been fully evaluated by the PNMT prior to that time. At the 3/29/12 PNMT meeting, Individual #301 was reported to have had a choking incident and Individual #250 had an aspiration event. These were not included in the list provided to the monitoring team. Individual #250 was admitted to the hospital several days later. There was no evidence of any further follow-up for these three individuals by the PNMT in the meeting documentation submitted.	
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.	New Employee Orientation Staff training was provided across key content areas related to PNM supports. Training for the dysphagia aspect had been revised since the previous review and was taught by Ron Hoffmann, MS, CCC-SLP. This addressed diet textures and liquid consistencies, mealtime positioning and using the dining plan and diet cards. Additional content included dining equipment, signs and symptoms of dysphagia, and triggers related to aspiration and GERD. Lifting training check-offs were completed by Competency Training and Development staff who were not licensed therapists. These staff had been trained previously by therapy staff, but observations, retraining, or validation for check-offs had not occurred in some time. This should be considered in the very near future to ensure consistency of content and standards for establishing competency. Additional content materials submitted were focused on risk issues and strategies to prevent these, including aspiration pneumonia, skin breakdown, injury, fractures, and falls. Further training addressed how to read and use the PNMP and when and how to	Noncompliance

#	Provision	Assessment of Status	Compliance
		document using the Aspiration Trigger Data sheet. The content appeared to be thorough, but the time allotted to all of these areas was limited. Dysphagia (one and a half hours), risk and PNM including lifting were taught from 8:00 am to 3:00 pm. A strong aspect of the training was the competency check-offs completed by the PNMPCs in three hours the following day. There were seven stations manned by a PNMPC to address: • Wheelchair positioning • Gait belt use • PNMP review • Dining Plan review • Liquid consistency • Food textures • Head of bed elevation These were observed by the monitoring team and instruction and content suggestions were made at that time and will not be repeated in this report. The Habilitation Therapies Director was also present and noted these. The effectiveness of any training depended on the instructor's ability to accurately and clearly present the content in a manner that is fun and interesting for adult learners with sufficient opportunities for practice. Though it was not possible to observe any training during this onsite visit, it will be a priority for the next review. Refresher training was limited to three to four one-hour modules related to lifting and PNM. Additional foundational training provided to staff beyond NEO included dining plan, diet card and PNMP reviews, gait belt use, and diet textures. Though these were described as competency-based, evidence of the checklists were not submitted. Though a specific curriculum had not yet been developed and implemented for the PNMPCs, competency checks in seven content areas were initiated in April 2012 for the seven PNMPCs. As of 8/9/12, 27 of the 49 check-offs had been completed (55%). Further competency checks should be integrated into the curriculum. Re-validation of competency should be completed at routine intervals as well. <u>Individual-Specific PNMP Training</u> Individual-specific inservice training was often taught by professional staff and a PNMPC(s). The training records submitted were limited to training related to dining plans and PNMPs. There were signature sheets, but no evidence that these were competency-based with return demonstration. While some of these appeared to be informational only (e.g., Individual #158, 6/15/12), others appeared to require	

#	Provision	Assessment of Status	Compliance
		demonstration that staff could competently perform specific skills (e.g., Individual #171, 4/13/12 and Individual #168, 6/7/12). Documentation for only one individual had been identified as true competency-based training with return demonstration by therapy staff (Individual #149). There were statements that established the skills required to be performed competently on the Request to Post Training Competency sheets. Staff signed the signature sheets and trainer initials were intended to reflect that the staff had met competency for all of the required skills. A system similar to this should be implemented for all PNM training that required return demonstration, though check-off sheets could be attached because the form did not provide sufficient space for a number of skills or drills. SASSLC had not clearly established which plans contained only foundational skills for which competency had been established in NEO (or refresher training) versus those with more specialized techniques (non-foundational) that required additional competency training and check-offs. If a change in plan was minor, an inservice could be provided without check-off, but these differences should be clearly stated. If further staff training was required, the therapists should establish competency of the PNMPC and/or home supervisors who could complete cascade training for the additional staff. Though these processes were planned per the Action Plan, this had not yet been implemented. This process will be a focus of future reviews by the monitoring team. It is important that staff were not to work with an individual at high risk until they had been trained and checked off. Pulled staff should receive this training by supervisors, managers and/or Habilitation Therapies as necessary. Training for pulled staff should not be limited to merely reading the plans. Though there was a plan to initiate training for new employees related to individual-specific training, this could not accomplished until the curriculum was completed and PNMPCs trained. This process should also address the issue related to existing staff and pulled staff who may be assigned to work with individuals who were considered to be at high risk. PNMPC training occurred on an ongoing basis, but there was no strategic curriculum yet established at the time of this review. It is critical that this be completed and implemented very quickly to ensure that there is greater consistency in monitoring and training provided by these key staff.	

#	Provision	Assessment of Status	Compliance
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Individual-Specific Monitoring The current monitoring system for implementation compliance and staff competency was to be based on individual risk levels. While this type of monitoring focused on staff performance, it was tracked per individual rather than per staff. This was different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function and risk levels. Thus, there was a need for greater focus on individual status monitoring and review of triggers, in addition to compliance monitoring. Individual status was generally evaluated routinely and effectively for individuals followed by the PNMT, but compliance monitoring data were not utilized consistently during the meetings. The monitoring team discussed this with the PNMT during their meeting. The potential links between the two should be identified via routine trend analysis. There was little evidence of this type of review conducted for individuals not served by the PNMT. Effectiveness Monitoring There was no evidence of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff. Consideration for how this could be addressed was needed promptly. Completed monitoring forms by the therapists were requested for one month. Only 33 meal observation forms were submitted. Analysis included: • Breakfast =8 • Lunch =22 • Dinner =2 • Snack =1 The summary of monitoring forms for the quarter running from 3/1/12 to 6/29/12 included: • OT =36 (mealtime and physical management) • PT =93 (physical management only) • SLP = 56 (mealtime only) This monitoring decreased over the course of the three month period, with only one physical management monitoring conducted by PT as of 6/1/12. No other monitoring by SLPs or OTs was documented. There was no evidence of monitoring of the PNMPs in May 2012 (though the facility later reported that monitoring was done). None of the observation forms indicated whether the plan was effective. The universal form used by the PNMPCs had an option for the monitor to mark if the plan was ineffective. This, however, was a clinical judgment--not one to be made by a non-licensed staff. In short, it appeared that no effectiveness monitoring occurred beyond the annual assessments or in response to identified problems/referrals. There was no proactive review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In the assessments reviewed, equipment and supports were described, but often stopped short of actually assessing or analyzing the impact on function, health, or risk levels. In many cases, the effectiveness of interventions and supports were not consistently and specifically addressed in the annual assessments. This should be a key function of the professional staff clinicians. This should be incorporated into routine quarterly/monthly reviews. Findings should be included in the IPNs rather than on a separate form not filed in the individual record. Similarly, this kind of analysis should be incorporated into routine, consistent documentation of other direct and indirect interventions. Effectiveness monitoring and additional staff training was indicated related to implementation of programs across all environments. <u>Validation of Monitoring by PNMPCs</u> Inter-rater reliability observations of the PNMPCs were accomplished via quarterly validation monitoring conducted by Habilitation Therapies Director. This complemented the competency-based training provided to ensure continued effectiveness and accuracy of the PNMPCs in conducting their job responsibilities. <u>Trend Analysis</u> Information gathered from the various types of monitoring was entered into a database with monthly analysis and reporting of some findings by the Habilitation Therapies. Trends or concerns were addressed via corrective action plans within the department and collaboratively with other departments if determined to be more systemic in nature.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Individuals Who Received Enteral Nutrition</u> There were 55 individuals who received enteral nutrition. Only Individual #302 was listed as having received a new tube placement since the previous review. Individual #165, Individual #284, Individual #228, Individual #343, Individual #30, and Individual #36 were listed as receiving oral intake of some type, though not specified. Individual #335, Individual #121, Individual #151, and Individual #149 were identified with pleasure feedings. All others were NPO (nothing by mouth). Only three individuals who received enteral nutrition were also listed with poor oral hygiene (Individual #349, Individual #108, and Individual #259). The list submitted that identified individuals with pneumonia in the last 12 months included 52 incidences for 29 individuals from 6/15/11 to 7/25/12. Fifteen of these individuals had more than one incidence of pneumonia. Eleven had pneumonia two times, two were listed with pneumonia three times (Individual #248 and Individual #40), and two individuals were listed with pneumonia four times (Individual #152 and Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		#176) in the last year. Twelve of those individuals received enteral nutrition and the others were reported to eat orally. There were 26 cases of aspiration pneumonia for 13 individuals. Six if these were listed with more than one incidence of aspiration pneumonia. Individual #152 was listed with four occurrences. Individual #248 and Individual #176 were each listed with two occurrences, but also had incidences of pneumonia categorized as other than aspiration related. This rate of incidence for pneumonia and aspiration pneumonia appeared high. There were other cases of pneumonia that should not necessarily be ruled out as aspiration. There was currently a committee that reviewed these cases to clarify whether aspiration pneumonia was likely. There were 10 APEN assessments submitted for review. Per policy, these were to be completed for individuals with aspiration pneumonia in the last year (5) and/or individuals who received enteral nutrition (5). While it was positive that these assessments were completed, many did not actually provide a sufficient rationale for continued enteral tube use or clearly present the rationale for the interventions and supports provided. The monitoring team does not specifically challenge that any of these individuals should not have a tube or receive enteral intake, but improvements in documenting the rationale for this were needed based on the assessments reviewed. There were five individuals who had been assessed for oral intake via MBSS or therapeutic trials and four of these had been returned to some level of oral intake since the previous review. This was a positive finding and review of these individuals will be a focus for subsequent reviews. It was reported in the self-assessment that of the APENs required for individuals at SASSLC, only 30% had been completed. <u>PNMPs</u> 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. Revise the Settlement Agreement Audit Tool to reflect meaningful indicators for self-assessment (O1–O8).
2. Establish effective leadership for PNMT facilitation (O1).
3. Continue to review and refine PNMT meeting process, meeting documentation and documentation for individuals reviewed by the team to ensure it is thorough yet concise and useful to the full IDT (O1 and O2).

4. Consider projection system for computer to permit all present at ONMT meetings to see documentation in real time (O1).

5. Review system of follow-up for individuals reviewed by the team (O2).

6. Develop operational policy to reflect process of referral, assessment, review and follow-up (O1).

7. Take steps to better integrate the PNMT Action Plan with the IDT plan. Ideally this should be a single plan developed in collaboration with both teams (O2).

8. Collaborate on implementation of guidelines to incorporate pertinent findings and improve PNMT analysis of findings and recommendations (O2).

9. Report monitoring data in assessments and use this information during meetings to better evaluate the effectiveness of interventions, supports and plans, as well as staff competency and compliance (O7).

10. Implement PNMP audit process (O4).

11. Establish criteria for integration of PNMPs in the ISPs (O3).

12. Clarify and correct issues related to preparation of modified textures, particularly for fruits and vegetables (O4).

13. Implement system of Mealtime Supervisors with specialized training for supervisor and back-ups (O4).

14. Review position and alignment for individuals in recliners and review use of blue geri-chairs (O4).

15. Complete and implement training curriculum for PNMPCs (O4–O6).

16. Identify PNMPs and Dining Plans with non-foundation skills requiring additional competency-based training for staff. Initiate competency-based training as required (O3–O7).

17. Clarify frequency of monitoring per risk level for PNMPCs and therapists, including both in assessments related to frequency and findings Broaden risk areas to include those relevant to PNM (O6-O8).

18. Remedy issues related to generic monitoring form to ensure the identification of trends for compliance and effectiveness monitoring (O6-O8).

19. Increase frequency of effectiveness monitoring by the therapists consistent with level of need based on risk levels (O6-O8).

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SASSLC client list 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 Guidelines for Therapist Monitoring Frequency o Settlement Agreement Section P: OT/PT Audit forms submitted o Individuals with PNM Needs (7/16/12) o Dining Plan Template o Adaptive Equipment Database (7/19/12) o Habilitation Therapies Trend Reports and Audits submitted o Universal Compliance Monitoring tool templates and instructions o Completed Physical Management Observation Forms (5/12) o Universal Compliance Monitoring Forms submitted (5/12 and 8/12) o Completed Meal Observation Forms submitted (5/12) o Monitoring Forms tracking log o Fall Evaluation/Investigation Form template o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Curriculum for Gait Belt training (5/5/12) o Pneumonia Committee Meeting Notes submitted o Hospitalizations for the Past Year o Summary List of Individual Risk Levels o Individuals with Modified Diets/Thickened Liquids o Individuals with Texture Downgrades o List of Individuals with Poor Oral Hygiene o List of Individuals with Aspiration and/or Pneumonia o List of Pneumonias in the Past Year o Individuals with Pain o Individuals with Choking Incidents and related documentation (Individual #171 o Individuals with BMI Less Than 20 o Individuals with BMI Greater Than 30 o Individuals with Unplanned Weight Loss Greater Than 10% Over Six Months

	o Individuals Having Falls Past 12 Months (7/10/12) o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o Skin Information from January 2012 – July 2012 o Individuals with Fractures Past 12 Months 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 Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted (Dining Plans and PNMPs) o PNMPS submitted o PNM Maintenance Log o Wheelchair documentation submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT/SLP Assessment template o OT/PT assessment audits submitted o Tracking log of OT/PT assessments completed February to June 2012 o OT/PT/SLP Assessments for individuals recently admitted to SASSLC: Individual #118, Individual #266, Individual #183, and Individual #195 o OT/PT/SLP Assessments, ISPs, ISPAs, and other related documentation for the following individuals: • Individual #155, Individual #173, Individual #69, Individual #314, Individual #170, Individual #208, Individual #104, Individual #191, Individual #78 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206 o PNMP section in Individual Notebooks for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171,

	Individual #215, and Individual #206 o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206 <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MA, CCC-SLP, Habilitation Therapies Clinical Coordinator o Allison Block Trammell, MS, CCC-SLP o Retha Skinner, OTR o PNMT members o PNMP Coordinators o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: SASSLC applied a new model for the self-assessment format for this review. Margaret Delgado-Gaitan, MA, CCC/SLP, the Habilitation Therapies Director, outlined specific assessment activities, some of which were based on previous reports by the monitoring team. She attempted to quantify each and presented findings in the self-assessment report as well as supporting documentation that demonstrated specific accomplishments or steps. The Presentation Book provided a sample of documents to illustrate some of the elements assessed and an analysis of the findings, accomplishments, and work products. While the existing audit tool was referenced in P2, these were not heavily relied on for self-assessment. This was a positive step. While some elements may be valuable in assessing compliance with this provision, others clearly were not and, as such, this tool may be revised to better reflect what is meaningful. The most important next step for Ms. Delgado-Gaitan is to minimally revise the existing audit tool for section P. A revised/new version of this tool may be used in addition to the other indicators identified by Ms. Delgado-Gaitan. The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. An action plan to address identified issues can illustrate how Ms. Delgado-Gaitan would intend to proceed toward compliance. This was discussed at

	length and hopefully will be helpful to her as she moves forward over the next six months. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the clinicians and Ms. Delgado-Gaitan and believes that the facility was continuing to proceed in the right direction. She is highly commended for her leadership, direction, and support to the speech staff through this process. Careful review of this monitoring report will provide additional insight into essential measures for self-assessment. The facility self-rated itself as noncompliant with all four items of P (P1 through P4). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: Considerable progress continued to be made related to this provision. The level of staffing for OT and PT clinicians remained consistent, though low for the number of individuals with identified needs. The OT and PT clinicians conducted their annual assessments together. They appeared to consistently work in a collaborative manner to develop PNMPs, to review equipment (e.g., wheelchairs), and to review other supports and services. Assessments were reviewed, and consistency for content was found to be improved since the last review. The audit system was thorough and was conducted in a manner to establish competence, but there was not a documented plan to ensure continued competence, though some plans were reported to be in development. Further, the reviews were completed after the assessments were submitted. Some slight modifications to the system would permit this and would be of benefit to the clinicians. P1 was very close to substantial compliance and the monitoring team anticipates this achievement at the next review if there is attention to the recommendations in this report and during discussion during the onsite review. Only a few individuals were listed with direct OT and/or PT, though there were no SAPs. Documentation, however, was inconsistent and there was insufficient rationale provided to continue or discharge from services. These interventions were not well integrated into the ISP process. The department continued to need to move forward to the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs, but also address preferences, interests, and potentials for skill acquisition, engagement and participation in the daily routine.

#	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> Margaret Delgado-Gaitan, MS, CCC-SLP, continued to serve as the Director for Habilitation Therapies. OT/PT staffing was generally consistent with that found during the previous review, though the contract staff continued to rotate in and out of service. There were three physical therapists, Edward Harris, DPT, Leesa Cotton, DPT, and Kelsey Wallin, DPT (each was contract, 40 hours per week). The contract PTs had expired contracts effective Friday of the week of this onsite review and did not plan to renew. Replacements were due to begin in September 2012. The occupational therapists were Joanna Van Hoove, OTR, (contract, 40 hours per week) and Retha Skinner, OTR (full-time state employee). One other contract OT had worked a three-month contract and did not renew, so was not working at SASSLC at the time of this review. There was only one OT from May 2012 through July 2012. There was also one PT Assistant, Cynthia Buckmeyer, PTA (full time state employee, and no OT Assistants. CVs were not requested or submitted to verify experience of these clinicians, though it was known to the monitoring team that Mr. Harris, Ms. Van Hoove, and Ms. Skinner each had previous experience in the provision of therapy services to individuals with developmental disabilities. • 6 of 6 (100%) therapy clinicians were verified with current licenses to practice in the State of Texas. There were two vacant positions for occupational therapy and one and a half positions for physical therapy. There was one OT and one PT technician. There were seven PNMPCs at the time of this review. The census at SASSLC was 275 individuals and 250 of them were listed with PNM needs. It was reported that the ratio for OT was 0:278 and 1:278 for PT. It was not clear how these ratios were calculated, but based on the current staffing, actual service ratios for the entire census were 1:138 for OT and 1:92 for PT, though only through 8/24/12. At that time the ratio shifted to 1:275 for PT. These were only slightly less for those listed with PNM needs only. In either case, these actual ratios were extremely high and, even if fully staffed, there would likely not be sufficient numbers of therapists to ensure adequate provision of necessary and effective supports and services as reported in the following sections of this report. <u>Continuing Education</u> Each of the six clinicians and OT/PT technicians reported participation in continuing education during the last six months. Topic areas included: • Wheelchair, Seating, Mobility and Positioning (three hours) • Managing Dysphagia (one hour) • Autism (two hours) • Manipalooza 2012 (32 hours)	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Trauma-Informed Care for Persons with Intellectual Disabilities (four hours) • Standing Justified (two hours) • Simply Seating (13.5. hours) • Simulation Casting and Molding (7.75. hours) • Ride Designs Custom Systems Practitioner training (eight hours) Unfortunately, those with the most extensive training hours included the three clinicians who were no longer working at SASSLC at the time of this writing. Even so, it continues to be important that all clinicians be encouraged to attend annual educational opportunities beyond just those offered by the state to ensure that they continue to expand their knowledge and skills. Participation in ongoing continuing education is critical and should be encouraged throughout the year. A continued focus on wheelchair assessment is recommended to ensure competence of all clinicians in this area. <u>New Admissions</u> Two individuals were listed as admitted to the facility since the last onsite review. Samples of new admission assessments completed since the previous review were requested and four were submitted. Each of the assessments for these individuals was completed within 30 days of admission <u>OT/PT Assessments</u> The Habilitation Therapy Comprehensive Assessment OT/PT/SLP format was modified slightly since the previous review. Prompts in the guidelines were also expanded to improve the analysis section and address the efficacy of existing supports, as well as to ensure inclusion of monitoring data, oral hygiene care, personal preferences, and SAP recommendations. The state format instructions indicated that the assessment should provide a current picture of the individual's status, in terms of functional abilities, health risks, and potential for community placement. By report, an Assessment of Current Function had been developed by the state, but was not in place at SASSLC. A template for any assessment updates was not submitted. Per the state format guidelines, the assessment findings were to address health conditions and clinical data reflecting the individual's function and guide provision of supports. Historical data and information gleaned from record review were to be pertinent to the assessment and provide an analysis of relevance to clinical findings and recommendations. Therapists were instructed to analyze the clinical information as each section was completed, so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated.	

#	Provision	Assessment of Status	Compliance
		These guidelines indicated that recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the monitoring team because all aspects of supports and services should be included in the ISP. Per the guidelines, the comprehensive assessment was to be completed within 29 days of admission and an update was to be completed at least annually regarding services provided during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content guidelines for each of these areas were extensive and comprehensive in nature. The SASSLC assessment format was a modification of this state-approved format and they had written their own content guidelines. Per the self-assessment, they had completed 272 of 276 assessments (99%). The five most current assessments for each clinician (10), new admission assessments (4), and the OT/PT assessments for the each of the 17 individuals in the sample selected by the monitoring team were submitted for review. ISPs were also requested and submitted for each individual except those who were newly admitted (27). Though 31 assessments were submitted, two were missing pages (Individual #241 and Individual #183), and five were expired at the time of this onsite review (Individual #138, Individual #122, Individual #270, and Individual #206). Each of the 25 other assessments was generally of the currently established format and was included for review. Comments are below: • 100% (25 of 25) were identified as comprehensive assessments. • 0 of 25 individuals had comprehensive assessments that contained each of the 23 elements outlined below. • Overall, the assessments were very good and were considerably improved since the previous review. The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The current state assessment format and content guidelines generally required that these elements be contained within the assessments. The percentage of assessments (25) that contained each element are listed below: • Signed and dated by the clinician upon completion of the written report (100%). • Dated as completed 10 days prior to the annual ISP (36%), though 21 were completed prior to the ISP (less than 10 days) and three were completed on the day of the ISP. The state required these to be completed 10 working days prior to the ISP per the ISP meeting guide.	

#	Provision	Assessment of Status	Compliance
		• Diagnoses and relevance to functional status (0%). • Individual preferences, strengths, interests, likes, and dislikes (68%). • Medical history and relevance to functional status (8%). • Health status over the last year (92%). • Medications and potential side effects relevant to functional status (8%). Some assessments listed only the purpose of the medications, others provided some potential side effects. It would be useful to report if any of these were experienced by the individual and/or impacted function. • Documentation of how the individual's risk levels impact performance of functional skills (0%). Some reported high and medium risks only (Individual #135) and others also reported low risk PNM-related areas (Individual #150). It would be important to address all areas of risk relevant to PNM to determine if the current ratings were accurate and if changes were necessary based on findings and to ensure supports and services sufficiently addressed these needs. • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day (96%). This was a strength in most of the assessments reviewed. • Description of the current seating system for those requiring a wheelchair (14 individuals) with a rationale for each component and need for changes to the system outlined as indicated (86%), though the rationale provided in many cases was generally weak. • Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) (60%). • Evidence of discussion of the PNMP as well as the effectiveness of the current version of the plan with necessary changes as required for individuals with PNM needs (44%). • Discussion of the <u>expansion</u> of the individual's current abilities (24%). • Discussion of the individual's potential to <u>develop new</u> functional skills (32%). • Discussion of the current PNMP and other supports and services provided throughout the last year and effectiveness, including monitoring findings (44%). Often the only the frequency was reported rather than the findings of compliance and/or effectiveness. • Comparative analysis of health and impact on functional status over the last year (36%). • Comparative analysis of current functional motor and activities of daily living skills with previous assessments (72%). • Addressed the individual's foundational PNM and functional skill needs including clear clinical justification and rationale (68%). The analyses for the assessments were significantly improved during this review period. • Identify need for direct or indirect OT and/or PT services (88%). Though this	

#	Provision	Assessment of Status	Compliance
		was usually clearly stated, most individuals were not provided direct services. Recommendations for skill acquisition were infrequent. • Reassessment schedule (92%). • Monitoring schedule (76%). In some cases, the frequency of PNMP monitoring did not appear to match the identified need. The monitoring schedules varied including quarterly for physical management (PM) (3), monthly PM (1), bimonthly PM (3), annually PM (6), bi-monthly for mealtimes (1), and annually for mealtimes (11). No monitoring frequency was identified for the other individuals). Given the PNM needs of the individuals reviewed, the frequency of monitoring was inadequate. • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs (16%). • Factors for community placement (4%). There was typically on a statement as to whether the clinicians believed that the individual could be served in a less restrictive environment, but the necessary supports and services were not outlined. • Manner in which strategies, interventions, and programs should be utilized throughout the day (60%). This was generally accomplished via the PNMP and mobility skills only. While most of the elements listed above were addressed by the current state assessment format and guidelines, the clinicians should consider each of these as specific content in the proposed headings to ensure assessments were comprehensive as required by the Settlement Agreement. Additional prompts or cues in the form of guiding questions may be helpful to ensure that key elements are addressed in each assessment. Additional findings: • The assessments inconsistently identified preferences, likes, and dislikes. These were important for establishing contexts for communication opportunities, but there was no clear link between these and functional participation in the daily routine. Observations in the natural environments would also provide important clues as to preferences as well as individual potentials for enhancing or expanding existing functional skills • There were 112 assessments completed from 1/1/12 to 6/30/12. Of these, one was for individual a newly admitted and only two were completed 10 days prior to the ISP (Individual #315 and Individual #125). • It was not known if SASSLC would adopt the Assessment of Current Status format recently developed as an update version of the comprehensive assessment. o It would be appropriate and desirable to conduct this type of modified assessment that was based on the original comprehensive assessment,	

#	Provision	Assessment of Status	Compliance
		primarily adding changes in status and the effectiveness of supports and services over the previous year with recommendations for the next year based on a sound rationale, rather than duplicating the extensive format of the comprehensive assessment. o This would permit more time for therapists to focus on the delivery of supports and services rather than on assessment. o Of course, a repeat comprehensive assessment would continue to be indicated in cases of a significant change in status and for individuals newly admitted to the facility. • The therapy clinicians did not consistently conduct post-hospitalization assessments and other change of status assessments (Individual #23, Individual #176, and Individual #248, for example). Evidence of documentation was absent or minimal at best. There was no consistent follow-up for interventions or supports implemented noted. • 40% of the assessments reviewed contained six to 10 of the 23 minimum elements. • 52% of the assessments reviewed contained 11-15 of the 23 minimum elements. • 8% of the assessments reviewed contained 16-20 of the 23 minimum elements. • 0% of the assessments reviewed contained more than 18 of the 23 minimum elements. For the ISPs (27): • 85% (23 of 27) of the ISPs submitted were current within the last 12 months. ISPs were not requested for the new admission assessments. Three of the current ISPs did not have attached signature sheets (Individual #314, Individual #170, and Individual #135) • 20% (4 of 20) of the current ISPs with signature pages submitted were attended by both OT and PT. • 25% (5 of 20) were attended by PT only. • 55% (11 of 20) of the current ISPs had no representation by an OT or PT. Audits were completed for assessments in a peer review manner for editing and teaching purposes to improve the quality. Competency was defined as three assessments meeting compliance at 90% or better. It was reported that, as of 7/30/12, five of the six therapists had achieved this level of competence. One therapist was only recently hired and was in the process of obtaining competency. Only 11 assessments were audited in the last six months and it was reported that nine of these met the 90% compliance level. The audit tool was detailed and thorough with a quantifiable score calculated related to content and format. The monitoring team scored	

#	Provision	Assessment of Status	Compliance
		the two samples submitted in the section P Presentation Book and, though the exact scores obtained were slightly lower than those recorded by the clinicians, the overall minimum scores were comparable. In other words, one assessment was 90% or better and the other was below 90%, the same as the scores obtained by the clinicians. It did not appear, however, that the assessments were corrected prior to submission. They may want to do so to ensure that all assessments met the minimum standard for competence. In addition, the elements listed above should be considered for inclusion in the audit tool if not already addressed. The sample size of audited assessments was small and there did not appear to be a system designed to address continued compliance. The scores reported by SASSLC and the review conducted by the monitoring team reflected a significant and consistent improvement in the quality of the assessments completed by the clinicians. There was no evidence that trends identified by the audit process were targeted for staff training. This system was dependent on the abilities of the peers to conduct these audits in a competent manner and would only be effective if adequate oversight and direction are provided to the clinicians for corrective actions. Over the next six months, the department should modify the system to incorporate findings into staff training opportunities (possibly via case study format, for example) to enhance overall performance. These findings would be useful to report and trend on a monthly basis. Corrective strategies could be developed as needed to address issues as indicated both for individual clinicians and teams.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing	<u>OT/PT Interventions</u> There were a limited number of interventions provided beyond the PNMPs. In some cases, these were documented on progress note forms and filed in the Habilitation Therapies tab of the individual record. As a result these would be difficult for other team members to access or even be aware of. In these and others included in the IPNs, a number did not have associated measurable objectives. The inconsistency of documentation did not reflect routine review of status or progress. In some cases the justification for changes, holding, or terminating the interventions were not well documented. Some examples included the following: • Individual #149: PT for general debilitation, three times a week. She was not included in the sample selected by the monitoring team, so documentation was not available for review. • Individual #215: PT for general debilitation, frequency not stated. His treatment was put on hold until further notice due to opened abrasions on his knees per an IPN on 2/12/12 by the PTA. There was no further documentation until 4/4/12 when it appeared that his PT had resumed. There was no rationale for a nearly	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	two-month hold. There was not a sufficient rationale for discharge from therapy on 6/1/12 by the PT based on IPNs noted by the PTA. • Individual #270: PT was provided for functional, independent ambulation from 10/17/11. A discharge summary was included in his individual record, but was incomplete. It was not known when he was discharged as the summary was not dated. There was no reference note in the IPNs to direct others to the discharge summary so it appeared that PT stopped for no reason as of 12/19/11. • Individual #176: OT was provided to promote skin integrity and reduce further contractures. There was no established baseline and no measurable objectives identified. Three was evidence of only three progress notes written from 1/26/12 through 7/31/12. These did not provide sufficient rationale to continue or discharge from intervention. This intervention was not clearly stated in her ISP dated 2/15/12. • Individual #248: Per an IPN dated 6/21/12, the IDT indicated the need for hand hygiene intervention by the therapy technician three times per week. There was an OT Progress Note dated 7/23/12 filed in the Habilitation tab of the individual record rather than in the IPNs. There was no baseline established and no measurable objectives. • Individual #23: Per OT Progress Note dated 4/10/12, a hand hygiene program was reinstated for Mr. Individual #23 on 3/22/12. This was also recommended to continue in his OT/PT assessment dated 6/5/12. This was also included in his ISP dated 6/6/12. Monthly notes were written through 7/23/12, but filed in the Habilitation tab of the individual record rather than in the IPNs. There was no established baseline or measurable objectives. • Individual #167: OT was provided for upper extremity range of motion. There was no assessment supporting initiation of this intervention. There was no baseline established and no measurable objectives. This was not included in his ISP. There was one Monthly Progress Note (6/26/12) in the record and it was not known from the documentation when this intervention began and if it was still in place at the time of this onsite review. Documentation of routine supports and services provided was minimal, or very limited, related to acute issues and upon discharge from the hospital for PNM-related concerns as described above. For example: • Individual #206: Referral to PT to address hip pain secondary to trochanter bursitis. The PT did not document an assessment, but per an IPN dated 7/6/12, indicated that she walked three times a week with PT. The stated plan was to continue the program and to monitor. No further documentation was noted through 8/20/12.	

#	Provision	Assessment of Status	Compliance
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.	Noncompliance
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 was included in the OT/PT assessments. Findings were reported, though these were generally compliance monitoring findings only. In many cases, monitoring for effectiveness was only on an annual basis, which is inadequate for most individuals with PNM needs. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT was included in the routine monitoring done by the PNMPCs as well as during quarterly reviews by wheelchair technicians, as described above in section O. A log of work orders was generated and tracked for completion and timeliness. The log tracked orders generated through routine PNMP monitoring, random checks, and reports by direct support and home management staff. This was monitored by the department director with weekly meetings held with the fabricators to ensure that maintenance and fabrication of new systems and modifications were completed in a timely manner.	Noncompliance

Recommendations:

1. Continue to recruit experienced OT/PT clinicians to at least maintain or improve staffing ratios (P1).

2. Modify audit system to address elements of review applied by the monitoring team (P1 and P4).

3. Improve consistency of the system of documentation. Ensure that the rationale was clearly stated to continue or discharge from services. These interventions were not well integrated into the ISP process. The department needs to move forward in the implementation of interventions beyond the PNMP with involvement in the home and day program areas to enhance the meaningfulness and functional activities that meet PNM needs, but also address preferences, interests, and potentials for skill acquisition, engagement and participation in the daily routine (P2).

4. Clearly establish baselines in the OT/PT assessments as the foundation for interventions and measurable, functional outcomes (P1).

5. Include measurable performance criteria in the objectives for interventions and refer to these in all documentation (P2).

6. Increase consistency of documentation and better integrate it with the IPNs (P2).

7. Explore ways in which attendance at the ISPs/ISPAs is improved (P1).

8. Include a discussion of the current PNMP and other supports and services provided throughout the last year and effectiveness, including monitoring findings. While each presented an extensive discussion of supports and services provided over the last year, none incorporated findings from the monitoring conducted related to compliance with implementation and effectiveness monitoring (P1).

9. Participation in ongoing continuing education is critical. A particular focus on wheelchair assessment is recommended to ensure competence of all clinicians in this area (P1).

10. 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 (P2).

11. Results and findings from PNM monitoring during the last year should consistently be reviewed and summarized (P1).

12. Documentation of direct therapy services should state a clear rationale to initiate, continue the service, modify the plan, or discharge. Measurable 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).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/17/10 o SASSLC Organizational Charts o SASSLC Self -Assessment Section Q o SASSLC Action Plan Section Q o SASSLC Provision Action Plan o SASSLC Dental Operating and Procedure Manual, 7/10/10 o SASSLC Medical/Dental Restraints 1/24/12 o Presentation Book, Section Q o Dental Data: Refusals, missed appointments, extractions, emergencies, preventive services and annual exams o Listing, Individuals Receiving Suction Toothbrushing o Dental Clinic Attendance Tracking Data o Oral Hygiene Ratings o Dental Records for the Individuals listed in Section L o Listing, Individuals Receiving Pretreatment Sedation January 2012 – June 2012 o Listing, Individuals Receiving Treatment with TIVA o Desensitization plan for Individual #77 o Annual Dental Summaries for the following individuals • Individual #335, Individual #145, Individual #11, Individual #230, Individual #171, Individual #101, Individual #117, Individual #35, Individual #62, Individual #204 o Annual Dental Assessments for the following individuals: • Individual #278, Individual #78, Individual #333, Individual #113, Individual #256, Individual #164, Individual #110, Individual #159, Individual #125, Individual #284, Individual #271, Individual #108, Individual #248, Individual #90, Individual #288, Individual #214, Individual #347, Individual #166, Individual #157, Individual #242, Individual #181, Individual #151, Individual #23, Individual #225, Individual #314 Individual #189, Individual #208, Individual #345, Individual #10, Individual #170, Individual #173, Individual #56, Individual #3, Individual #67, Individual #75, Individual #69, Individual #85 Interviews and Meetings Held: o Joyce Munoz, DDS, MBA, Contract Dentist o Carmen Mascarenhas, MD, Medical Director o Amy Jo Hush, RDH, Dental Hygienist o Joann Smith, RN, Medical Program Compliance Nurse o Ralph Henry, Facility Director

	Observations Conducted: o Dental Clinic o Informal observation of oral hygiene regimens in residences o ISP for Individual #281
	Facility Self-Assessment: As part of the self-assessment process, the facility submitted three documents: (1) the self-assessment, (2) an action plan, and (3) provision action information. The medical director described, for both provision items, a series of activities engaged in to conduct the self-assessment. For each activity, a result or data point was reported and used to help determine an overall compliance rating. For the most part, the assessment looked at many areas reviewed by the monitoring team. The facility will need to invest time in exploring data accuracy due to the discrepancies noted for many data elements. To take this process forward, the monitoring team recommends that the medical director continue this type of self-assessment, but expand upon it by adding additional metrics that are specific to clinical outcomes in dentistry. The dental peer review should be helpful in determining those metrics. Moreover, it will be important for the self-assessment to comment on all areas reviewed by the monitoring team. The facility rated itself in noncompliance for both provisions. The monitoring team agreed with the facility's self-rating.
	Summary of Monitor's Assessment: The dental clinic saw no progress over the past six months. In fact, it was evident very early during the review that the clinic had shown regression. The number of appointments decreased, compliance with annual assessments remained poor, and missed appointments were not sufficiently addressed. The medical director attributed much of the decreased provision of services and compliance deficiencies to the clinic relocation and SASSLC's inability to provide care with TIVA. Problems were identified with the provision of emergency care and home oral care was often noted by the dentists to be poor. Informed consent continued to present challenges and the dentists noted repeatedly that care was delayed due to the processing of consents. The facility established a Performance Improvement Team to address the problem, but even recent dental documentation reflected continued problems. The response to refusals and missed appointments was inadequate. One desensitization plan was developed, but the larger issue was that the dental clinic could provide no information on strategies implemented to address refusals and failed appointments. The lack of submission of data resulted in challenges for the completion of this review. In many instances,

	there was evidence of gross inaccuracy of the information submitted. Additionally, several document requests resulted in responses that no data were received. It appeared that when teams failed to respond to data requests, the dental clinic staff made no additional effort to obtain information. The facility director and the medical director appeared to be unaware of this. The monitoring team did not understand the lack of awareness because this was specifically highlighted as a problem during the last review. SASSLC staff was aware of many of these issues and they were discussed with the dental clinic staff and the facility director during the compliance review. The facility did not have a dental director at the time of the review and was planning to conduct interviews to fill the position. Stability of the clinic staff will be vital in evaluating and resolving the many issues identified in this report.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	In order to assess compliance with this provision, the monitoring team reviewed records, documents, and facility-reported data. Interviews were conducted with the members of the clinic staff, medical staff, medical director, medical compliance nurse and facility director. The monitoring team also attended several meetings in which the dentist and dental hygienist were active participants. The monitoring team also observed treatment provided to individuals in the dental clinic. <u>Staffing</u> The clinic underwent a series staffing changes, having employed two dental directors over the past six months. The current dentist who started 7/5/12 was working under contract and was scheduled to end her work at the facility on 8/31/12. At the time of this compliance review, the clinic was staffed with this contract dentist, a full time dental hygienist, and a dental assistant. The dental clinic was operated in a new building which provided generous space for working. The transition occurred in May 2012 and at the time of the onsite review, the clinic was fully functional with three operatories and provided services five days a week. The dental clinic was under the purview of the medical director. All of the staff reported to the medical director. The contract dentist expressed concerns about the supervision arrangement for the dental hygienist (RDH), that is, that the RDH was supervised by the medical director, yet was required to have supervision by the dentist with whom she worked. This was explored with the medical director who indicated that the dentist could not provide supervision without having completed a management class. The monitoring team needs to point out that the functional supervision of the RDH must be under the treating dentist. Although complicated, the facility will need to differentiate functional and administrative supervision when using the services of a contract dentist.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Provision of Services SASSLC operated a fulltime dental clinic five days a week. Basic dental services were provided, including prophylactic treatments, restorative procedures, such as resins and amalgams, and x-rays. The total number of clinic visits and key category visits are summarized below.	

Dental Clinic Appointments 2012							
	Jan	Feb	Mar	Apr	May	June	Total
Preventive	53	63	44	31	36	73	300
Restorative	0	1	0	0	1	3	5
Emergency	3	5	5	5	2	3	23
Extractions	0	0	0	2	0	1	
Total Appointments	68	77	68	59	66	101	439

The 439 appointments were 15% fewer than completed during the previous six months. According to the medical director, this was the result of the clinic move and the inability to treat individuals without the use of TIVA. The dental clinic decreased the amount of time allocated for each appointment, so that more individuals could be treated. This change resulted in more scheduled appointments during the month of June 2012, 35% of which were annual assessments.

During previous visits, it was noted that some individuals whose needs were not met at SASSLC received treatment by a local oral surgeon. The former dental director reported that the community capacity was not enough to meet the needs of the individuals, which made the implementation of TIVA even more important. During this visit, it was reported that no one received services off campus other than one individual who required emergency treatment. That appeared to be incorrect information because other documents reviewed by the monitoring team reveled that several individuals received treatment off campus. Thus, the numbers reported and included in the table above did not reflect overall all of the services provided. This omission did, however, show that there were problems with the data maintained and reported by the dental clinic.

Emergency Care

Emergency care was available during normal business hours. After business hours, the on-call physician was contacted and made a determination about the need for urgent dental care. Individuals were referred to the emergency department for dental emergencies. Emergency visits to the facility clinic increased three fold over the last reporting period when seven emergency visits were documented.

In order to evaluate the provision of emergency care, the IPNs from start of emergency to closure and a copy of the dental evaluation and treatment were requested. The facility

#	Provision	Assessment of Status	Compliance
		submitted the dental treatment records (usually one page) for each individual who received emergency treatment. This area will be reviewed further during the next visit when adequate documentation of care is provided. As part of the review of treatment provided by non-facility dentists, Individual #225 was identified as having received emergency treatment. The dental treatment records pertaining to emergency treatment were not submitted because the individual was not identified as receiving emergency treatment. Nursing documented in the IPN that at 8 am on 5/14/12, Individual #225 was referred to the local emergency department for dental care. There was no IPN documentation, by a primary provider or by the dental clinic, of an assessment prior to the transfer. Nursing documentation indicated that the physician and dental clinic were notified of the individual's pain, "notified MD and dental, ok to give PRN Tylenol." The plan was to monitor. There was no documentation of which practitioner authorized transfer to the emergency department. The individual was hospitalized and subsequently underwent multiple extractions related to an abscess. The management of this dental emergency was not consistent with the facility's guidelines. During the period that this event occurred, the facility had a full time dental director. The transfer also occurred during normal work hours. There did not appear to be any discussion between the PCP and dental director regarding the individual's assessment and the plan of care. <u>Oral Surgery</u> The monitoring team requested a list of individuals who received any dental treatment or assessment off campus. The facility submitted the name of Individual #225. The medical department's clinic tracking database indicated that six individuals received treatment off campus, including one who was listed as having surgery. The procedures were not specified. <u>Oral Hygiene</u> Historically, SASSLC presented quarterly oral hygiene ratings. The documents given to the monitoring team this time, however, did not include any data on oral hygiene for 2012. The self-assessment reported 2012 cumulative hygiene ratings as of 6/30/12. This represented a new approach to reporting the data. The monitoring team, therefore, requested quarterly data. The cumulative and quarterly data submitted are presented in the table below.	

#	Provision	Assessment of Status	Compliance

Oral Hygiene Ratings 2010 - 2012			
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
3/31/12	30	39	31
6/30/12	24	33	43
2012	19	40	41

While the data indicated an improvement in oral hygiene ratings, it was not clear how the 2012 cumulative ratings could have been reported based on the quarterly data submitted. The hygienist reported that she made no changes in how data were maintained.

During discussions with clinic staff and the dentist, reports of problems with home oral hygiene care were evident. The facility dentist clearly indicated that home care was not adequate.

A total of 37 (two edentulous) annual dental summaries completed during the months of April 2012 through June 2012 were reviewed. A significant number of individuals included in the sample had documentation of poor oral hygiene. Similar to the February 2012 review, the dentist indicated, in a majority of documents, that improved home care was needed. The cumulative hygiene rating from those documents are summarized below. Good hygiene was documented for a minority of individuals.

Oral Hygiene Ratings Annual Dental Summaries April – June 2012			
Poor	Fair	Good	Unknown
31	23	20	25

In response to the request for corrective action plans to improve oral hygiene, the document submitted stated "the dental department obtained no corrective action plans to improve oral hygiene." The hygienist did report that, when individuals were identified with poor hygiene in the clinic, the direct care professionals attending the clinic were provided training and instructions on home care.

There were five individuals who received suction toothbrushing, based on data submitted. The medical director indicated that the number was much higher. The direct

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>care professionals provided this treatment and were trained by the dental hygienist. The facility had failed to develop a formal program or procedures regarding the provision of suction toothbrushing. It was reported that a Performance Improvement Team was developed to address this issue.

The role of habilitation services in the dental clinic was also discussed. It was reported that the department did not have fulltime staff, so involvement in the dental services was limited. The hygienist and dentist reported that they followed special precautions based on the PNMP, but devices for measuring the angles/tilting of chairs were not utilized at SASSLC for those with special positioning needs.

<u>Staff Training</u>
All new staff received competency-based training during new employee orientation. An annual oral hygiene refresher was available online through iLearn and was required for direct care professionals.</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 facility maintained a dental services policy. Several policies were undergoing revision. The need for a suction toothbrushing procedure remained outstanding. The current dentist also believed that the dental clinic was in need of additional policies related to the operations of the clinic. It appeared that management of inventory was problematic resulting in issues related to expired equipment and supplies.

<u>Annual Assessments</u>
In order to determine compliance with this requirement, a list of all annual assessments completed during the past six months along with the date of previous annual assessment was requested. Assessments completed by the end of the anniversary month were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.

<table>
<tr><td colspan="7">Annual Assessments 2012</td></tr>
<tr><td></td><td>Jan</td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td></tr>
<tr><td>No. Exams</td><td>14</td><td>11</td><td>0</td><td>7</td><td>12</td><td>35</td></tr>
<tr><td>Compliant Exams</td><td>12</td><td>5</td><td>0</td><td>5</td><td>4</td><td>24</td></tr>
<tr><td>% Compliance</td><td>86</td><td>45</td><td>--</td><td>71</td><td>33</td><td>68</td></tr>
</table>

SASSLC continued to have problems completing annual assessments in a timely manner. The overall compliance score was 61%. The compliance score for the previous six months was 65% indicating no improvement in this area.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The comprehensive annual assessments for 10 individuals were reviewed. One individual did not allow an exam. The following is a summary of information found in the assessments: • 10 of 10 (100 %) assessments included an entry on cooperation, behavioral issues, and the need for sedation/restraint use • 9 of 9 (100%) assessments had entries for oral hygiene, teeth and restorations, and periodontal conditions • 9 of 9 (100%) assessments included documentation of oral cancer screenings • 5 of 9 (50%) assessments included oral hygiene recommendations • 4 of 9 (45%) assessments documented the risk rating • 6 of 9 (67%) assessments documented x-rays or the need for x-rays As part of the facility's requirement to provide assessments and evaluate the quality of those assessments, the state dental services coordinator will need to develop tools to assess the quality of dental assessments. This should fold into the facility's dental peer review process. Management of assessments is discussed further in section H1. <u>Initial Exams</u> The facility submitted data for four individuals admitted since the last onsite review. All of the individuals completed initial dental evaluations. Individual #285 did not have an initial exam completed within 30 days. <u>Dental Records</u> Dental records consisted of initial/annual exams, annual dental summary, dental progress treatment records, and documentation in the integrated progress notes. Providers documented in the integrated progress notes. An entry was also made in the dental treatment record. IPN entries were written in SOAP format and were generally dated, timed, and signed. The annual dental summary continued to include good information presented in a manner that could be understood by the IDTs. Overall, recommendations to the IDTs and information regarding home care was less than noted in summaries provided for previous reviews. Copies of the complete dental records, including the IPNs were not provided. Nonetheless, through the process of record reviews, the monitoring team noted that integrated progress notes continued to include pointer notes that directed the reader to the dental treatment records contained within the integrated record. The notes were electronically generated.	

#	Provision	Assessment of Status	Compliance
		Failed Appointments The facility reported data on refusals, failed/no show, and missed appointments. The numbers as identified and reported by SASSLC are summarized in the table below:	

	Jan	Feb	Mar	Apr	May	June
Refused	3	0	6	3	5	5
Failed /No Show	12 (18%)	0 (10%)	20 (30%)	10 (17%)	22 (33%)	12 (12%)
Missed	9	8	14	7	17	4
Total	68	77	68	59	66	101

The hygienist reported that missed appointments were the sum of refusals and failed/no show appointments. Previous comments from SASSLC indicated that SASSLC tracked refusals and no shows and added them to get the total of missed appointments. As observed in the table above, that did not appear to be the case. The data reported in the document given to the monitoring team also differed from data presented in the self-assessment. Even so, for the months of February 2012 and June 2012, the reported data would seem incorrect. Based on submitted data, the overall failure/no show rate for the reporting period was 20%. This was significantly higher than the failure rate for the previous six months, which was 12.6%. The dental clinic tracking data were not helpful because they only reported clinic appointments. Tracking data should list all scheduled appointments, noting those that were refused, missed, etc.

The monitoring team requested documentation of the interventions and strategies that were implemented to address missed appointments and refusals. The hygienist indicated that there were none. She reported that teams did not respond to the request for information. An email, dated 7/11/12, from the dental hygienist to the QDDPs was provided for review. Teams were requested to submit plans, minutes from meetings, and follow-up that addressed failed appointments.

There were no follow-up emails or any other evidence to indicate that the dental clinic took a proactive approach in resolving these issues. The medical director, who supervised the hygienist, had no further explanations. The facility director indicated that he was not aware of the problem and the failure to submit requested data. It appeared that no one in the chain of command had reviewed the document submissions, but more importantly, there was a failure on the part of the dental clinic to address problems of refusals and missed appointments in a manner such that IDTs were requested to develop appropriate responses in a timely manner. The email clearly indicated the information was needed "for DOJ."

#	Provision	Assessment of Status	Compliance
		Dental Restraints The number of individuals receiving pretreatment sedation and general anesthesia is summarized below.	

Individuals Requiring Sedation and General Anesthesia 2012						
	Jan	Feb	Mar	Apr	May	Jun
Oral Sedation	9	8	0	0	2	13
General anesthesia	0	0	0	0	0	0
General anesthesia (community)	--	--	--	--	--	--

The facility reported no off campus appointments other than one visit to the emergency department. Several individuals received treatment off campus. The monitoring team had no additional information on the nature of the treatment or the sedation used.

SASSLC began using TIVA in July 2012. The data for those individuals was requested following the onsite week of this compliance review. A total of eight individuals received dental treatment with TIVA over a period of three days in July 2012. All of the individuals had extensive treatment including x-rays, cleaning, extractions, and restorations. Sixty-two percent of the individuals had documented poor oral hygiene. The remainder had ratings of good hygiene.

Strategies to Overcome Barriers to Dental Treatment
As previously noted, there was no information provided on strategies and interventions used to overcome barriers to treatment. The facility submitted one desensitization plan developed in January 2012 for Individual #77. The plan was not a formal desensitization plan, but represented a series of strategies that would be utilized to help the individual receive the hygiene and dental care that was necessary. The plan, which was individualized to meet specific needs of the individual, was developed in January 2012, but no updates on the status of the individual were provided.

Informed Consent
The consent process used at SASSLC continued to present challenges and barriers to the completion of dental treatment. During the February 2012 review, there were numerous accounts of delays in treatment that were attributed to the failure to obtain informed consent. A Performance Improvement Team was developed to address this issue. The hygienist and medical director reported that consents were now integrated with the ISP. Moreover, the turn around time was better for individuals with no LAR. The facility dentist expressed concerns about delays in treatment related to the consent process, however, she also reported that working with the facility director, she was able to

#	Provision	Assessment of Status	Compliance
		identify individuals who were in need of treatment and expedite some consents. Nonetheless, record and document reviews continued to record delays in treatment related to obtaining consent for treatment. The following are examples of problems identified by the dentist in the Annual Dental Summaries: • Individual #170, 4/20/12: The annual dental summary indicated that many attempts were made to see the individual. "Consent for oral sedation has been processed however due to dental constraints the individual has not been seen. The individual will be seen when able." • Individual #208, 4/26/12: Consents were initiated on 10/26/10 and 1/15/11. They were not sent to HRC at the time the summary was completed. • Individual #173, 4/26/12, had a number of refusals. A request was made for a plan. • Individual #159, 6/1/12: Rampant decay due to poor oral care at home and a soda habit was documented. Consent for sedation was initiated, so that treatment could be provided. • Individual #225, 6/8/12: The dentist documented that the individual had a cavity diagnosed on 6/28/11. Consents were initiated, but never returned. The individual was sent to the ER and required extractions of three teeth in the hospital. The dentist noted with emphasis through capitalization - Please do not let this happen again. Please process her paperwork. Additional examples were noted in the dental treatment notes of the record sample: • Individual #113, 6/6/12: The annual assessment documented possible decay, but no x-rays were taken due to lack of cooperation. Treatment was pending the completion of the consent process. • Individual #201, 1/24/12: The treatment records noted poor oral hygiene. Moderate caries risk – unable to determine extent. Sedation consent outstanding. Will schedule more complete exam when received. There was no further dental documentation in the records. • Individual #5 refused dental treatment. Consent for sedation was initiated on 5/12/11. During two subsequent visits, it was noted that the consents were outstanding. The individual expired prior to receiving treatment. • Individual #256, 12/8/11: The dentist documented that the individual was uncooperative with oral sedation and had had poor oral hygiene. It was noted that care was deferred until TIVA was available. There were no further dental entries. • Individual #89, 11/17/11: Consent was initiated for treatment of several severe caries. Multiple follow-up visits documented outstanding consents. On	

#	Provision	Assessment of Status	Compliance
		6/26/12, the dentist completed some restorative work, but noted that multiple restorations were now needed. • Individual #67, 4/20/12: This individual had a bridge that was loose because an anchor tooth had a non-restorable deep cavity. New consents were initiated. The original consent was submitted 8/24/11. The dental entry for 9/12/11 documented evidence of neglect and absence of oral hygiene. On 7/16/12, the dentist noted the presence of non-restorable tooth, and consent for treatment was initiated. On 8/1/12, the notes indicated that the individual would return for extraction when consent was completed. Problems related to informed consent appeared to continue to delay treatment in spite of the efforts to improve the process. As illustrated in the examples, the delays in treatment allowed progression of dental disease. Restorable teeth, in the absence of proper treatment, were rendered non-restorable. Individuals were subjected to extractions that could have potentially been avoided. Moreover, the oral health of individuals was allowed to deteriorate. There were also individuals who appeared to receive appropriate care. For the record sample reviewed, 4 of the 10 individuals had routine care with no documented outstanding issues. Other individuals awaiting consent had relatively minor problems. The facility will need to re-evaluate the consent process in order to prevent individuals from experiencing deterioration in oral health. Consent was not the solitary issue for the SASSLC dental clinic. The facility will need to address many issues with the stability of the staff being a priority. SASSLC will need a dental director who is fully engaged in all aspects of the provision of dental services. With a new dental director, the facility will be able to address issues, such as oral care in the homes, appropriate responses to appointment failures and other compliance issues noted in this report. The facility and state office should consider remediation of these problems an urgent issue.	

Recommendations:

1. The facility must move quickly to hire a dental director. The state dental services coordinator should be involved in the selection process (Q1).
2. The facility must evaluate the use of the clinic time and the provision of services to ensure that maximal efficiency occurs (Q1).
3. The facility director should review the emergency case presented in the report to determine the sequence of events that led to transfer. The medical director must ensure that the dental clinic is following the policy related to emergency care (Q1).

4. The facility must ensure that community resources are utilized as needed to provide advanced services to individuals supported by the facility. Data related to the provision of those services must be accurately documented (Q1).

5. The facility must ensure that those with poor oral hygiene have adequate plans in place to assist in improvement of oral health. Individuals who demonstrate deterioration in hygiene status should also have development of a plan (Q1).

6. The facility must develop a program for administration of suction toothbrushing. The criteria for use of suction toothbrushing should be outlined as well as the process for identification, referral and implementation (Q1)

7. The low compliance with timely completion of annual assessments must be addressed remediated (Q2).

8. The state dental services coordinator should develop tools to determine the quality of the dental assessments completed at the facility (Q2).

9. The state dental services coordinator should work with the facility to correct problems with the reporting of data related to clinic appointments. SASSLC should report data a standardized data set to eliminate confusion (Q2).

10. SASSLC must report data on the use of sedation and general anesthesia for on-campus and community appointments as previously done (Q2).

11. The facility director should determine why problems continue with the reporting by the IDTs of strategies and intervention implemented to address missed appointments (Q2).

12. The facility must do a comprehensive evaluation of the issue of informed consents to ensure that treatment is not excessively and unnecessarily delayed because of the processing of consents.

13. The facility must determine conduct a comprehensive review of the clinic to determine what the outstanding needs of the individuals are. A plan should be developed to correct any backlogs of treatment using all of the community resources available (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:** Documents Reviewed: o Admissions list o Budgeted, Filled, and Unfilled Positions list, Section I 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 Comprehensive Communication Assessment template o Communication Monitoring tool template o AAC-related spreadsheets and summary reports o Individuals with Behavioral Issues and Coexisting Language Deficits o Individuals with PBSPs and Replacement Behaviors Related to Communication o List of individuals with PBSPs o List of individuals with AAC o List of common area AAC devices o List of individuals receiving direct speech services o Behavior Therapy Committee meeting minutes o OT/PT/SLP Assessment template o NEO curriculum materials related to PNM, tests and checklists o Assessment Tracking Log o Assessment audits submitted o Communication –Hearing-Environmental Control Equipment Observation Forms submitted o Compliance Monitoring forms submitted o Communication Assessments, ISPs, and ISPAs for the following: • Individual #311, Individual #177, Individual #272, Individual #48, Individual #13, Individual #47, Individual #287, Individual #259, Individual #118, Individual #, 143, Individual #79, Individual #300, Individual #45, Individual #11, Individual #311 o Communication Assessments, ISPs, ISPAs, SPOs, and communication and AAC-related documentation for the following: • Individual #333, Individual #104, Individual #255, Individual #174, Individual #31, Individual #335, Individual #180, Individual #112, Individual #225 o Communication Assessments for individuals recently admitted to SASSLC: • Individual #195, Individual #183, and Individual #266 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, Annual Nursing Assessment, Quarterly Nursing Assessments, Braden Scale forms, Annual Weight Graph Report, Aspiration Triggers Data Sheets (six months including most current), Habilitation Therapy tab, and Nutrition tab, for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206. o PNMP section in Individual Notebooks for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206. o Dining Plans for last 12 months, PNMPs for last 12 months, Aspiration Trigger Sheets for the following: • Individual #302, Individual #138, Individual #135, Individual #32, Individual #150, Individual #122, Individual #248, Individual #176, Individual #268, Individual #241, Individual #58, Individual #270, Individual #114, Individual #167, Individual #171, Individual #215, and Individual #206. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MA, CCC-SLP, Habilitation Therapies Director o Allison Block-Trammell, MA, CCC-SLP o Various supervisors and direct support staff o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day Programs and work areas
	Facility Self-Assessment: SASSLC applied a new model for the self-assessment format for this review. Margaret Delgado-Gaitan, MA, CCC/SLP, the Habilitation Therapies Director, outlined specific assessment activities, some of which were based on previous reports by the monitoring team. She attempted to quantify each and presented findings in the self-assessment report as well as supporting documentation that demonstrated specific accomplishments or steps. The Presentation Book provided a sample of documents to illustrate some of the elements assessed and an analysis of the findings, accomplishments, and work products. While the existing audit tool was referenced in R3, this was not heavily relied on for self-assessment. This was a positive step. While some elements may be valuable in assessing compliance with this provision,

	others clearly were not and, as such, this tool should be revised to better reflect what is meaningful. The most important next step for Ms. Delgado-Gaitan is to minimally revise the existing audit tool for section R. A revised/new version of this tool may be used in addition to the other indicators identified by Ms. Delgado-Gaitan. The activities for self-assessment listed for each provision were numerous and will not be listed here. The findings were presented in narrative form and it may be useful to supplement that with data in a graph or table format to illustrate change and improvements over time. An action plan to address identified issues can illustrate how Ms. Delgado-Gaitan would intend to proceed toward compliance. This was discussed at length and hopefully will be helpful to her as she moves forward over the next six months. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the clinicians and Ms. Delgado-Gaitan and believes that the facility was continuing to proceed in the right direction. She is highly commended for her leadership, direction, and support to the speech staff through this process. Careful review of this monitoring report will provide additional insight into essential measures for self-assessment. The facility self-rated itself as noncompliant with all four items of R (R1 through R4). While actions taken were definite steps in the direction of substantial compliance, the monitoring team concurred with this finding.
	Summary of Monitor's Assessment: Staffing levels were decreased at the time of this review, though there had been significant efforts made to hire speech language pathologists. Contract hours had also been reduced. Progress in the completion of assessments was slow and, per the current schedule, would not be complete until June 2013. Any further reduction in staffing in the meantime would further delay completion of these key assessments for individuals with identified needs for communication supports. As always, the SLPs were responsible for communication supports and mealtime supports for all of the individuals, and responsibility for the PNMT was also assigned to one SLP. The current ratio for caseloads continued to be high. Consideration for a Speech Assistant position should occur. While the assistant would not be licensed to conduct assessments, he or she would provide very valuable supports related to direct therapy and indirect supports for modeling, training, and monitoring. There continued to be individuals who were considered to have priority needs related to communication who had not yet received the new comprehensive assessment. The clinicians were attempting to develop communication programs and supports as these assessments were completed. It is important that the facility understand that this process is complicated. It is not a simple matter of distributing programs and devices. It is true that staff can be trained to understand how the device works, but it is not intuitive in the sense of knowing how to actually integrate it into activities throughout the day in an appropriate and meaningful way.

	Staff tend to see these systems as an exercise or a single activity rather than as a way to interact with others. This cannot actually be taught or trained in an inservice class, but rather modeled and coached in the moment. Integration of communication strategies and AAC systems should not be the sole responsibility of direct support and day program staff. Engagement in more functional skill acquisition activities designed to promote actual participation, making requests, choices, and other communication-based activities, using assistive technology, should be an ongoing 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 these programs for individuals and groups. This requires significant time from the professional staff. Thus, the completion of assessment is but a step in the continuum of the provision of communication services. The therapists are encouraged to step up their efforts to immerse themselves into the routines of the individuals they support to capitalize on the teachable moments with staff so that they may learn to capture teachable moments with individuals. Overall, the monitoring team was very encouraged by the current strategies and infrastructure for staff training and monitoring in place to address communication supports for individuals living at SASSLC and looks forward to continued progress.

#	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 four SLPs, two full-time, Ron Hoffmann, MS, CCC, CCC-SLP and Allison Trammell, MA, CCC-SLP, and two part-time contract clinicians, Bobbie O'Connor, MS, CCC-SLP, and Melissa Garcia, MA, CCC-SLP. Ms. O'Connor worked 32 hours per week and Ms. Garcia worked 20 hours per week. Per the list submitted to the monitoring team, there were three budgeted positions for SLPs plus two contractors who averaged 40 hours each. This list indicated that there were two positions filled, two contractors, and one unfilled position. Each of the four clinicians was listed as full time, though the documented ratio was 1:93, the approximate equivalent of three full time therapists. By report, a fourth full time position was cut when the individual filling that position resigned. There was currently a speech/audiology technician, Aimee Miller, who worked full time. Ms. O'Connor was assigned to homes 673 and 668. Mr. Hoffmann was assigned to homes 766, 665, 671, and 672. Ms. Trammell was assigned to homes 674 and 670 and also served on the PNMT. Ms. Garcia filled in at all homes as needed. Each clinician provided both communication and dysphagia supports and services. <u>Qualifications</u> • 4 of 4 SLPs (100%) were licensed to practice in the state of Texas. Evidence that the facility consistently verified both state licensure and ASHA certification	Noncompliance

#	Provision	Assessment of Status	Compliance
		for each clinician will be requested prior to the next compliance review. <u>Continuing Education:</u> A list was submitted as evidence of participation in communication-related continuing education in the last 12 months. • 3 of the 4 (75%) SLPs participated in continuing education related to communication including the following: o Texas Speech and Hearing Association 2012 Annual Convention, 10 to 15 hours (Trammell and Hoffmann) o Augmentative Alternative Communication, 13 hours (Trammell and Hoffmann) o Achieving Communication Competence, one online hour (Garcia) While this was ample for Ms. Trammell and Mr. Hoffmann, it was inadequate for Ms. Garcia. Ms. O'Connor had not attended any communication-related courses in the last 12 months. She, Ms. Trammell, and Mr. Hoffmann attended Wheelchair, Seating, Mobility and Positioning (three hours) in July 2012, which was excellent and had an indirect application to AAC. The monitoring team anticipated that each of the clinicians would be supported to participate in further communication-related continuing education courses over the next year. This is critical to ensure improved clinical assessment and program development for AAC and language for individuals with developmental disabilities. <u>Facility Policy</u> No local policy existed for the provision of communication services at SASSLC. The following components should be considered in the development of such a policy: • Outlined assessment schedule • Timelines for completion of new admission assessments (within 30 days of admission or readmission) • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.) • Frequency of assessments/updates • Timelines for completion of comprehensive assessments (within 30 days of identification via screening, if conducted) • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within five days of identification as indicated by the IDT) • A process for effectiveness monitoring by the SLP • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment • Methods of tracking progress and documentation standards related to intervention plans	

#	Provision	Assessment of Status	Compliance
		• Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution This provision item was not in substantial compliance due to the diminished staff ratios during most of this review period and limited continuing education attended by speech clinicians. The facility did not provide an adequate number of speech language pathologists or speech assistants with specialized training or experience as further evidenced by noncompliance with R2 through R4 below.	
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.	<u>Assessment Plan</u> The Master Plan, dated 7/23/12, listed only those individuals who still required a comprehensive assessment that met "current agreed-upon standards." It must be clarified that "agreed-upon" should not imply that there was an agreement between the facility and the monitoring team, but rather an internal agreement among the clinicians. All existing communication assessments were audited to determine if (a) they met the currently established format and content guidelines and (b) for those that did not, whether they were scheduled for completion per the annual ISP schedule without prioritization based on need. This was acceptable as long as each individual was on schedule to receive an appropriate comprehensive assessment in a timely manner. At least 143 individuals, however, were listed as requiring a new comprehensive communication assessment with an average completion of 10 per month, with all completed as of August 2013. There were approximately 50 of these individuals who had previously been identified as nonverbal and approximately 22 identified as limited verbal and, as such, considered priorities. There were 14 of those in Priority 1 and 10 of those with Priority 2 who were scheduled for assessment in 2013, as late as June 2013. All others scheduled were Priority 3 or considered to be functionally verbal, per the initial screening. Most of those considered to be Priority 1 had received an assessment in 2009 (14) and 2010 (22), but there was no consistent evidence of updates in the interim. Two individuals had not received assessments for over 10 years, including Individual #99 (2001) and Individual #313 (1996). There were 15 individuals scheduled for assessments in July 2012 and each was listed with a newly completed assessment. On the other hand, 10 individuals were scheduled for August 2012, but as of 8/23/12, none were listed as completed. Seven of these individuals were Priority 1 and three were Priority 2, four of whom had not received an assessment in over three years (Individual #12, Individual #205, Individual #206, and Individual #6).	Noncompliance

#	Provision	Assessment of Status	Compliance
		On the positive side, the clinicians were making an effort to ensure that all individuals who had received a new assessment would be provided a communication-related SAP and any AAC supports identified. It was not clear that this goal could be consistently achieved, however, at the current rate of completion. For example, only 43 had been completed in the last six months. Only 13 were completed prior to or on the established deadlines. Thus, these were unavailable for the ISP process. It was also not clear that once the assessments were indeed completed, that appropriate supports and services could be effectively implemented with appropriate and timely follow-up with annual updates to document progress and/or ongoing needs. Based on review of this schedule and other documents submitted: • 3 of 3 individuals (100%) admitted during the last six months received a communication screening or assessment within 30 days of admission or readmission. • Comprehensive communication assessments were provided to all individuals newly admitted to SASSLC rather than only a screening. • 19 of 43 individuals (53%) had communication assessments completed within 10 or more days of their annual ISP. <u>Communication Assessments</u> Communication assessments were requested and submitted as follows: • Individuals in the sample selected by the monitoring team (14 of 17 were submitted) • Five of the most current assessments by each speech clinician (14 were submitted for four SLPs) • Individuals newly admitted to SASSLC (three were submitted) • Individuals who participated in direct communication intervention, had SAPs, were provided AAC, had PBSPs, and/or presented with severe language deficits (assessments for nine individuals were requested and submitted) A number of multiple year assessments were submitted for individuals, though only those current in the last 12 months were included in the sample for review. In other cases, a comprehensive assessment had been previously completed and annual updates were provided. This included Individual #333, Individual #255, Individual #104, and Individual #225. The most current assessments for some individuals were completed more than 12 months ago, though annual assessments/updates would be expected for each (Individual #174, Individual #112, and Individual #31).	

#	Provision	Assessment of Status	Compliance
		Current assessments for only seven individuals in the sample selected by the monitoring team were submitted. The assessments for seven others were completed more than 12 months ago: 2010 (Individual #138 and Individual #122), 2006 (Individual #150), 2005 (Individual #167), 1992 (Individual #270 and Individual #206), and 1989 (Individual #248). Five of these were scheduled for a new comprehensive assessment: Individual #206 (August 2012), Individual #270 (July 2013), Individual #150 (December 2012), and Individual #122 and Individual #138 (November 2012). Individual #248 or Individual #167 were not scheduled for new comprehensive assessments until 2014 and 2015 respectively. There was no evidence of any communication assessment in the individual records for Individual #215, Individual #241 or Individual #268. Individual #215 was scheduled for a new communication assessment in March 2013 and Individual #268 was scheduled in February 2013, though Individual #241 was not scheduled until 2014. All totaled, there were 23 current assessments available for review. Four of these were updates to a previously completed comprehensive assessment (Individual #333, Individual #255, Individual #225, and Individual #104). These were intended to addend a previously completed comprehensive and, as such, contained abbreviated content to update the individual's current year status. Each of the original comprehensive assessments, as well as additional updates, was submitted for these four individuals. No other updates were noted in the documents reviewed. A template for the Speech-Language Communication Comprehensive Assessment was submitted and this state-approved format was adopted at SASSLC on 6/15/12. No content guidelines were submitted. Only three of the comprehensive assessments (Individual #171, 7/24/12, Individual #183, 6/25/12, and Individual #266, 6/15/12) were completed using this format submitted as current. 0 of 14 individuals had comprehensive assessments that contained <u>all</u> of the 22 elements outlined below. These were the minimum basic elements necessary for an adequate comprehensive communication assessment. Many of these elements were missing or they were inadequately addressed. The current state assessment format and content guidelines generally required that these elements be contained within the assessments. The elements most consistently included were: • Individual preferences, strengths, interests, likes, dislikes • Description of verbal and nonverbal skills with examples of how these skills were used functionally throughout the day. • Comparative analysis of current communication function with previous assessments	

#	Provision	Assessment of Status	Compliance
		• Identify need for direct or indirect speech language services • Reassessment scheduled • Manner in which strategies, interventions, and programs should be utilized throughout the day The percentage of assessments that included each individual element are listed below: • Dated as completed 10 days prior to the annual ISP (48%). • Diagnoses and relevance of impact on communication (12%). Most assessments merely listed the diagnoses. • Individual preferences, strengths, interests, likes, and dislikes (88%). Though identified for most individuals, some of these were minimal and the information was not consistently utilized to design individualized AAC systems or programs building on strengths and interests. • Medical history and relevance to communication (12%). Medical history, particularly from the last year, was limited. • Medications and side effects relevant to communication (12%). Most of the assessments did not even list the medications prescribed. Those that did generally identified issues that would impact communication abilities. • Documentation of how the individuals' communication abilities related to their health risk levels (4%). Most of the assessments reviewed did not address this. • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day (96%). This was a strength of the assessments reviewed. • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) (52%). • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal (8%). The clinicians did not provide examples of information included in the dictionaries, did not routinely discuss if these were still accurate and effective, and did not discuss specific changes needed. Some of the statements were merely rote descriptions of how a communication dictionary could assist staff. • Discussion of the expansion of the individual's current abilities (40%) The adequacy of content related to this varied greatly. • Discussion of the individual's potential to develop new communication skills (28%). The adequacy of content related to this varied greatly. • Effectiveness of current supports, including monitoring findings (0%). This was not consistently present in the assessments reviewed and none presented findings from monitoring conducted throughout the last year. • Addressed the individual's AAC needs including clear clinical justification and	

#	Provision	Assessment of Status	Compliance
		rationale as to whether the individual would benefit from AAC (68%). This was improved from previous reviews, but content continued to be variable. In some cases, the clinician established that the individual was not ready for application of AAC for immediate use, yet many did not address methods to address this via skill acquisition or availability during meaningful activities. • Comparative analysis of health and functional status from the previous year (12%). • Comparative analysis of current communication function with previous assessments (92%). This was generally a report of the developmental levels of language/communication skills as determined by testing. The assignment of a developmental level would not usually impact the design of a communication plan. Life experiences of an adult, despite intellectual challenges and language deficits, are not comparable to those of a preschool child and, as such, these age levels are not usually of use for program development. • Identify need for direct or indirect speech language services (96%). • Reassessment schedule (88%). • Monitoring schedule (0%). • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits (72%). • Factors for community placement (8%). The clinicians offered general communication based supports only. • Recommendations for services and supports in the community (8%). One assessment indicated that skilled speech services were not needed in the community though specific communication supports were recommended. None of the others outlined specific service needs in the community. • Manner in which strategies, interventions, and programs should be utilized throughout the day (84%). In the cases that specific communication strategies were listed in the assessment, they were generally functional and could be applied throughout the day. Additional findings: • 0 of 25 (0%) assessments contained five or fewer of the elements outlined above. • 17 of 25 (68%) assessments contained six to 10 of the elements outlined above. • 8 of 25 (32%) assessments contained 11 to 15 of the elements outlined above. • None of the 25 assessments contained more than 15 of the 22 elements outlined above. • Only three assessments submitted were completed per the assessment format submitted as current (Individual #171, Individual #183, and Individual #266**)**.	

#	Provision	Assessment of Status	Compliance
		• Augmentative/Alternative Communication and Assistive Technology: Content in this section varied across assessments, though most showed improvement. • Clinical Impressions: The analysis sections of these reports were somewhat improved, though most provided insufficient rationale for the recommendations. The assessments for Individual #171 and Individual #266 presented elements of an adequate analysis of assessment findings and, in part, justified the recommendations made. The assessment for Individual #183 provided some new objective information not previously introduced, summarized other data, and presented some clinical analysis, though none of these provided a rationale for the recommendations. • The assessments did not generally identify important life activities or inventory ways for greater meaningful participation in them. • Most assessments identified preferences, likes, and dislikes. These were important for establishing contexts for communication opportunities, but the clinicians did not establish a clear link between these and functional participation in the daily routine. Observations in natural environments would also provide important clues as to preferences as well as individual potentials for enhancing or expanding existing communication skills There were 124 individuals listed with severe language deficits (45% of the current census). Eight-five of these individuals were listed as nonverbal and another 39 individuals were described as having limited verbal skills. Only 72 (58%) of them had received a communication assessment since 2011 (34 others were scheduled for an assessment before the end of calendar 2012). These individuals had the greatest need for communication supports, yet they had not been prioritized via the Master Plan. While they were now scheduled for an assessment, this should have been provided in a more timely manner. At least 19 individuals were not scheduled until at least 2013, even though some had not had an assessment in over 10 years (e.g., Individual #220 (2004), Individual #315 (1989), Individual #294 (1998), Individual #90 (1993), and Individual #193 (2000)). <u>SLP and Psychology Collaboration</u> There were 63 individuals with PBSPs and replacement behaviors related to communication. Overall, only 39 individuals (62%) of those on this list had received a communication assessment during 2011 or to date in calendar year 2012. Ten others were scheduled prior to the year's end. Others were not scheduled until at least 2013 and as stated above, these individuals should have been prioritized based on their needs for a comprehensive assessment in a more timely manner. A number of individuals for whom communication assessments were submitted also had	

#	Provision	Assessment of Status	Compliance
		PBSPs. The assessments of nine were reviewed to determine if the communication strategies identified were integrated into these plans (Individual #171, Individual #167, Individual #270, Individual #268, Individual #122, Individual #150, Individual #135, Individual #138, and Individual #302). • Individual #138: The most current communication assessment was 10/26/10 and, as such, current information was not available to psychology. Further, the BSP was expired 12/2/11. Individual #138 had limited verbal skills. • Individual #150, Individual #167, and Individual #270: Their most current communication assessments were 3/22/06, 2/6/05, and 6/23/92 respectively. As such, there was no current information available to psychology for application of specific communication strategies into their BSPs. • Though Individual #302 had a current communication assessment 2/17/12, it was completed over a week after the ISP conducted. The BSP in his record expired on 3/8/12. His plan provided for use of a voice output device as replacement behavior for a target behavior of aggression toward others. The communication assessment reported that this had not been successful and was not recommended as a method for communication. There was no evidence of a revised BSP in the record as submitted. • Individual #135: Her BSP was designed to address food stealing, pica, and mouthing inappropriate objects. By report, this was not related to communication issues. The strategies outlined in the plan were generally consistent with the findings and recommendations for the communication assessment. She was identified as nonverbal. • Individual #122: The most current communication assessment was 12/7/10 and was incomplete. As such, there was no current information available to psychology. He was identified with limited verbal skills. • Individual #268: There was no evidence of any communication assessment. There were, however, a number of communication strategies in the BSP. There was no current information available to psychology for application of specific communication strategies to be incorporated into his BSP. He was nonverbal. Behavior Therapy Committee meeting minutes for the last six months were reviewed. Minutes with attendance lists were submitted for 27 meetings from 1/10/12 through 7/30/12. A SLP had attended only 30% of these meetings (three in May 2012 and five in July 2012, only). This is a key opportunity for discussions regarding effective communication strategies and for collaboration between the SLPs and psychologists in the review of PBSPs. There was, however, other collaboration. The current communication assessment format included a section titled Behavioral Considerations, which indicated if the	

#	Provision	Assessment of Status	Compliance
		individual had a PBSP and the types of behaviors noted during the assessment. Each of these were steps toward compliance in this area. The quality of content of this section varied greatly across assessments, and did not consistently appear to be used in the analysis of assessment findings section, for the design of communication supports and services, or for making recommendations. • In the case of Individual #171, it was reported in his communication assessment, dated 7/24/12, that the psychologist said that his behaviors may be related to communication deficits and that his target behaviors may be used functionally to communicate to others. The SLP stated that the communication strategies in the PBSP were appropriate to his communication abilities. The SLP also stated that the psychologist suggested that Individual #171 learn to use a VOD (voice output device) to request a drink or to go outside. The SLP also reported that he rarely spontaneously used a VOD, but that it appeared to have meaning to him. When modeled to activate the device, Individual #171 smiled in response to the voice message. When paired with a drink, it was reported that he took more interest. o However, since Individual #171 did not identify objects or pictures or demonstrate knowledge of sign language, AAC was not recommended by the clinician. It did not appear that the SLP recognized the potential for Individual #171 to learn the meaning of a single message by pairing it with a preferred activity such as drinking or going outside and that this constituted functional AAC use. o Even so, a SAP for home training was recommended. The objective stated that he would activate a VOD stating "I want more to drink" during mealtimes. o This was viewed as environmental control rather than an objective to learn to communicate a request for more. It was of significant concern to the monitoring team that this quite basic premise was not known to this SLP and perhaps others working at SASSLC. o There appeared to be a consistent view of AAC that, if the individual did not spontaneously use the system even when presented in an environment or situation out of a routine or preferred activity, that the individual would not benefit from AAC use. o The clinicians are strongly encouraged to approach assessment and supports with the recognition that meaning and language is learned and device use is the media for learning. Use may increase as meaning is attached through learning in a functional context. <u>Assessment Audits</u> An audit tool was implemented on 3/1/12 to ensure that assessments included the required elements. Three samples were submitted with the section R Presentation Book. The audit tool elements were extensive. They were reviewed with the clinicians during	

#	Provision	Assessment of Status	Compliance
		the previous onsite visit by the monitoring team. These should now be reviewed for consistency with those outlined above. As per the self-assessment, audits were completed from March 2012 through 8/7/12 (28). It was reported that 75% of the assessments met criterion/competency, defined as ≥ 90%. In future reviews, it would be useful for the monitoring team's reviews if the department also used this tool to conduct a comparative analysis of assessments to validate the audits conducted by the clinicians. Per the self-assessment for this section, it was recognized that continued improvement and consistency were needed in the assessment reports. There was, however, a marked improvement over previous reviews (though actual content elements required continued improvement as described above and per the facility's own self-assessment). The department was clearly examining its performance in this area. This provision of section R of the Settlement Agreement was not in substantial compliance due to the documented weaknesses in the existing assessments as reviewed. It is appropriate that many individuals were receiving new assessments and these were clearly much improved compared with previous monitoring reviews. The department should reconsider the timeline for completion.	
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> Based on review of the sample of ISPs, the following was noted: • 32 of 37 ISPs submitted and reviewed (86%) were current within the last 12 months. 30 individuals had documented communication needs. • In 17 of 30 current ISPs reviewed (57%) for individuals with communication needs, an SLP attended the annual meeting. • In 10 of 18 current ISPs (56%) reviewed for individuals with AAC, the specific type was identified, though for most, these were new recommendations identified through the ISP process rather than already in use. The ISPs for Individual #268 and Individual #112 were better examples of addressing communication and AAC. • 14 of 32 ISPs reviewed (44%) included a description of how the individual communicated, though three did not include the AAC system (if he or she had one). More of the new format ISPs contained this information, so this was an improvement. Most of the descriptions, however, were minimal and did not provide a functional description of how the individual communicated or ways staff could effectively communicate with them. ISPs for Individual #268, Individual #112, and Individual #143 addressed communication the most adequately. • 15 of 32 ISPs reviewed (47%) contained skill acquisition programs related to communication skills. Ten others had action steps stating the individual would	Noncompliance

#	Provision	Assessment of Status	Compliance
		have a communication plan or would activate a device, but no specific communication-related training objective(s). <u>AAC Systems</u> Many individuals at SASSLC were provided communication dictionaries. In addition, there were 77 individuals using 90 different AAC systems of various types. These included voice output devices, picture folders, sign language pictures and boards, picture cards, Cheap Talk and Twin Talk devices, object and picture rings, picture wallets, picture books, and boards, and other more advanced electronic AAC systems. Of these, AAC was provided to 53 individuals who were considered to be Priority 1, 20 to individuals listed as Priority 2, and four for individuals identified as Priority 3. There were 97 individuals who were Priority 1 and considered nonverbal, and 23 who were Priority 2 with limited verbal skills for whom no AAC was provided. A number of these individuals had received a communication assessment since 2011 and the provision of AAC may have been ruled out. Though, as described above, in some cases, AAC was dismissed when an individual failed to activate a switch during an assessment rather than incorporated into meaningful activities. In some of those cases, there was no plan to provide SAPs or other supports to promote skill acquisition related to AAC. In other cases the responsibility was placed on the home or day program staff with minimal supports from the therapists. Also the speech clinicians appeared to consider only the hands as a means to activate a switch, whereas a number of individuals might have been able to gain access in alternate ways. Collaboration with OTs and PTs may be helpful in the identification of these alternatives. There were approximately 34 individuals identified as Priority 1 or 2 who had not received a recent communication assessment. For nine individuals, their most current communication assessment was 10 or more years ago (Individual #99, Individual #206, Individual #215, Individual #336, Individual #315, Individual #193, Individual #90, Individual #313, and Individual #12). Communication plans were consistently provided, though they usually did not include pictures. There were at least 81 of these plans in place as of 8/7/12. There were an extensive number of general use devices located in various environments across nine homes and five locations in the development center. Individuals often had more than one system, one for use in a work environment and one for the home environment. Consistent implementation was an ongoing concern and, as such, meaningful and functional use by the individuals often did not occur and was not observed by the monitoring team. In the Senior Program at the development center, Individual #180 had a two-message switch to make a choice between a puzzle and Connect 4 activities, but it	

#	Provision	Assessment of Status	Compliance
		was kept on a table that was not accessible to Individual #180. Staff reported it had been put away after using it for the initial choice making. Unfortunately, it was not available to her throughout her time in the center in order to make another choice. When requested by the monitoring team, it was placed near her, she grabbed it, and appeared to unintentionally activate the switch selecting the Connect 4. She was working on a puzzle at the time, making this an excellent opportunity to provide the alternate activity to assist her in attaching meaning to the two switches. There was a general use switch in the same room that was for individuals to activate as they left, in order to say "I'll see you later" and "I'm going home." Individuals left the room without prompts to use the switch. <u>Direct/Indirect Communication Interventions:</u> Generally accepted professional standards of care for documentation by the SLP related to communication interventions included the following: • Current communication assessment identifying the need for intervention with rationale. • Measurable objectives related to functional individual outcomes included in the ISP. • Routine IPN or other SAP documentation contained information regarding whether the individual showed progress with the stated goal. • Routine IPN or other SAP documentation described the benefit of device and/or goal to the individual. • Routine IPN or other SAP documentation reported the consistency of implementation. • Routine IPN or other SAP documentation identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. • Termination of the intervention was well justified and clearly documented in a timely manner. Direct communication-related interventions were provided for four individuals (Individual #31, Individual #335, Individual #112, and Individual #225). The focus for Individual #31 and Individual #112 was related to use of their AAC systems. It was to improve speech intelligibility for Individual #225. Intervention for Individual #335 was on hold until a new AAC device was acquired. Communication assessments were submitted for each individual as follows: • Individual #225: Comprehensive Communication Evaluation (6/3/11), Interim Communication Update (6/8/12) • Individual #31: Comprehensive Communication Evaluation (2/16/11) • Individual #112: Comprehensive Communication Evaluation (9/2/10), Interim Communication Update (8/22/11)	

#	Provision	Assessment of Status	Compliance
		• Individual #335: Comprehensive Communication Evaluation (9/26/11) As noted, only Individual #225 and Individual #335 had current assessments. The others were expired at the time of this review. The facility intended to provide interim assessment updates for individuals. This, however, was not noted for the individuals reviewed. Recommendations for these interventions were supposed to be included in the assessments and ISPs for each individual along with functional measurable objectives. An audit had been conducted on 6/15/12 to address this issue with variations or omissions identified for correction in the ISPs for 48 individuals. Compliance with this was reported to be 82% for the 33 current ISPs located during this process. Documentation for four of four individuals (100%) was submitted, however, none of the documentation was adequate as per the indicators outlined above (0%). As such, the provision of these interventions did not meet basic minimum standards for speech services. Identified issues were as follows: • Individual #225: Though it was indicated that Individual #225 was currently in direct therapy, the only data sheets submitted were for April 2012. There was a monthly progress report only for July 2012. Documentation was incomplete. • Individual #335: Progress notes for October 2011 through January 2012 were submitted, but there were no data sheets available. A series of notes indicated the device not being available, being out for repair, and then being un-repairable. A recent note stated that therapy would start again in September 2012. It was not acceptable that Individual #335 had to wait five months for this device. There was no documentation of this in the SAP progress notes or in the IPNs. • Individual #31: Though it was indicated that Individual #31 was currently in direct therapy, data sheets submitted were for the months of February 2012 through April 2012 only. There was no comparative analysis of the data sheets submitted in the manner of a monthly or quarterly progress note. A speech therapy progress report for June 2012/July 2012 was submitted, but no data sheets were. There was no documentation for the month of May 2012. • Individual #112: Progress notes for January 2012 through July 2012 were submitted. The note format was awkward and differed considerably from that submitted for the other individuals. Consistency of participation in therapy sessions could not be determined. A clinician's recommendation was to continue with the current program as soon as her computer was repaired, but there had been no documentation that her computer was not working. Various notes indicated failure of provision of direct service. It was unacceptable that over seven months' time Individual #112 received only a total of five sessions of	

#	Provision	Assessment of Status	Compliance
		direct therapy over three of the seven months. Indirect communication supports were provided for a number of individuals and documentation for five individuals was reviewed (Individual #333, Individual #180, Individual #104, Individual #255, and Individual #174). Assessments and ISPs were submitted for all five, but documentation related specifically to communication was submitted only for Individual #333 and Individual #174. There were data sheets with no evidence of review by the SLP. Two task analyses for Individual #174 included poorly worded steps and many steps that were staff actions not skills of the individual. Further, the data sheets showed that she completed each step correctly, exactly every seven days for the month of July 2012. Clearly, the documentation was not accurate in either of her programs and there was a need for revision of the steps. It was not known who was responsible for the development of these, but collaboration was needed to ensure that the steps were correct and meaningful as well as to ensure that the data collection by staff was accurate. <u>Competency-Based Training and Performance Check-offs</u> New employees participated in NEO classroom training prior to their assignment in the homes and they completed initial competency check-offs for specific skill sets related to PNM and communication. It was reported that there was a four-hour expanded session related to communication taught by one of the speech clinicians that began 3/16/12. The outline submitted in the section R Presentation Book, however, indicated that this portion of the training was for one hour and forty minutes only. If so, this amount of time was sorely inadequate to teach the necessary skills, provide opportunities for active participation and practice of the skills, and teach strategies for effective communication partners. The amount of time listed in the NEO schedule indicated that it was a three hour block. Three to four hours is the minimal timeframe needed to ensure that staff can have the adequate time to absorb the information presented, practice the application of concepts learned, and demonstrate competency. There was no evidence that communication was taught as an aspect of the annual block refresher training. While the interactions of staff with 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. Sometimes, there was a tremendous amount of staff talking to/at the individuals during activities, but without appearing to understand how to facilitate better interaction, engagement, and participation with the individuals. • Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology where appropriate), should continue to be a priority. This will only be possible when the clinicians are sufficiently	

#	Provision	Assessment of Status	Compliance
		available to routinely model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. • Rather than only co-designing written programs and providing formal training, actual implementation should be collaborative with demonstration in real time activities. Many of the communication strategies outlined or the ability to incorporate assistive technology is not naturally intuitive for direct support professionals. o Group and individual activities should be routinely co-directed by speech clinicians and DSPs in the homes, work, and day program environments, so that the clinicians can model how to appropriately use these strategies during the activities to expand and enhance staff's partnering skills as well as to expand and enhance active participation of the individuals via communication. o Also, collaborating with OT and PT in this capacity will further promote functional and meaningful activities for individuals.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	<u>Monitoring System</u> Monitoring of communication supports was provided using the Communication-Hearing-Environmental Control Equipment Observation Form and the PNMP Compliance Monitoring form. These were used to evaluate staff knowledge regarding the required supports, the presence and condition of the supportive equipment, and the appropriate implementation of the supports. The frequency of this monitoring was not clear to the monitoring team, but should be based on prioritized communication needs. The monitor was to provide immediate feedback and correction to the DSP related to identified concerns. Findings were entered into a tracking database. Findings and analyses were reported to the QAQI Council. There was no local policy related to monitoring of communication supports that outlined service delivery or more specifically related to monitoring. Completed monitoring sheets (46 Communication Observation Forms and 11 Compliance Monitoring forms) were submitted for approximately 33 individuals completed in May 2012 through July 2012. Fifteen were completed by PNMPCs and the rest by SLPs. The Communication Observation Forms were not scored, but rather nine indicators were marked "yes", "no" or "N/A" (not applicable). An additional section to be completed only by the SLP included three indicators to determine if the system was effective.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Sixteen forms were marked as full compliance with all "yes" responses on the first nine indicators. There were 28 of 32 (88%) forms completed by the SLPs where AAC was identified as effective. These were completed quarterly by the clinicians for each individual with communication and/or environmental control systems. In the cases of Individual #171, Individual #333, Individual #122, and Individual #24, their AAC was deemed ineffective, yet the rationale for this was not documented, and there was no documentation of follow-up or closure on the monitoring form (even though there was a place on the form to do that). The compliance forms produced a score, and eight of those were scored at 100%. All of the others ranged from 80% to 90%. A trend tracking system was developed and implemented in March 2012 to track monitoring by the PNMPCs and therapists and to track identified issues and follow-up. Monitoring findings were not documented in the individual record or integrated with the ISP review process. The SLPs did not reference these findings in their annual assessments. Monitoring of communication programs and systems should be based on level of need 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. Findings reported in the section R self-assessment indicated that staff were knowledgeable of the communication supports for individuals in 87% of the cases. Staff knowledge is only one aspect of the process. Evaluation of the frequency and consistency of implementation is another key indicator that was not reported. The tracking log for monitoring conducted over the last six months was not submitted, so the frequency and consistency of monitoring by both the PNMPCs and SLPs could not be determined, but will be a focus during the next review by the monitoring team.	

Recommendations:

1. Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were nonverbal should be addressed in the communication assessment and reviewed routinely throughout the year (R2).

2. The clinicians should clearly describe communication abilities and opportunities across a variety of settings as observed by the therapist in the assessments. The daily activities should be observed for potentials for communication partners to facilitate participation. For example, encouraging an individual to look toward their wheelchair before a transfer or blinking or vocalizing for "go" to initiate the transfer are ways in which the individual can participate in a way that is communication-based. Holding a self-care object, like a toothbrush, while the DSP brushes

their teeth is another way in which opportunities can be captured during routine activities throughout the day. These activities must be observed however to capitalize on those potentials. Clinicians must consider training and functional integration of AAC throughout the day as an option. Clinicians should include more opportunities for working with direct support staff and day program staff to model and coach ways to integrate communication and AAC throughout the day (R2).

3. Continue efforts to acquire full time SLPs to ensure that the facility is able to meet the identified needs of individuals and meet the requirements of the Settlement Agreement in a timely manner. Consideration of the addition of a Speech Assistant should be strongly considered as another means to provide training and coaching for appropriate implementation of communication plans (R1).

4. Support participation in continuing education opportunities related to communication for all SLPs (R1).

5. Develop guidelines and training for QDDPs as to how to integrate communication-related information into the ISP (R3).

6. Develop guidelines for documentation of communication supports and services to improve content and consistency (R4).

7. Evaluate content and instructional methods for NEO and other communication training (R3).

8. Monitoring of communication supports and services should be based on need (R4).

9. Develop an operational policy related to communication-related processes (R1).

10. Review and increase the current rate of completion of assessments per the Master Plan (R2).

11. 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).

12. Continued staff training and modeling are indicated to ensure appropriate and consistent implementation of recommended AAC systems (R3).

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: • Individual #163, Individual #268, Individual #73, Individual #314, Individual #47, Individual #2, Individual #164, Individual #104, Individual #256, Individual #170, Individual #216, Individual #85, Individual #31, Individual #113, Individual #240, Individual #156, Individual #62, Individual #327, Individual #36, Individual #173, Individual #281 o Skill Acquisition Plans (SAPs) for: • Individual #216, Individual #85, Individual #31, Individual #113, Individual #240, Individual #156, Individual #62, Individual #327, Individual #36, Individual #173, Individual #278 o Quarterly reviews of SAP progress for: • Individual #31, Individual #240 o Monthly review of SAP progress for: • Individual #173, Individual #113, o Functional Skills Assessment (FSA) for: • Individual #113, Individual #240, Individual #173, Individual #36, Individual #62, Individual #85 o Personal Focus Assessment (PFA) for: • Individual #113, Individual #240, Individual #85, Individual #173, Individual #36 o Vocational assessments for: • Individual #240, Individual #85, Individual #173, Individual #36, Individual #62 o Sensory Skills Program Assessments for: • Individual #62 o Section S Presentation Book, undated o SASSLC self-assessment, dated 8/7/12 o SASSLC action plans, dated 8/9/12 o Section S Work Group Meetings, dated 4/16/12, 5/15/12 o Active Treatment Coordinator meeting agenda/notes, 6/1/12, 6/8/12 o Home 672 Pilot Project meeting agenda/notes, 6/11/12, 7/16/12 o Engagement data for the month of June o Engagement data for each training site, January-June, 2012 o IOA engagement graph o Integrated Individual Support Plan Monthly Review, undated o Skill acquisition observation tool, dated 2/16/12

	o A list of instances of skill training provided in community settings, undated o A summary of community outings per residence for the past six months o Community objective goals per home, undated o A list of individuals who are employed on-and off-campus, undated o Description of day and work program sites, undated o A list of dental desensitization plans developed since the last onsite review o List of individuals who were under age 22, indicating if each was attending public school and the name of the school (13 individuals since last onsite review) o ISP, ARD/IEP, and recent progress reports for: • Individual #122, Individual #184, Individual #113 o SASSLC ISPA notes regarding review of SAISD progress reports (8 individuals) • Individual #122, Individual #184, Individual #113 <u>Interviews and Meetings Held</u>: o Gina Dobberstein, Active Treatment Coordinator o Karla Baker, QDDP; Gina Dobberstein, Active Treatment Coordinator o Juan Villalobos, Unit I Director; David Ptomey, Unit II Director; Greg Vela, Unit III Director o Mark Boozer, psychologist, Vinne Khamphoumanivong, QDDP, Eric Saenz, QDDP, SASSLC liaisons to SAISD <u>Observations Conducted</u>: o Active Treatment Meeting o Individual Support Plan (ISP) meeting • Individual discussed: Individual #281 o Observations occurred in various day programs and residences at SASSLC. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals.
	Facility Self-Assessment: Overall, the self-assessment included relevant activities in the "activities engaged in" sections. Further, the self-assessment appeared based directly on the monitoring team's report. SASSLC's self-assessment consistently included a review, for each provision item, of the activities engaged in by the facility, the topics that the monitoring team commented upon in the last report, and any suggestions and recommendations made within the narrative and/or at the end of the section of the report. This allows the facility and the monitoring team to ensure that they were both focusing on the same issues in each provision item, and that they were using comparable tools to measure progress toward achieving compliance with those issues. The monitoring team wants to acknowledge the efforts of SASSLC in completing the self-assessment, and believes that the facility was proceeding in the right direction. 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 recommends that the facility establish, and focus its 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: Although no items of this provision of the Settlement Agreement were found to be in substantial compliance, the monitoring team noted several improvements since the last review. These included: • Conducted training across the facility on the implementation of SAPs (S1). • Began to collect interobserver agreement (IOA) for engagement measures (S1). • Began assessing the integrity of SAP implementation (S3). • Began to graph SAP outcomes to increase the likelihood of data based decisions concerning the continuation, revision, or discontinuation of specific SAPs (S3). • Began to establish community-training goals per home (S3). • Developed a plan to implement a pilot program to address the items in Provision S (S1, S2, S3). The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that the rationale for each SAP clearly states how acquiring this skill is related to the individual's needs/preference (S1, S2, S3) • Ensure that each SAP has a plan for maintenance and generalization that is consistent with the definitions below (S1) • Initiate an interdisciplinary team to address the use of general compliance plans, dental desensitization plans (S1) • Document how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2). • Expand the graphing of SAP data to increase the likelihood that the continuation, modification, or discontinuation of SAPs is the result of data based decisions (S3). • Expand the collection of treatment integrity data to all SAPs (S3). • Increase the implementation of SAPs in the community (S3).

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, 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 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 is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. <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 Active Treatment Coordinators. 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 preferences. In other words, for skill acquisition plans to be most useful in promoting individuals' growth, development, and independence, they should be individualized, meaningful to the individual, and represent a documented need. 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 47 SAPs across 11 individuals. Thirteen of the 47 SAPs reviewed (28%) had no rationale for the selection of the SAP. In 23 of the remaining 34 SAPs reviewed (68%), the rationale appeared to be based on a clear need and/or preference. This represented an increase from the last review when 55% of SAPs were judged to have a clear rationale. The following are examples of rationales that were judged to not be specific enough for the reader to determine if they were practical and functional for the individual: • The rationale for Individual #327's SAP of correctly identifying the number of pills he takes was "It was determined through the discussion that (Individual #327) would benefit from learning his medications…" • The rationale for Individual #113's SAP of money management read "It was determined through team discussion that it is important to learn how to manage his money."	Noncompliance

#	Provision	Assessment of Status	Compliance
		On the other hand, examples of rationales that appeared to be based on a clear need and/or preference were: • The rationale for individual #278's vocational SAP indicated that the selection of this SAP was based on direct observations during his vocational assessment, and also incorporated his preference to work in a quieter environment. • The rationale for Individual #173's SAP of learning to cross the street was "…will receive city bus ride training…and learning to cross a street is imperative for his success as well as his safety." SASSLC should ensure that each SAP contains a rationale for its selection. Additionally, the rationale should be specific enough for the reader to understand that the SAP was practical and functional for that individual. 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 SAP training sheets contained all of the above components. As discussed in the last report, the maintenance and generalization plans, however, did not consistently reflect the processes of maintenance and generalization. A generalization plan should describe how the facility plans to ensure that the behavior occurs in appropriate situations and circumstances outside of the specific training situation. A maintenance plan should explain how the facility would increase the likelihood that the newly acquired behavior will continue to occur following the end of formal training. Overall, 23 of the 47 SAPs reviewed (49%) included a plan for generalization that was consistent with the above definition. This was a slight improvement over the last report	

#	Provision	Assessment of Status	Compliance
		when 42% of generalization plans were judged to be consistent with the above definition. Fourteen of the 47 SAPS reviewed (30%) included a plan for maintenance that was consistent with the above definition. This represented an improvement from the last review when only 16% of maintenance plans reviewed were judged to be consistent with the above plan. An example of a good generalization plan was: • The plan for generalization in Individual #156's vocational SAP of completing tasks with less than three verbal prompts stated, "Residential and vocational staff can use formal and informal training opportunities to teach (Individual #156's) to perform other activities with a limited number of prompts." • The plan for generalization in Individual #327's SAP of identifying the Men's restroom sign, stated that he be encouraged to identify other men's restrooms in the community. An example of an unacceptable plan for generalization was: • The plan for generalization in Individual #240's vocational SAP stated that he "….will be encouraged to participate in activities and to become more independent in the areas of work, home, and leisure." An example of a good maintenance plan was: • In Individual #113's SAP of crossing the street, the plan for maintenance stated once he has attained the skill of safely crossing the street, he will be encouraged to continue to cross streets in the community. An example of an unacceptable maintenance plan was: • The plan for maintenance in Individual #36's SAP of brushing his teeth stated, "Consistent training will improve (Individual #36) oral hygiene." The results concerning the acceptability of the rationale, generalization, and maintenance discussed above are consistent with the facility's self-assessment, which indicated that 30% of reviewed SAPs contained an acceptable rationale, and plans for generalization and maintenance. As discussed in the last report, many 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).	

#	Provision	Assessment of Status	Compliance
		SASSLC continued to use various training methodologies, including total task training (e.g., 278's vocational SAP), shaping (e.g., Individual #62's activation of a voice output device SAP), and forward chaining (e.g., Individual #216's vocational SAP) and backward chaining (e.g., Individual #240's vocational SAP). This represented an improvement, over past reports, in the variety of training methodologies used. <u>Desensitization skill acquisition plans</u> Desensitization plans, designed to teach individuals to tolerate medical and/or dental procedures, were developed by the psychology department. No dental desensitization plans were developed since the last onsite review. At the time of the onsite review, the facility was in the process of developing an interdisciplinary team to reduce the use of sedation for routine dental assessments. Additionally, the psychology department reported that they were initiating an assessment procedure to determine if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. It is recommended that SASSLC implement the plan for an interdisciplinary team to address the use of general compliance plans, dental desensitization plans, and sedating medications. It is also recommended that 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. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> 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. <u>Communication and language skill acquisition</u> The monitoring team was encouraged to encounter several new communication SAPs during this review. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs. Also, see section R. <u>Service objective programming</u> 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).	

#	Provision	Assessment of Status	Compliance
		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 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 consistently observed staff attempting to engage individuals in active treatment at SASSLC. As found in past reviews, the ability to maintain individuals' attention and participation in the activities, however, varied widely across staff and homes. For example, in Home 665, the staff were engaging individuals in several lively small group discussions. On the other hand, in many other homes, staff and individuals appeared less enthusiastic with the process of active treatment. The engagement activity topics, at times, appeared impractical to the monitoring team and may have contributed to lack of enthusiasm. For example, topics such as dinning room etiquette, and meal preparation did not appear to be topics that were relevant to all individuals observed. When DCPs were questioned about the practicality of the engagement activity topics, they simply indicated that these are the topics they were told to discuss. It is recommended that a group of individuals (including DCPs and their supervisors) be charged with identifying the range of activities for each home to ensure that they are maximally relevant and interesting to the individuals residing in that home. The average engagement level across the facility was 45%, a steady decrease over the last three reviews (i.e., 61%, 59%, and 50%). As discussed in the last review, the engagement data collected and monitored by the facility revealed a substantially higher engagement level. For example, the engagement level of all home and vocational sites for the month of June 2012 averaged 76%. 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, data were recorded as each individual engaged or not engaged based on what was seen at that moment of observation. On the other hand, the facility, did a three-minute time sample. That is, the	

#	Provision	Assessment of Status	Compliance
		facility's observer watched a particular individual for three full minutes and recorded engagement if that individual was engaged at anytime during the three-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. For example, it was typical to observe individuals only engaged when staff was directly interacting with them. When the staff moved on to direct the activity to the next individual, the other individuals in the group often appeared not to be engaged. This scenario would likely result in a higher level of engagement using the facility's partial interval measure, relative to the monitoring teams momentary time sample. Finally, the monitoring team was encouraged to learn that SASSLC recently began to collect interobserver agreement (IOA) measures on engagement data. A consistently high (above 80%) IOA level across the facility would greatly increase the confidence of the engagement data. Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
Home 668	2/8	2:8
Home 668	1/5	2:5
Home 668	1/6	1:6
Home 670	1/7	2:7
Home 670	1/6	2:6
Home 766	3/3	1:3
Home 665	3/3	1:3
Home 674	2/6	2:6
Home 673	0/1	0:1
Home 673	0/1	1:1
Home 670	1/7	1:6
Home 670	3/7	2:7
Home 665	1/1	1:1
Vocational Workshop	7/16	3:16
Vocational Workshop	2 /4	1:4
Vocational Workshop	10/10	3:10
Vocational Workshop	8/16	4:16
Vocational classroom	3/7	3:7
Vocational classroom	5/7	2:7
Vocational classroom	3/3	1:3
Vocational classroom	2/7	2:7
Home 674	3/5	3:5
Home 671	1/5	1:5

#	Provision	Assessment of Status	Compliance

Forever Young	3/8	2:8
Forever Young	3/8	3:8
Forever Young	4/8	3:8

Educational Services

Mark Boozer, psychologist, and QDDPs Vinne Khamphoumanivong and Eric Saenz were the facility's liaisons with the public school, San Antonio Independent School District (SAISD). Overall, the facility continued a positive relationship with the ISD that resulted in beneficial outcomes for the individuals. Thirteen individuals received SAISD services over the past six months. The new school year was to begin the week following this onsite review.

The liaisons reported that the monthly SAISD-SASSLC meeting continued (described in detail in the previous monitoring report), they attended ARD-IEP meetings, and they were planning for a number of student transitions, such as from middle school to high school and from high school into the ISD's community based vocational training program. Also, three students had summer school. It lasted 12 weeks, for 5 days per week, and was for full days, too.

They reported that they worked very well with SAISD special education and administrative staff as well as with the individuals' classroom teachers regarding any behavioral issues. Further, the QDDPs reported that they incorporated some of the ARD-IEP goals and objectives into home programming at the facility. This had been accomplished for many, but not yet all, of the students. Further, a special ISPA IDT meeting was held after grades and progress reports were issued, so that the team could review school progress and issues. Including ARD-IEP goals in the home, and holding a school progress IDT meeting were accomplishments. The monitoring team acknowledges this progress and attention to recommendations from previous monitoring reports.

In addition to meeting with the liaisons, the monitoring team reviewed a set of documents from the facility. Based on this, the monitoring team does not have any further recommendations for the facility, other than to continue with all of the collaborative activities that were occurring over the past six months, including incorporating ARD-IEP goals into the home, and regularly reviewing SAISD progress and grade reports.

#	Provision	Assessment of Status	Compliance
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 continued to struggle with the documentation of how this information impacted the selection of skill acquisition plans. This item was rated as being in noncompliance, because not all individuals had skill, preference and vocational assessments, and it was not clear that assessments were consistently used to develop SAPs. At the time of the onsite review, 173 of the 275 individuals at SASSLC (63%) had transitioned from the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). The facility self-assessment also indicated that approximately 50% of individuals had a personal skills assessment (PSA), and 87% had a vocational assessment. All individuals should have assessments of preference, strengths, skills, and barriers to community integration. The monitoring team reviewed six FSAs, five PSAs, and five vocational assessments. The majority of those assessments were complete (Individual #85's PSA was the exception). The FSA appeared to be an improvement over the PALS in that it provided more information (e.g., necessary prompt level to complete the skill) regarding individual's skills. No assessment tool, however, is going to consistently capture all the important underlying conditions that can affect skill deficits and, therefore, the development of an effective SAP. Therefore, to guide the selection of meaningful skills to be trained, assessment tools often need to be individualized. The FSA may identify the prompt level necessary for an individual to dress himself, but to be useful for developing SAPs, one may need to consider additional factors, such as context, necessary accommodations, motivation, etc. For example, the prompt level necessary for getting dressed may be dependent on the task immediately following getting dressed (i.e., is it a preferred or non-preferred task), and/or the type of clothes to be donned, whether the individual chooses them or not, etc. Similarly, surveys of preference can be very helpful in identifying preferences and reinforcers, however, there is considerable data that demonstrates that it is sometimes necessary to conduct systematic (i.e., experimental) preference and reinforcement assessments to identify meaningful preferences and potent reinforcers. There was no documentation of the use of individualization of assessment tools to identify SAPs. Additionally, review of ISPs and assessments did not consistently document how assessments impacted the development of programs. The following were typical: • Individual #85's vocational assessment stated that he generally stayed on task. Nevertheless, he had a SAP for staying on work tasks. Additionally, his FSA	Noncompliance

#	Provision	Assessment of Status	Compliance
		stated that he understood what money was worth and how to use it and count it, but he had a purchasing (money management) SAP. • Individual #240's ISP indicated he continue his administration of medications SAP without any discussion of his FSA results, or discussion of any assessment data, that led to the conclusion that those skills were practical and functional for him. • Individual #62 had a dressing SAP, but no mention in his ISP of any assessment results (e.g., FSA or PSA) that suggested that independent dressing was a practical SAP for him. • Individual #281's ISP indicated that he had no skills and no interest in money, however, his SAP included a money management SAP. His ISP (observed by the monitoring team) provided no assessment information or rationale as to why this particular SAP was chosen for Individual #81. Finally, Individual #113's FSA indicated that he independently brushed his teeth and used mouthwash. His ISP, however, included a tooth brushing SAP without any explanation of how a skill that he apparently possessed was a practical or functional SAP. In response to the monitoring team's question about this apparent inconsistency between the FSA results and the selection Individual #113's tooth brushing SAP, the active treatment coordinator was able to explain that, although he COULD independently brush his teeth, he did not routinely brush them thoroughly. The tooth brushing SAP, therefore, was selected to teach him to brush his teeth thoroughly. This appeared to be an example of how the FSA assessments were used to develop a meaningful skill acquisition plan. There was, however, no documentation of this individualized use of an assessment that resulted in a functional skill acquisition program. The facility should ensure that assessments are consistently used and documented to select individual skill acquisition plans.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		

#	Provision	Assessment of Status	Compliance
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	There was improvement in this provision item, however, the graphing of SAP outcomes and the collection and monitoring of treatment integrity data needs to be expanded to all SAPs before this item can be rated as being in substantial compliance. Additionally, SASSLC needs to demonstrate that data-based decisions concerning the continuation, revision, or discontinuation of SAPs consistently occurs, and that SAPs are consistently implemented with integrity. At the time of the onsite review, QDDPs at SASSLC summarized SAP data and were transitioning from quarterly to monthly presentation of those data. As in the last review, none of the quarterly data summaries reviewed by the monitoring team included graphed data. Additionally, reviews of SAP quarterly data typically indicated if progress was maintained or progressing, but did not consistently present actual SAP data. As recommended in the last report, SASSLC had recently begun to graph monthly SAP data. It is now recommended that graphed data summaries of SAP performance be extended to all SAPs. Additionally, these graphed data summaries of individual SAP progress should be used to make data based decisions concerning the continuation, discontinuation, or modification of skill acquisition plans. Another area of improvement was the recent initiation of training of DCPs in the implementation of individual SAPs. At the time of the onsite review, 140 of 160 employees who implemented SAPs had been trained. As in past reviews, the monitoring team observed the implementation of SAPs in the day programs and homes to evaluate if they were implemented as written. The implementation of all SAPs reviewed appeared to be consistent with the SAP. This represented an improvement over previous reviews when inconsistencies between SAP implementation and SAP plans were found. Nevertheless, the only way to ensure that SAPs are implemented as written is to conduct integrity checks. This is another area of improvement since the last review. The facility recently began to pilot the implementation of treatment integrity of SAPs. It is recommended that measures of treatment integrity be extended to all SAPs, that integrity data are tracked, acceptable treatment integrity levels established, and that the facility achieves those integrity levels. The monitoring team is encouraged by the progress in this provision item, and looks forward to seeing continued progress in the next review.	Noncompliance

#	Provision	Assessment of Status	Compliance
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SASSLC enjoyed various recreational and training activities in the community. In order to achieve substantial compliance with this provision item, the facility needs to develop a data system to track recreational activities and training in the community, establish acceptable levels of each, and demonstrate the that those levels are consistently achieved. The facility developed a list of skill training in the community. The self-assessment, however, indicated there had been reliability problems with the recording of community training. It is recommended that recreational and skill training activities in the community be separately recorded so that trends can be tracked. SASSLC had, however, made progress in the establishment of community training goals in each home. At the time of the onsite review, the facility had community training goals for 45% of the individuals. It is recommended that the facility complete the development of community-training goals per home. At the time of the review, three individuals at SASSLC worked in the community. Two individuals were reported to work in the community during the last onsite review.	Noncompliance

Recommendations:

1. Ensure that each SAP contains a rationale for its selection. Additionally, the rationale should be specific enough for the reader to determine that it was practical and functional for that individual (S1).

2. 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) (S2).

3. Initiate an interdisciplinary team to address the use of general compliance plans, dental desensitization plans, and sedating medications (S1).

4. Dental desensitization plans should be incorporated into the new SAP format (S1).

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

6. Ensure that engagement activities are maximally relevant and interesting to the individuals residing in home (S1).

7. All individuals should have assessments of preference, strengths, skills, and barriers to community integration (S2).

8. The facility should ensure that assessments are consistently used (and documented) to determine individual skill acquisition plans (S2).

9. Graphed data summaries of SAP performance should be extended to all SAPs. Additionally, these graphed data summaries of individual SAP progress should be used to make data based decisions concerning the continuation, discontinuation, or modification of SAPs (S3).

10. It is recommended that measures of treatment integrity be extended to all SAPs, that integrity data are tracked, acceptable treatment integrity levels established, and that the facility demonstrate that they achieved those levels (S3).

11. Skill training activities in the community should be recorded so that trends could be tracked (S3).

12. Complete the development of community-training goals per home (S3).

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, attachments, January 2012 o SASSLC facility-specific policy, 300-21A, Facility Most Integrated Setting Practices, 12/1/11 o SASSLC organizational chart, undated, but probably July 2012 o SASSLC policy lists, undated, but probably 6/30/12 o List of typical meetings that occurred at SASSLC, undated o SASSLC Self-Assessment, 8/7/12 o SASSLC Action Plans, 8/9/12 o SASSLC Provision Actions Information, no entries for section T. o SASSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/20/12 o Community Placement Report, last six months, 2/1/12 through 8/24/12 o List of individuals who were placed since last onsite review (1 individual) o List of individuals who were referred for placement since the last review (9 individuals) o List of individuals who were referred and placed since the last review (0 individual) o List of total active referrals (15 individuals), as of 8/24/12 o List of individuals who requested placement, but weren't referred (7 individuals) • Documentation of activities taken for those who did not have an LAR (6 individuals) ▪ Of these 6, one was referred in the weeks following the onsite review ▪ Documentation was submitted for only 1 of the other 5 individuals • List of individuals who requested placement, but weren't referred due to LAR preference (1 individual) o List of individuals who were not referred solely due to LAR preference (1 individual) o List of rescinded referrals (2 individuals) • ISPA notes regarding each rescinding • Special Review Team minutes for each rescinding (none) o List of individuals returned to facility after community placement and related ISPA documentation (0 individuals returned during this period) 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, and a brief narrative for each case (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 under alternate discharge procedures and related documentation (0 individuals) o APC weekly reports • Statewide weekly enrollment report, five, 5/25/12 through 6/29/12 • Detailed referral and placement report for senior management (none) ▪ One email with some detail on status, 8/19/12 o PowerPoint slides presented to QAQI Council on 8/2/12 o Job descriptions for APC, PMM, and transition specialists o Information and emails regarding statewide APC trainings held in June 2012 o Email clarifying that summaries of assessments, not full assessments go into the CLDP, 7/27/12 o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, August 2012 ▪ Attendance sheets, individual and staff preparation materials, booths visited • Community tours, 5/25/12 through 6/27/12 (7) and ISPAs/reports (none) • Meetings with local LA (1), 5/21/12 • New employee orientation (none) • Sessions with facility staff (none) • Self-advocacy meeting, 8/322/12 • Family association meetings, 6/10/12 • Facility newsletter, section on admission and placement (2) o Description of how the facility assessed an individual for placement (state policy) 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), and any obstacles, undated o List of individuals who had a CLDP completed since the last review (2 individuals) o Blank checklist used by APC regarding submission of assessments for CLDP that were <u>not</u> within the CLDP, and completed checklists (none) o DADS central office written feedback on CLDPs (2 individuals, 100% of the CLDPs) o For the three statewide monitoring tools for section T: • Blank tools • Completed tools: Review of CLDP (1), not summarized o State obstacles report and SASSLC addendum, October 2011 o PMM tracking sheet, created during week of onsite review o Community provider's daily log with ENE support checklist, from Draco services o Transition T4 materials for: • Individual #140 (ISPA notes regarding discussion of possible referral to another SSLC) o ISPs and assessments in the September 2011 style for: • Individual #198, Individual #47, Individual #199, Individual #208, Individual #226, Individual #13, Individual #301, Individual #195, Individual #245 o ISPs in the February 2012 style for: • (none) o ISPA meeting documents for:

	• Individual #223, Individual #245, Individual #272 (DFPS investigation) o List of community-based training objectives, per home, undated o CLDPs for: • Individual #272, Individual #159 o Draft CLDP for: (none) o In-process CLDPs for: • Individual #15, Individual #63, Individual #216, Individual #123, Individual #245, Individual #223 o Pre-move site review checklists (P), post move monitoring checklists (7-, 45-, and/or 90-day reviews), and ISPA documentation of any IDT meetings that occurred after each review, conducted since last onsite review for: • Individual #276: 90, post-90 • Individual #103: 90 • Individual #272: P, 7 o Follow-up notes for previous placements, Individual #107, Individual #269, May 2012 <u>Interviews and Meetings Held</u>: o Loren Williams-Jones, Admissions Placement Coordinator o Darlene Morales, Post move monitor o Carmin Santos, Joan O'Connor, Tania Fak, Transition specialists o Community provider staff and manager at Community Options residential provider staff, Vanessa Vara, case manager, Donnie, house manager o Community provider Day Haven day service provider staff, Dede Perriman, Harold Reynolds, and Laura o Meeting regarding incident during Individual #272's pre-placement overnight visit in July 2012 <u>Observations Conducted</u>: o CLDP Meeting for: (none) o CLDP assessment review meeting for: (none) o ISP Meeting for: • Individual #281 o Community group home and community day program visits for: • Individual #272 o Self-advocacy meeting, 8/22/12
	Facility Self-Assessment The APC had further developed what was presented last time by including a variety of activities in the self-assessment. In that regard, she made progress in that she was trying to look at actual activities and outcomes for each provision item. The monitoring team and APC spoke at length about the self-assessment during the onsite review.

	The most important next step is for the APC to make sure that she includes everything in her self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. The current three tools used by the APC had numerous problems in content and in implementation (see T1f). For example, in T1a, the APC only used the living options monitoring tool. As noted below in T1f and in previous reports, there were many problems with this tool. Therefore, basing the self-assessment on an inadequate, somewhat invalid tool renders the self-assessment fairly useless. Moreover, implementation at SASSLC was not consistent or reliable, as honestly noted by the APC in the self-assessment. A reading of section T1a in the monitoring report shows the topics reviewed by the monitoring team. It may be that a thorough reading of the report can be used as a guide for the APC to develop a more adequate self-assessment tool. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the APC and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in substantial compliance with six provision items: T1b, T1f, T1h, and T4. The monitoring team, however, rated T1c3 and T1h in substantial compliance. A reading of the report below describes why T1b and T1f were not in substantial compliance and why T1c3 was in substantial compliance. T4 was not rated by the monitoring team because no individuals were discharged or transferred as per this provision item's requirements.
	Summary of Monitor's Assessment SASSLC made progress since the last onsite review regarding many aspects of provision T. This occurred because a new Admissions and Placement Coordinator (APC) and new post move monitor (PMM) were hired. In addition, three new transition specialist positions were created and filled. All five of these new staff were just beginning to get systems in place. The specific numbers of individuals who were placed remained very low, at a rate of less than 1% of the census (1 individual). The number of individuals on the active referral list was also low, at 5% of the census (15 individuals), however, this was the highest since monitoring began at the facility. SASSLC was transitioning to the newest iteration of the ISP process. In the ISP meeting observed during the week of the onsite review, community living was discussed at various times during the meeting. Professionals were not, however, asked to give their opinions. Statements at the end of the written ISP, in a section titled Living Option Determination, these were not yet written adequately or in enough detail.

	The two CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. Nine activities regarding education of individuals, families, LAR, and staff were reviewed. SASSLC was engaging in some, but not all, of these activities. The APC made progress regarding the provider fair and in arranging tours and having individuals and staff participate. The APC appeared to have already established a good working relationship with the local authority. The rights officer continued to regularly include community living topics in the self-advocacy meeting. Two individuals moved before their CLDP transition work was completed on what were called extended transition visits, or furlough visits. Thus, the individuals actually moved, but were not officially transitioned. Assessments were not all completed within 45 days prior to the individual leaving the facility, and in many cases, the monitoring team could not determine if assessments were completed at all (e.g., psychiatry). Further, the assessments need to focus more upon the individual moving to a new residential and day setting. The lists of ENE supports in the two CLDPs were inadequate. Important supports were missing, the supports that were included were not written in measurable terms, and the descriptions of what evidence the provider needed to show were not defined in a sufficient manner. A quality assurance process for section T needs to be planned out and included in the facility-specific policy for most integrated setting practices. Since the last review, 3 post move monitorings for 3 individuals were completed. All occurred within the required timelines and were documented in the proper format. The PMM did a good job of following up when there were problems. She must, however conduct post move monitoring in a more assertive, detailed, and thorough manner.

#	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	SASSLC made progress since the last onsite review regarding many aspects of provision T. This occurred because a new Admissions and Placement Coordinator (APC) was hired to replace the APC who retired. The new APC, Loren Jones, was very energetic and was working hard to move the facility forward in its most integrated setting practices. She was only on the job for a few months at the time of this review. In addition, there was a new post move monitor (PMM), Darlene Morales, and three new transition specialist	Noncompliance

	proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	positions were created and filled. Although the transition specialists worked under the direction of a central office coordinator, the APC said that she expected for them to be fully included in all community living related activities at SASSLC. The monitoring team observed them at numerous meetings during the week of the onsite review. The specific numbers of individuals who were placed remained very low, at a rate of less than 1% of the census. The number of individuals on the active referral list was also low, at 5% of the census, however, this was the highest since monitoring began at the facility. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 1 individual was placed in the community since the last onsite review. This compared with 2, 5, 1, 3, and 5 individuals who had been placed during the periods preceding the previous reviews, respectively. o The low number was likely due to the change in APC and PMM. • 9 individuals were referred for placement since the last onsite review. o This compared with 8 who were newly referred at the time of the previous review. o 0 of these 9 individuals were both referred and placed since the last onsite review. • 15 individuals were on the active referral list. This compared with 10, 9, 4, and 3 individuals at the time of the previous reviews, respectively. o This was the largest number of individuals since monitoring began. o 6 of the individuals were referred for more than 180 days. Activities, however, were continuing towards their placements. • 7 individuals were described as having requested placement, but were not referred. This compared with 5 and 7 individuals at the time of the previous reviews, respectively. o 1 was not referred due to LAR preference, 1 was not referred due to medical issues, 1 was not referred due to legal citizenship reasons, 1 was not referred because he only wanted to live with his family and this was not an option, 1 was not referred due to an unspecified IDT decision, and 2 were not referred because the LA was not present at their IDT meeting. o The facility should immediately address the 2 individuals for whom the LA was not present. This was noted in the previous monitoring report. Further, DADS had since changed procedures, and LA presence was no longer required for a referral to occur. Although this change was noted in one of the APC's PowerPoint slides, there was no evidence that the issue had been addressed for these two individuals. o For the other 4 individuals, some sort of placement review or placement appeals process needs to occur. In the weeks following the onsite	

		review, 1 of these 4 individuals was referred for placement (Individual #22). • 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. This was noted in the previous monitoring report, too. For example, based on the written ISP, it seemed that Individual #301 should be included in this list. There are probably others, too. • The referrals of 2 individuals were rescinded since the last review. This compared to 4, 2 and 3 at the time of the previous reviews, respectively. o Each individual's IDT met and an ISPA report was issued that provided information indicating to the monitoring team that the decision to rescind was reasonable and done thoughtfully. The rescindings were due to the individual's choice (as best as the IDT could determine) and to legal issues. o A special review team meeting, however, was not held for each of these rescinded referrals. o As recommended in previous reports, however, the 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. Note that the ISPA and the SRT notes provided a lot of detail regarding the decision to rescind. The purpose of the APC review is to assess the referral and placement processes. o Note, however, that the new ISP process may result in an increase in referrals and, as a result, an increase in the number of rescinded referrals. If this occurs, it should not necessarily be viewed as an increase in failure by the facility. • 0 individuals were returned to the facility after community placement since July 2009 (one individual who was placed in 2005, however, was re-admitted). This compared with 0 and 1 individuals at the time of the previous reviews. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had run away from their community placements, or had other untoward incidents were available for the first time: (0 incidents). o These data, however, did not seem to be correct since it appeared that Individual #276 had a change in residence, Individual #103 had a change in day program, and Individual #107 had a psychiatric hospitalization and a change in provider. o For these, and if there should be any incidents in the future, a detailed	

		review/root cause analysis should be conducted for any significant post-move events in order to assess the referral and placement processes. • 0 individuals had died since being placed since the last onsite review. This compares with 0 at the time of the previous review. • 0 individuals were discharged under alternate discharge procedures (see T4). The monitoring team again recommends that each of the above bullets should be graphed separately. The new APC had begun to do some of this as evidenced in the slides presented at QAQI Council on 8/2/12. These data should also be submitted and included as part of the facility's QA program (see sections E above and T1f below). <u>Other activities</u> None described. <u>Determinations of professionals</u> This aspect of 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 was discussed at length in previous monitoring reports. Primary responsibility for meeting this requirement belongs to the QDDPs and the professionals. Thus, the monitoring team looks for indications in each professional's assessment, during the conduct of the annual ISP meeting, and in the written ISP that is completed after the annual ISP meeting. SASSLC was transitioning to the newest iteration of the ISP process (see section F). As a result, the monitoring team was limited in its ability to review professional determinations. During the week of the onsite review, the first new style annual ISP meeting was held. The monitoring team observed this meeting. The completed ISP document, however, was not completed (it was not due for 30 days after the meeting). As a result, the monitoring team used its observation of the one meeting, and a review of a sample of ISP documents completed for meetings held in March 2012 through June 2012. The monitoring team understands that the content and processes used in these ISP meetings and documents were to be updated. Nevertheless, the monitoring team provides some comments below and in section T1b1. First, for the written assessments, professional determinations were regularly provided in habilitation, communication, and nursing assessments. They were sometimes included in vocational/day program assessments. This was probably due to the template for the assessment providing a prompt for the professional to make this determination for those professionals. Adding a prompt to all of the assessments would be one way to	

		improve this. Second, in the ISP meeting observed during the week of the onsite review, community living was discussed at various times during the meeting. Professionals were not, however, asked to give their opinions. It may have been that the individual's mother, who was his LAR, was very clear that she did not want a referral for her son Individual #281. Further, she agreed to visit some community group homes over the next year, which the IDT felt was a very positive step. • Or, it may have been that the new style of ISP meetings will no longer include asking each professional his or her determination/opinion during the ISP meeting and instead have the IDT and QDDP rely on the content of the written assessments. • The monitoring team, however, has found this one-by-one verbal statement to be of value in the ultimate decision-making of the entire IDT. The monitoring team remains open to further discussion with DADS and the DADS consultant regarding this component of the ISP meeting. Third, in the sample of completed now-old-style ISP documents (representing the work of many different QDDPs), there was discussion of living options in every one of them. Moreover, there was a statement or paragraph about each of the professionals and his or her determination and opinion. This was good to see, however, this might not be in future ISP documents if the meetings will no longer include a statement of each professional's determination. The monitoring team has noted different "approaches" to way professionals give their determinations and opinions. The monitoring team recommends that the facility and state office consider providing more direction to the professionals, so that there is a consistent approach to this requirement. It may be that all three of these aspects of the professional's opinion should be addressed (that is the recommendation of the monitoring team). 1. A description of what supports that individual would need if he or she lived in the community. This, alone, was not really an adequate indication of the professional's opinion. 2. A statement of whether needed supports could be provided in the community, based upon the professional's knowledge of available community supports. 3. A specific declarative statement regarding whether the professional believed the individual should be referred and whether the individual was likely to do well in the community. <u>Preferences of individuals</u> The preferences of individuals continued to be sought and met by SASSLC IDT members. During previous reviews, the monitoring team had concerns about the way individual's	

		preferences were determined and supported. The monitoring team did not observe any problems during this review, but wanted to make sure that the new APC was sensitive to this issue and was aware of previous concerns. She should be sure to read the section T1a of all of the previous monitoring reports for SASSLC. <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 the weekly statewide enrollment report. As recommended in previous reports, she had just begun to complete a more detailed weekly report with more thorough and up to date information about each individual who was on the active referral list. She should work towards completing a weekly report much like the completed by the Lufkin SSLC APC. In addition to completing this more detailed report, the APC should do an occasional verbal presentation of the status of the active referrals, and on how some of the individuals who have moved are doing in their new homes, at their new day programs, and with their new lifestyles.	
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 completed and the DADS state office was expecting to disseminate it very soon. As noted in previous reports, on 5/16/11, the three monitoring teams submitted a number of comments related to the DADS draft policy for the state's consideration. It was anticipated that the state would address the monitoring teams' concerns in the revised version of the policy. 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. Further, at the parties' meetings in July 2012, the parties agreed that the rating for T1b would be based solely on the development of adequate state and facility policies. The sections T1b1 through T1b3 would be considered stand-alone provisions that required implementation independent of T1b or any of the other provision items under T1b.	Noncompliance

		The state and facility had not yet finalized adequate policies related to most integrated setting practices, therefore, the facility remained out of compliance with this provision.	
	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.	The newest style ISP process described in the previous report had been brought to SASSLC, but was only implemented for the first time during the week of this onsite review. The new ISP was to include items that had been missing from previous ISP formats, such as professional's opinions (T1a), the identification of protections, services, and supports (T1b1), the identification of individual obstacles (T1b1), and a thorough living options discussion and determination (T1b3). <u>Protections, Services, and Supports</u> The reader should see sections F and S of this report regarding the monitoring team's findings about the current status of ISPs and the IDT's ability to adequately identify the protections, services, and supports needed for each individual. Recently, DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was also found for these three provision items of section F: F1d, F2a1, and F2a3 The two CLDPs reviewed by the monitoring team indicated that no special actions were taken after an individual was referred to ensure that skill acquisition programs were considered and developed based upon the individual's referral to the community. The monitoring team recommends that, upon referral, the APC seek out the IDT, and the active treatment coordinator to talk about what SAPs might be considered now that the individual was referred for placement. This should be documented in the CLDP. If this type of discussion occurred during the ISP meeting in which the individual was referred, it should be explicitly documented in the ISP, too. That being said, the Active Treatment Coordinator had begun to focus on community-based training (see section S). To that end, she had begun to collect data on the number of individuals in each home who had objectives for community skills and she had a list of every individual and his or her community-based objective (if there were any). An incomplete list was given to the monitoring team, therefore, it could not be determined how many of the 15 individuals on the referral list had one or more community training objectives and if so, whether they were relevant to their upcoming transitions. The APC should obtain this list and cross-reference it to each of the individuals on the referral list. <u>Obstacles to Movement</u> Given that a new iteration of the ISP was just underway, the monitoring team's ability to comment on this aspect of this provision item is extremely limited. Going forward, the facility should ensure that obstacles to referral and to placement are appropriately identified and included in the new ISP (the ISP template format included this). Further,	Noncompliance

		there should be an action plan to address whatever obstacle or obstacles were identified. The monitoring team recommends that the next revision to the facility's self-monitoring tool for section T contain a determination of whether the ISP identified obstacles to referral and placement, and if the ISP included a plan to overcome any identified obstacles. These data could then be incorporated into the data set described in T1a above. The APC had expanded a chart that was begun at the time of the previous review. It contained most, but not all, individuals at the facility. It had a column for whether the individual could express his or her own opinion and three columns for up to three obstacles. Unfortunately, the chart was not fully completed, and the content for many of the individuals did not line up with what was in the ISP.	
	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.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. SASSLC was engaging in some, but not all, of these activities. <u>1. 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>: There was some progress towards developing an individualized plan in that the ISPs described activities the individual and/or LAR would take over the upcoming year, such as visiting some community providers. All three of the above open bullets, however, were not included in any of the ISPs. This may require an additional prompt in the ISP or standard expectations about what is in an action plan for community living. <u>2. Provider fair</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs <u>SASSLC status</u>: The APC made progress regarding the provider fair. She continued the work group the plans to have two fairs each year. A two-day fair was held in August 2012. Prior to the fair, the APC and her staff visited every home at SASSLC to talk with individuals and with staff about the fair to help them prepare for it, such as by suggesting a number of questions to be asked of providers. The APC collected	Noncompliance

		data on each individual's attendance, which provider booths each individual visited, staff attendance, and LAR/friend attendance. This was good to see. The data, however, need to be summarized and reviewed. Survey/satisfaction data from participants that included suggestions for improvement were not yet being collected. 3. Local MRA/LA • Regular SSLC meeting with local MRA/LA SASSLC status: The APC appeared to have already established a good working relationship with the local authority. Quarterly meetings were supposed to occur, but documentation was provided only for one (May 2012). Topics for that meeting appeared to be relevant. The quarterly meeting was important for the ongoing collaborative work between SASSLC and the LA. The APC should ensure that meetings occur at least once each quarter. 4. Education about community options • Outcomes/measures are determined and data collected on: o Number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options. o 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 APC should consider summarizing the data from all of the CLOIP reviews, including the recommendations made by the LA CLOIP workers. 5. 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: Much progress was made in arranging tours and having individuals and staff participate. Since the end of May 2012, it appeared that one to two tours occurred every week, at least through the end of June 2012. For each tour, the provider name and address and the individuals and staff scheduled to attend were listed on a one page provider tour schedule document. This was all good to see and a step in the right direction. To move forward, there needs to be: o A short, one page report or form regarding the individual's participation and response o The report/form information needs to go the IDT, so that it could be used by the team for planning purposes o A tracking system so that the APC knows if all individuals for whom a tour is appropriate indeed went on a tour.	

		o Thus, there should be (at least) three pieces of data related to tours: number of tours, number of different individuals who went on tours, and percentage of individuals for whom a tour was appropriate who went on a tour. These data could then be included in the facility's QA program and included in the set of data described in T1a. 6. Visit friends who live in the community SASSLC status: SASSLC was not yet implementing this activity in any organized manner. 7. 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 continued to regularly include community living topics in the self-advocacy meeting. During the week of the onsite review, a former resident of SASSLC spoke to the self-advocacy group about her experiences and she made suggestions to attendees. The APC made an extensive presentation to the family association in June 2012. It included introduction of the new transition specialists and description of their role, and presentations from two community providers. There were no house meetings for individuals. 8. A plan for staff to learn more about community options • management staff • clinical staff • direct support professionals SASSLC status: There was no plan to address this item. The APC, however, reported that she and her staff attended ISP and ISPA meetings and they wrote a column in the quarterly facility staff newsletter. A plan to address this item should include such activities as new employee orientation, periodic meetings with the discipline departments and the QDDPs, and periodic emailing of policies and other announcements to management and clinical staff. 9. 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 remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The APC presented the state policy on most integrated settings. 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: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual assessments. o Progress was observed, as noted in T1a, but this was not yet being done for all assessments. • 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. o This seemed to be occurring in the set of now-old-style ISPs reviewed, but it was unclear to the monitoring team if this was to continue because it did not occur at the one ISP observed during the week of the onsite review (Individual #281). • Living options for the individual were thoroughly discussed during the annual ISP meeting. o Discussion of living options to occurred during every ISP, however, the depth and breadth of these discussions varied greatly across ISPs. The living options discussion during the meeting observed had many good components to it, such as the individual's mother/LAR describing some of her thoughts about possible relocation, and her willingness to begin to visit community providers. The LA and the SASSLC transition specialist participated. As a result, specific action plans were added to the ISP. • 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 o Although there were statements at the end of the ISP, in a section titled Living Option Determination, these were not yet written adequately or in enough detail. o The recommendation for one individual contained a statement that he should seek community placement, but then he was not referred. This was not explained in the ISP (Individual #208).	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the	The APC submitted two CLDPs to the monitoring team for one individual placed since the last review and one individual who was in the last stages of transition. This was 100% of the CLDPs completed since the last review. A set of in-process CLDPs was also reviewed.	Noncompliance

	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:	Timeliness: One individual was referred in 2010 and the other in 2011, thus, their placements took much longer than 180 days. Even so, a CLDP could still be considered to be timely because there are many reasons for delays that are not due to lack of activity by the APC, IDT, or provider. In both of these cases, however, there were long gaps (i.e., months) where it was not clear what, if anything, was occurring regarding their referrals. For example, for Individual #272, the CLDP noted that "after a six month stall," they got back to work. Then, beginning in early June 2012 (really a seven month stall), there were frequent meetings, visits to the provider, and planning activities until his eventual placement on 8/15/12. Individual #159 was referred in October 2010, but had to have kidney surgery in March 2011. There's no other entry or information in the CLDP until May 2012, so the reader doesn't know what happened during the interim. These gaps occurred prior to the new APC taking on the job of APC. The monitoring team believes that the APC was keeping up on the CLDPs and, therefore, this was unlikely to continue to be an issue. Initiation of the CLDP: Rather than waiting until right before the individual moved, the CLDP document should be created at the time of referral. This was now occurring at SASSLC, usually at a meeting called the APC-PMM-IDT meeting. This typically occurred at the ISP meeting (if a referral occurred then) or within a week or so after the referral. The CLDP contents were then developed and completed over the months during which referral and placement activities occurred. All individuals on the referral list were reported to have a CLDP. The APC now included the date of initiation of the CLDP on the front page of the CLDP. This was helpful to see and was on Individual #272's CLDP, but not on Individual #159's. A sample of the in-process CLDPs were reviewed. They were for referrals that occurred approximately 30, 90, and 120 days. These CLDP contained some relevant information. The amount of information corresponded with the length of time since the CLDP was developed. For the newest referrals (e.g., Individual #15), the CLDPs were initiated in a timely manner. IDT member participation: IDT members need to be very involved in the placement activities of the individuals. Team members should thoughtfully evaluate the homes and day programs being explored by the individual. By being highly involved, and with the leadership of the APC, every one of the placements will be more likely to be individualized and the path that each individual takes to placement will more likely be based around his or her needs and preferences. To accomplish this, there need to be many visits to providers, overnight trials, and IDT meetings to review and discuss. For both individuals, however, the involvement of the IDT in the selection and review process was unclear. For Individual #272, the home was chosen by his mother and his	

		CPS guardian without any apparent involvement from the IDT. Although the guardian and mother may indeed make the decision as to where the individual will move, the IDT must visit the new providers and provide an opinion about the home, day program, supports, etc. For Individual #159, the CLDP merely stated that he will be going to the named provider. How this was determined was not described. Lack of IDT involvement in the selection process was noted as a problem in previous monitoring reports. That being said, it appeared that the new APC was now taking a much more active role in the provider selection process and by doing so, was involving the IDTs. Thus the problem of lack of IDT involvement may be much improved by the next onsite review. The monitoring team based this on a review of the brief one or two sentence status summaries in her 8/19/12 email, an ISPA for Individual #245, and discussions while onsite. Moreover, the APC reported that 10 of the individuals had now selected a provider and transition activities were under way. The 5 who had not yet selected were the 5 most recent referrals. They were, or were soon to be, engaging in selection activities, such as visiting providers. An example of IDT involvement was the way the APC and IDT responded to a behavior problem during Individual #272's pre-placement visit. He wandered over to a neighbor's home and refused to leave. Ultimately, police were called to assist. The IDT met and added a support to his CLDP (door chimes) and provided additional training to the provider staff regarding communication. <u>CLDP meeting prior to move</u>: A CLDP meeting was not scheduled during the week of the onsite review. Therefore, this aspect of this provision item could not be rated. The monitoring team spoke with the APC about ways to ensure that the monitoring team can assess a CLDP for the next onsite review. <u>Post post-move monitoring IDT meetings</u>: It was not clear if IDT meetings occurred after post move monitoring visit. There was no documentation of IDT meetings for the two post move monitorings conducted (also see T2a), however, there were some emails from the PMM trying to schedule an IDT meeting for Individual #276. The third completed post move monitorings submitted to the monitoring team was for the observation conducted during the week of the onsite review (see T2b) and, therefore, the IDT team meeting was not yet expected to have occurred. <u>Extended transition visits</u>: Two individuals moved before their CLDP transition work was completed (Individual #159, Individual #232) on what were called extended transition visits, or furlough visits. Thus, the individuals actually moved, but were not officially transitioned. The intent was to have the move happen even though all of the	

		paperwork (e.g., birth certificate) was not completed. The plan was to have an official CLDP meeting and transition date occur sometime a few weeks after the move. The monitoring team understands the reason for doing so, especially when the individual and the provider (e.g., HCS group home, family foster care) were ready. The problem, however, was that the systems put in place to ensure safe and successful transitions were not in place, such as a completed high-quality CLDP, a pre move site review, local authority involvement, and 7-day post move monitoring. The facility (with help from state office) needs to come up with a way to address this so that these important processes are not skipped.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	Three CLDPs developed and completed since the last onsite review 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 LA and community provider. Some comments regarding the actions in the CLDP are presented below. • The CLDPs did not adequately identify the need for training for community provider staff. The CLDPs did not include good descriptions of the content of what was to be trained. To move forward with this aspect of this provision item, the APC should address the following: o All of the specific community provider staff who <u>needed to</u> complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff) were not identified. o The method of training was not indicated, such as didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP. o Training should have a competency demonstration component. • Collaboration between the facility clinicians and the community clinicians (e.g., psychologists, psychiatrists, medical specialists) was not addressed. • 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. The assigned staff person was included, which was good to see. The completion of these activities also need to be documented. DADS central office continued to conduct reviews of CLDPs at SASSLC. Feedback was given for the two CLDPs. The content was relevant and important. It will be very important for the new APC to receive this type of feedback on her CLDPs, especially given that she is new, and especially given that these first two CLDPs needed much improvement.	Noncompliance

	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs did not adequately indicate the staff responsible for certain actions and activities and the timelines for these actions. This was especially absent in Individual #159's CLDP. Therefore, unfortunately, the monitoring team was unable to continue a previous rating of substantial compliance for this provision item.	Noncompliance
	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. Individuals and their LARs were very involved in the 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.	A meeting was held a few weeks prior to the CLDP meeting to review the set of assessments. The APC reported that she used the assessment tracking tool described in previous reports, however, only a blank one was submitted to the monitoring team. The monitoring team's review of the two CLDPs indicated that these sets of assessments were not all completed within 45 days prior to the individual leaving the facility, and in many cases, the monitoring team could not determine if assessments were completed at all (e.g., psychiatry) because the assessments were not attached to the CLDP. The only assessment-related information was what was found in the two CLDPs. The assessments sections of the CLDPs were quite a mess. Some sections were entirely missing, some were much too short, and some were merely cut and pasted from the larger assessment. Both individuals had serious psychiatric histories and both were taking many psychotropic medications (five and seven). There was no psychiatry discussion in either CLDP. For Individual #272, the psychology section merely recommended that there be a PBSP. Instead, there should have been commentary on what were the key important things to know about his behavior problems and for developing a BSP. • The assessments sections of the CLDPs also had many problems in formatting and presentation. Information was cut and pasted that seemed unnecessary, such as a page of diagnoses codes and pages and pages of communication dictionary information. Paragraphs were in different fonts and font sizes; some things were in bold and others weren't; indentations were inconsistent; the numbering of sections was wrong. All of this made it difficult to read and understand the CLDPs. In each subsection of the assessment review section of the CLDP, there should be a summary of the assessment, deliberations (discussion) that occurred <u>during</u> the CLDP meeting, and recommendations that came <u>out of</u> the CLDP meeting. • If a recommendation in an assessment does not make it into the list of ENE	Noncompliance

		supports, it should be documented as to why. Furthermore, the assessments need to focus more upon the individual moving to a new residential and day setting. All of the staff who wrote assessments were well aware of where the individual was moving, however, their assessments usually made little reference to the new home or day program. Further, the assessments, for the most part, did not place any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. Perhaps they were primarily assessments that were updated from the standard annual ISP assessment. • The monitoring team recommends that the assessment updates have prompts to the writer, such as "Instructions to provider" and/or "Recommendations in the community setting." These sections can help focus the professionals on the individual's specialized needs in his or her upcoming new home and day settings. The APC and his staff should thoroughly look at these recommendations to ensure that they are sufficiently future-oriented.	
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 no progress in developing adequate lists of essential and nonessential (ENE) supports as evidenced in the two CLDPs reviewed. The ENE support list is one of the most important parts of the CLDP. The APC should read the previous monitoring reports for section T1e. She would also benefit by reading section T1e from the previous monitoring reports from the other SSLCs monitored by this monitoring team. Below are comments on the list of ENE supports for the two individuals. Individual #272: • According to CLDP he needed structure and consistency (page 3), but this was not addressed as an ENE support. This need for structure and consistency was very apparent during the post move monitoring visit. Perhaps if it had been included as an ENE support, Individual #272 would have had more activity scheduling. • His need for communication was noted, but his only ENE support was for a communication assessment, which he'd already had at SASSLC. Instead, the IDT should have required that he have communication/language instruction and programming, such as a training objective. • He had a group of serious diagnoses, including autism, ADHD, OCD, IED, and constipation. These were not adequately addressed with ENE supports. Further, there was inconsistency in the diagnoses throughout the CLDP (e.g., in the medical section). • He was receiving five different psychotropic medications. The only ENE support was to see a psychiatrist. This was not sufficient.	Noncompliance

		• He had adaptive equipment, but there was not an ENE support. • Training objectives were not carried forward in money management, laundry, hygiene, etc. • In the CLDP, there was a suggestion of having someone with an education background in his life so that he could continue to learn, especially since he just graduated out of school. This was not addressed. • Going outside and to the park were noted as important, but were not included as an ENE support, other than a broadly written ENE support called "outings." • During his 3-day visit to the provider in June 2012, he had serious issues around access to the refrigerator. This was a problematic because of his lactose intolerance issues (if he grabbed and consumed milk products) and the need for food to be chopped (if he were to grab and consumer larger food items). This was not addressed by the IDT or by the provider. If it had been an ENE support, there might have been a plan, such as creating an instructional program for him to learn to be around a refrigerator. During the post move monitoring visit, he took milk out of the refrigerator, was interrupted by staff, and then engaged in tantrum and self-injurious behaviors. • On the other hand, during his July 2012 3-day visit, after he ran over to the neighbor's house, an ENE for a door chime was added. • The description of the evidence that the PMM should look for was inadequate. Evidence of implementation of some ENE supports might include some sort of a checklist Individual #159: • There were no ENE supports about any of the things that were important to him: o Having a garden o Improving communication and social skills o Living a social life, being in a city o Going to church, participating in choir o Having hats and magazines • The importance of understanding his personal space, not ignoring him, and attending to any snort/animal-like sounds were not addressed with an ENE supports. • There was no ENE support about his adaptive equipment. • There were no ENE supports about his many medical issues, including tuberous sclerosis, seizures, constipation, osteomalacia, and having one kidney. • There was no ENE support related to his need for a high calorie, high fiber, and chopped food diet. • He was receiving seven different psychotropic medications. There was no ENE support related to this. • Most of the ENEs were poorly written, in vague terms, such as "access to dietary	

		services." • The evidence required to show provision of each ENE support was blank for most items. Further, the monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below. • Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. • All safety, medical, and supervision needs were addressed. • What was important to the individual was captured in the list of ENE supports. • The list of supports thoroughly addressed the individual's need/desire for employment. Many individuals are excited to move to the community and do not fully understand that it may take months, if not longer, to find a job. • Positive reinforcement, incentives, and/or other motivating components to an individual's success procedures were included in the list of ENE supports. • There were ENE supports for the provider's implementation of supports. That is, 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. • Topics included in training had a corresponding ENE support for implementation. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of ENE supports should have a rationale. • Every ENE support included a description of what the PMM should look for when doing post move monitoring (i.e., evidence). This provision item also requires that: • Essential supports that are identified are in place on the day of the move. For Individual #272, the pre-move site review was conducted by the PMM and showed that the essential supports were in place. A pre-move site review was not conducted for Individual #159 even though he had moved. The PMM might consider bringing an IDT member along as well. Each review indicated that each essential support was in place. • Each of the nonessential supports should have an implementation date. All of them did for Individual #272. None of them did for Individual #159. • Some facilities hold an IDT meeting immediately following the pre-move site review before the individual moved. SASSLC might consider this.	

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.	The quality assurance process for section T needs to be planned out and included in the facility-specific policy for most integrated setting practices. The monitoring team recommends that this be a separate facility-specific policy. When planning a full quality assurance process for section T, all aspects must be included (e.g., living option discussion, CLDP development, CLDP content, ENE supports, CLDP implementation, post move monitoring). Three statewide tools were available. One was implemented, by the QA department staff, for one CLDP. A new set of tools needs to be developed. Once relevant quality assurance processes are in place, data graphs should be created. To create a more organized (and thereby more effective and useful) process, the state office and APCs should align their activities with the content of the Settlement Agreement and with the content of the monitoring team's report. That is, the APC, when self-assessing provision T, should be looking at the same activities and documents that the monitoring team looks at. The APC should then judge both the occurrence/presence and the quality of those activities and documents. This means that the department will need to self-assess its performance on every provision item by observing, collecting data, reporting data, and making changes based upon these data. Please also see the comments at the beginning of this section of the report in Facility Self-Assessment. The monitoring team, however, noted that the APC created a set of PowerPoint slides for presentation at a recent QAQI Council meeting. It was good to see the department beginning to assemble data and think about its presentation. Once a relevant set of data are collected, these types of presentations will be even more meaningful to the department, senior management, and QAQI Council.	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	The same state and facility report that was discussed in the previous monitoring report was again submitted. It was an annual report. The new report was due sometime in October 2012. Because this was the same report, please refer to the previous monitoring reports for discussion.	Noncompliance

	appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 2/1/12 through 8/24/12. 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

	Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	SASSLC demonstrated good progress towards substantial compliance with this provision item. The PMM was new and given that there were few transitions, only had a few opportunities to engage in post move monitoring. Nevertheless, good progress was seen and it is likely that further progress, if not substantial compliance, will occur by the next onsite review. <u>Timeliness of Visits</u>: Since the last review, 3 post move monitorings for 3 individuals were completed. This was 100% of the post move monitoring that was required to be completed. All of these were completed by the new PMM, Darlene Morales, with assistance from state office on 2 of the 3. All 3 (100%) were reviewed by the monitoring team. All 3 (100%) occurred within the required timelines. The PMM visited both the residential and the day program sites. The PMM had not maintained a spreadsheet indicating each individual, the deadline for completion of each post move monitoring, and the actual date of completion of each post move monitoring. During the onsite review, this tracking sheet was created and the PMM planned to use it going forward. As noted in T1c above, some individuals had moved prior to completion of their CLDPs and prior to initiation of the other section T-related processes (Individual #159, Individual #232). It was not clear if post move monitoring should have occurred because these individuals had indeed moved. This will need to be resolved by state office. As discussed with the APC, a simple review should be done of all placements to find out if any serious incidents occurred for the period of one year following placement. A simple phone call would be an easy way to obtain this information. The APC was keeping this set of data informally, but as noted in T1a, some incidents had occurred. <u>Content of Review Tool</u>: All 3 (100%) post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement. • Post move monitoring report forms were completed correctly and thoroughly.	Noncompliance

		Good information was included. • The overall summary at the end of the post move monitoring reports was good to see. • Detail was not provided regarding the training provided for each of the training-related essential supports. • The monitoring team liked that the PMM completed the checklists in a cumulative format, that is, she scored each item as yes/no for the current review, but she kept her comments (with dates) from any previous reviews in all of the boxes on the form. Thus, the 90-day checklist became a single cumulative document showing every visit from pre-move through the 90-day. This made it very easy for read to follow the individual through his or her first 90 days in the community. • It was not clear how many/if all staff were interviewed. • The individual's psychiatric diagnoses, psychiatric medications, and medical conditions might be inserted right into the post move monitoring form within the series of additional questions. This will make it easier for the PMM as well as for the reader to understand the individual's issues and what it is that the provider staff were expected to be informed about. Of the 3 individuals who received post move monitoring, all 3 (80%) transitioned very well. In the time since transitioning, one appeared to be happy and having a great life, one appeared to be going through some problems, and one had only very recently moved and, therefore, it was still to be determined. <u>Use of Best Efforts to Ensure Supports Are Implemented:</u> IDTs, the APC, and the PMM put a lot of effort into these placements. The PMM did a good job of following up when there were problems. The PMM did additional post move monitorings past 90 days if there were unresolved issues. Even so, some issues did not appear to be readily resolved. When that occurs, the PMM should readily call upon the APC and, in turn, the facility director and/or state office. Examples of the PMM's follow-up were: • For Individual #276, things seemed fine at 90-days, but then there were multiple problems, such as her day program changed to the residential provider's, she changed residences, and the residential provider was not responding to SASSLC phone calls. An IDT was held on 7/18/12 at SASSLC and some good suggestions were offered, but there was no further documentation was provided, so her current status remained unknown to the monitoring team. Documentation did, however, show that the PMM was trying to use her best efforts.	

		• For Individual #103, there was a report of him having had alcohol on a family home visit. Although he was an adult, he also took medications for which mixing with alcohol was not advised. The PMM found out more information from the facility's pharmacy department and interacted with the family about this. • She visited with 2 other individuals who had moved about a year ago. Documentation from these activities was also reviewed by the monitoring team, however, a regular post move monitoring form was not completed (but didn't need to be). IDT meetings were held not regularly held following the post move monitoring visits, but they should be.	
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.	SASSLC was not in substantial compliance with this provision item, but this was not unexpected given that the PMM was new to post move monitoring and she had few opportunities up to this point. The monitoring team accompanied the PMM and the APC on a 7-day post move monitoring visit to the home and day program of Individual #272. In fact, this was the PMM's first independent post move monitoring of an individual in a group home. Day Haven was the day provider Community Options was the residential provider. The day program was in a plain building. When the visit began, at 2:45, all 23 of the individuals were seated on chairs in a back room waiting for their transportation home, according to the staff. This went on for about an hour. During this time, there was no activity or engagement other than a large TV playing on the side of the room. The PMM and APC, however, said that during previous visits, at earlier times of the day, there was much more activity going on. The PMM asked some questions of some of the staff. Individual #272's home was pleasant enough, though sparsely furnished and somewhat dark. He lived with three other men. Both the day and home staff reported that, overall, he was doing well, though they were still getting to know him. The PMM conducted the post move monitoring in a very professional manner, proceeding through all of the items, asking questions, and asking for documentation. In order to meet substantial compliance, however, she must conduct post move monitoring in a more assertive, detailed, and thorough manner. The PMM should never forget that she is the eyes and ears of the IDT, facility, and DADS. She should never hesitate to question anything she sees, even if it is not something directly related to a specific ENE support. Below are some comments that should be helpful to her. Further, the monitoring team and the PMM spoke at length during and after the post move	Noncompliance

		monitoring visit. The PMM needs to be thorough, such as ask to see paperwork, look at things in the house (rather than ask staff to describe it), and directly interview all staff (interview at least one staff member fully and do some probe/sample questions with all other staff). At this home, she only interviewed the case manager, which was not sufficient, especially because the case manager is not a direct care staff member. The PMM's initial impression of the day and home program was that Individual #272 was doing things meaningful to him, such as sitting on his bed watching TV, walking into the living room and sitting on the sofa watching ESPN, and going to the refrigerator. The monitoring team pointed out that since we first saw Individual #272 at the day program at 2:45, until the end of the home visit at 6:00 pm, Individual #272 was engaged in no activities, had no schedule, and was not asked to participate in anything. The monitoring team pointed out that his CLDP noted that he should have structure and consistency and, moreover, that he was a young man who needed things to do. Without activities, over time, his behavior was likely to worsen, and he would become even more resistant to participating. Indeed, during the observation, he engaged in aggression, tantrum, noncompliance, and self-injury. After discussion with the case manager, she agreed to develop a schedule for him. The monitoring team also pointed out those ENE supports for which the PMM had difficulty determining what it was she was supposed to look for, and at what criterion (e.g., frequency). As a result (the monitoring team hopes), she was able to see the importance of her role in helping IDTs define the evidence for ENE supports during CLDP development in future CLDPs. The monitoring team reviewed the completed post move monitoring report, which was submitted during the week following the onsite review. The content corresponded with what the monitoring team observed.	
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	This item does not receive a rating.	

	a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	There were no discharges during this review period that met the criteria for this provision item. There was discussion about some initial work being done to refer Individual #140 to another SSLC. If so, then his transition would fall under these T4 requirements.	Not Rated

Recommendations:

1. 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 local authority was not present (T1a).

2. 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).

3. Conduct a special review team meeting for both rescinded referrals and any future rescinded referrals (T1a).

4. Do a detailed review (i.e., root cause analysis) of each rescinded referral and any other untoward post move serious incidents to determine if anything different should be done in future transition planning to reduce the likelihood of these types of problems occurring (T1a, T2a).

5. Each of the bullets in T1a should be graphed separately, and included as part of the facility's QA program (T1a, T1f).

6. Implement procedures so that professionals' opinions and determinations regarding community placement are in their annual assessments, in the ISP meeting discussion, and in the ISP document (T1a, T1b3).

7. The monitoring team has noted at least three different "approaches" to way professionals give their determinations and opinions. All three should be included. Provide more direction to the professionals, so that there is a consistent approach to this requirement (T1a, T1b3).

8. The APC should read previous SASSLC section T1a monitoring reports regarding individual preferences (T1a).

9. Do an oral presentation to senior management of referral status of those who have been referred, and the post move lifestyle status of individuals who have moved (T1a).

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

11. Upon referral, the APC should seek out the IDT and others as noted in T1b1 to talk about what training objectives might be considered now that the individual was referred for placement (T1b1).

12. Address obstacles to referral and placement at the individual level (T1b1).

13. Attend to the detail provided in T1b2. The nine bulleted lists might be used in the facility's self-assessment process (T1b2).

14. Ensure that there are thorough living options discussions and living option determinations. The living option determinations should include a clearly worded rationale for the decision made by the IDT as a whole (T1b3).

15. CLDPs need to be developed in a timely and ongoing manner (T1c).

16. Hold IDT meetings after post move monitorings (T1c, T2a).

17. Address the issue of individuals who have moved prior to the completion of the section T processes (T1c, T2a).

18. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency) (T1c1).

19. Collaborate with community and provider clinicians (T1c1).

20. Document completion of day of move activities (T1c1).

21. State office should continue to provide feedback on SASSLC CLDPs (T1c1).

22. CLDPs need to include the responsible person and timelines (T1c1).

23. The CLDPs need to include a full set of assessments/summaries, they need to be done within the required 45 day timeline, and the discharge assessments need to focus upon the individual moving to a new residential and day setting (T1d).

24. In each subsection of the assessment review section of the CLDP, deliberations (discussion) that occurred during the CLDP meeting, and recommendations that came out of the CLDP meeting need to be clearly described (T1d).

25. A full comprehensive set of ENE supports must be chosen for each CLDP (T1e).

26. Ensure that all topics included in training have a corresponding ENE support for implementation (T1e).

27. Clearly describe the ways the PMM should evidence the occurrence of the implementation of supports by the provider (T1e).

28. The monitoring team suggests the APC do an ENE support self-assessment prior to finalization of the list of ENE supports. A suggested initial list of items for a self-assessment of ENE supports is bulleted below (T1e).

29. Develop an organized QA program for section T (T1f).

30. Develop new self-monitoring tools (T1f).

31. Conduct post move monitoring more thoroughly as per the detail in the report above (T2a, T2b).

32. Insert the individual's psychiatric diagnoses, psychiatric medications, and medical conditions right into the post move monitoring form within the series of additional questions (T2a).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SASSLC Guardianship Policy dated 6/21/12 o SASSLC Rights Assessment Tool o SASSLC Section U Presentation Book o A Sample of HRC Minutes o Documentation of activities the facility had taken to obtain LARs or advocates for individuals o Need for Guardian Discussion IDT training outline Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Gevona Hicks, Human Rights Officer o Audrey Wilson, QDDP Coordinator o Charlotte Fisher, Psychology Coordinator Observations Conducted: o Observations at residences and day programs o Unit Morning Meeting for Unit 1 and Unit 3 o Daily Clinical Services Meeting o Incident Management Team Meeting o Annual ISP meetings for Individual #281 o Human Rights Committee Meeting o Restraint Reduction Committee Meeting
	Facility Self-Assessment: SASSLC submitted its self-assessment. The self-assessment was updated on 8/7/12. For the self-assessment, the facility described, for each provision item, the activities the facility engaged in to conduct the self-assessment, the results of these self-assessment activities, and a self-rating for each item. The human rights officer had put considerable thought into the development of a self-assessment system to assess compliance with section U. The resulting facility self-assessment looked at many of the same things that the monitoring team used to determine compliance. For example, not only was she attending ISP meetings to determine if IDTs were discussing the need for guardianship, she had created a tool to rate the quality of the IDT discussion. Her focus was not on whether or not a priority list was in place to meet the requirements of U1, but on ensuring that the list developed by the facility was an accurate reflection of each individual's need for guardianship. Results of her initial audit were included in the self-assessment.

	The facility self-assessment described criteria used to evaluate compliance for each item and details on specific findings. For example, for item U1, the self-assessment activities engaged in by the facility included: observation of IDT meetings, a review of ISPs and Rights Assessments, and review of the facility guardianship policy. The result of the self-assessment was described in detail. The facility self-rated U1 as out of compliance based on findings of the self- assessment. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance rating for U1 and U2. The newly developed audit tool should be beneficial in guiding the facility's efforts to achieve compliance with section U.
	Summary of Monitor's Assessment: Some positive steps that the facility had continued in regards to consent and guardianship issues included: • The Human Rights Officer had developed a tool to assess individual's ability to give informed consent. • There had been an increased focus on providing training and opportunities for self-advocacy for individuals at the facility. • The Human Rights Officer had developed an audit system to assess discussions taking place at IDT meetings regarding each individual's functional capacity to make decisions. These actions were a good step towards ensuring that the priority list for guardianship is accurate, which is compliance with U1. Then U2 will be the next step, which is procuring guardians for individuals assessed as high priority. Findings regarding compliance with the provisions of section U are as follows: • Provision item U1 was determined to be in noncompliance. The monitoring team commends the facility's progress in attempting to identify individuals who are in need of an LAR through meaningful assessment and discussion. In order to gain compliance with U1, the facility will need to ensure that all IDTs are 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. Once a priority list of those in need of a guardian has been developed, then the facility can move forward with procuring guardianship for individuals with a prioritized need.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	The facility continued to make very good progress on obtaining compliance with the requirements of section U under the direction of the Human Rights Officer. A prioritized list of individual lacking both functional capacity to render a decision and a LAR to render such a decision had not yet been created. The following steps had been taken by the facility to work towards compliance: • A procedure had been developed for IDTs to identify those individuals in need of an LAR. • A training curriculum on the need for guardianship discussion had been developed for IDT members. • The facility's rights assessment had been revised to include prompts that would guide the IDT in determining whether or not a guardian or advocate was needed for each individual. • A prioritization database was created. • The facility continued to provide information to family members regarding the guardianship process. • The Human Rights Officer was working with the Community Relations Department to develop guardianship recruitment strategies. IDTs were not yet holding 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 compliance with this provision.	Noncompliance
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities	The facility continued to make efforts to obtain LARs for individuals through contact and education with family members. A prioritized list of individuals who need guardians or advocates will need to be developed to proceed with U2. The facility did have some rights protections in place, including an independent assistant ombudsman housed at the facility, and a human 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. Observation of the HRC process during the monitoring team's visit confirmed that the committee engaged in good discussion around rights issues for each individual. Alternative strategies were discussed prior to restricting an individual's rights in any area and the committee required strategies to be in place to reduce the need for long term restrictions when appropriate. The facility continued to offer self-advocacy opportunities for individuals at the facility,	Noncompliance

#	Provision	Assessment of Status	Compliance
	seeking to advance the rights of persons with disabilities.	including an active self-advocacy group. The group met often and discussed a variety of topics related to advocacy. Additionally, committee members were given the opportunity to identify and address problems at the facility. The Human Rights Officer had plans to begin using a self-advocacy training curriculum to facilitate discussion at meetings. Officers for the facility's self- advocacy group attended the Texas Advocates Conference for additional advocacy training. Prompts had been added to the Rights Assessment to encourage IDTs to discuss what training might be provided to individuals to increase choice and decision making skills when the team had determined that an individual lacked the ability to make decisions about various areas of their lives. For example, the assessment encouraged IDTs consider whether or not training would be effective when individuals did not have the skills necessary to handle their finances. The monitoring team encourages the facility to continue to explore new ways to support the rights of individuals while working through the guardianship process.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).
2. Maintain a prioritized list of individuals who need a guardian based on IDT recommendations (U1).
3. 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 SASSLC facility-specific policies: • Consumer record policy 5/1/10 and Protection and management of client records 2/24/10, no changes since last review o SASSLC organizational chart, undated, but probably July 2012 o SASSLC policy lists, undated, but probably 6/30/12 o List of typical meetings that occurred at SASSLC, undated o SASSLC Self-Assessment, 8/7/12 o SASSLC Action Plans, 8/9/12 o SASSLC Provision Actions Information, most recent entries 8/3/12 o SASSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 8/20/12 o List of all staff responsible for management of unified records o Tables of contents for the active record and individual notebooks, updated February 2011, and for the master record, updated 5/9/12 o List of other binders or books used by staff to record data (one) o Description of the SASSLC shared drive o A five-page spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, undated, probably July 2012 o Email regarding state office expectations for facility-specific policies, from central office SSLC assistant commissioner, Chris Adams, 2/15/12 o Meeting notes regarding what was important to keep in the individual notebooks, 5/15/12 o Medical consultation tracking and scheduling documents o Email about what is allowed into the IPN, 5/4/12 o Record clerk audit forms, blank and sample of completed forms o Document return process documents, May 2012 o Blank tools used by the URC o List of individuals whose unified record was audited by the URC, February 2012 through July 2012 o Completed unified record audit tools for 10 individuals, May 2012 and June 2012 • Statewide self-monitoring tool • Active record and individual notebook • Master record • V4 questionnaire • Comments o Completed statewide self-monitoring tools for individuals February 2012 through April 2012

	o Description of how managers are notified of any errors, and emails for each month to which the monthly audits were attached, for reviews done February 2012 through June 2012 o Corrective action plans for nursing, medical, psychology, and QDDP entries, May 2012 o Inservices regarding active record entries (two), March 2012 o Missing documents list o Data and graphs regarding recordkeeping, including section V from QA reports o Additional V4 interviews o Review of active records and/or individual notebooks of: • Individual #281, Individual #332, Individual #299, Individual #115, Individual #41, Individual #166, Individual #344, Individual #89, Individual #301, Individual #293, Individual #331, Individual #342, Individual #94, Individual #291 o Review of master records of: • Individual #195, Individual #128, Individual #243 <u>Interviews and Meetings Held</u>: o Janet Prince-Page, RHIT, Coordinator of Medical Records o JC Crouch, new Unified Records Coordinator, Kevin Elder, QA program auditor, Larry Algueseva, QA director, Paula McHenry, QA director Lufkin SSLC o Some home records clerks o Pat Combs, Director of CT&D <u>Observations Conducted</u>: o Records storage areas in residences o Overflow and master records storage area in administration building
	Facility Self-Assessment The Coordinator of Medical Records (CMR) and the Unified Records Coordinator (URC) had further developed what they presented last time by including additional activities and outcomes. In that regard, they made progress in that they were trying to look at actual activities and outcomes for each provision item. The most important next step is for the CMR and URC is to make sure that they include everything in the self-assessment that the monitoring team looks at. This can be done by going through the monitoring team's report, paragraph by paragraph, and including all of those topics in the self-assessment (and perhaps in a new self-assessment tool, too). It is possible that new tools might include everything that comprises the self-assessment, or (more likely) it may be that the new tools are a part, but not all, of the self-assessment. For example, in V1, they correctly used the results of the audits to determine the quality of the unified records. On the other hand, they only used the results of the statewide self-monitoring tools, not the table of contents tool, too. Further, there were other aspects of the unified record system that the monitoring

	team discussed in the report below, such as policies for the department, relevant activities, and detail on each component of the unified record (as well as the shared drive and overflow files). For V2, they only looked at any policies and any training for recordkeeping. The monitoring team looked more in depth at the status of all state and facility-specific policies, and the entire system of training (how done, documentation, percentages, etc.) for all state and facility-specific policies for all 20 of the provisions of the Settlement Agreement. For V3, the CMR and URC started off correctly by reviewing whether some important aspects of the quality assurance monthly audit process were being done adequately, such as looking at record audits and graphs. Then, however, they went on to describe the results of these activities rather than self-assessing the quality of the audit process, the audits, the error/correction data, graphs, action plans, and so forth. The outcome of the audits is an assessment of the unified record and, therefore, is a part of the self-assessment of V1, not part of the self-assessment for V3. For V4, they reported on the only two activities that were being conducted (V4 interviews and IPN reviews). As noted in V4 below, there are six aspects to V4 that need to be implemented and self-assessed. Even though more work was needed, the monitoring team wants to acknowledge the continued efforts of the CMR and URC and believes that the facility was continuing to proceed in the right direction. The facility self-rated itself as being in noncompliance with all four provision items of section V. The monitoring team agreed with these self-ratings.
	Summary of Monitor's Assessment: SASSLC demonstrated continued progress. A new URC was recently appointed, but had not yet started. The coordinator of medical records will need to spend as much time as is needed to ensure that his transition, training and orientation, and completion of duties are all done thoroughly and correctly. The facility used the term medical records. Instead, the term unified records should be used. The active records continued to be in good shape, due in large part, to the work of the record clerks. Even so, there continued to be a need for further improvement regarding documents missing from the active record, legibility of written entries, and the content of the IPNs. To address these needed improvements, the CMR instituted a number of actions. SASSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks. The individual notebooks, however, were not always readily available to staff. The CMR initiated a new master record table of contents in May 2012, based upon suggestions from state office. Only four were in the new format so far. The CMR had not resolved what to do about items that should be in the master record, but were not.

	SASSLC improved upon its spreadsheet used to list out all 20 provisions of the Settlement Agreement and the corresponding state and facility-specific policies. It should be expanded to include any relevant aspects of the DADS memo from the assistant commissioner, dated 2/15/12. The facility should specify staff training data for these policies. Five quality assurance audit reviews were not conducted each month, as required. The reviews that were conducted, however, were done in a consistent manner. The typical number of errors found was around four to 10. A number of recommendations from the previous monitoring report were implemented by the URC. There was progress in the graphic presentations of error and correction data. The same procedures were implemented for provision item V4, that is, short interviews of staff following ISP meetings and a review of IPNs. No action was taken to explicitly address the six aspects of V4 that were reviewed during the last monitoring review (and reviewed again during this onsite review).

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	SASSLC demonstrated continued progress with the unified record requirements of this provision item. Recordkeeping remained under the supervision of Janet Prince-Page, the Coordinator of Medical Records (CMR). The veteran Unified Records Coordinator (URC), however, retired about six weeks prior to this onsite review. She completed all of her responsibilities before her last day. The newly appointed URC, JC Crouch, was not scheduled to begin as URC until the first week of September 2012. He worked as a direct support professional at SASSLC for the past six or so months. Therefore, he was relatively new to the facility and its operations. The CMR will need to spend as much time as is needed to ensure that his transition, training and orientation, and completion of duties are all done thoroughly and correctly. One aspect of his orientation should be to read previous monitoring reports for section V for SASSLC as well as for the other four SSLCs reviewed by this monitoring team. The monitoring team had the opportunity to briefly speak with some of the record clerks. They continued to be committed to their jobs. This was also evident in the overall good status of the unified records. A new monthly audit of one active record and individual notebook was assigned to the record clerks. It was a shorter review than done by the URC, but was likely to result in improvements in documents being in the record. Because it was not a full review, it did not meet the requirements of section V3 and, therefore, is described here rather than in V3. State policy and facility-specific policies remained the same since the last onsite review and, therefore, no new comments are provided here. To repeat from the previous report, given that a number of changes and improvements had been made in recordkeeping practices over the past year to two, the URC and CMR should update their facility-specific policy #300-10, which had not been revised in almost two years.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The table of contents and maintenance guidelines were updated in February 2011 for the active record and individual notebook, and in May 2012 for the master record. The master record table of contents update was based on suggestions from state office. The CMR and the facility used the term medical records. Instead, they should change their terminology to refer to the unified record. This would be more accurate and help with consistency across departments, policies, etc. Also, the unified record is more than only medical-related. <u>Active records</u> The active records continued to be in good shape, due in large part, to the work of the record clerks. The activities noted in the previous report continued (e.g., green card in the observation note section of individual notebook, training for staff). Even so, there continued to be a need for further improvement as found in the facility's own reviews and the monitoring team's review of a sample of active records and individual notebooks. The main areas for improvement were documents missing from the active record (primarily ISP-related assessments and forms), improving legibility of written entries, and the content of the IPNs. For example, the 6/21/12 QAQI Council minutes included this statement: "continuous issues with sections F and psychology (section K) regarding missing documents in the active record. Missing documents will be corrected by respective department." To address these needed improvements, the CMR instituted an audit tool for the record clerks (noted above) that focused primarily on ISP-related documents, created a spreadsheet called Missing Documents List, and developed a system called Document Return Routing. The Document Return Routing system turned out to be ineffective and too cumbersome and was abandoned. It was, however, good to see the CMR working towards making improvements via systematic processes. The most promising was the audit of the active record 30 days after the ISP meeting to see if everything that was supposed to be in the active record was there. A number of inservices were conducted and a number of corrective action plans put in place. These are described in V3 below. In addition, the CMR re-instructed the record clerks to remove emails and faxes from the IPNs. It is expected that a directive from state office will soon be issued that will fully clarify what should and should not be in the IPNs. Observation notes appeared appropriate and were moved from the individual notebook	

#	Provision	Assessment of Status	Compliance
		into the active record in a timely manner. Staff, in home 668, appeared knowledgeable about the active record. When asked a question by the monitoring team, the staff referred to the active record and then asked the home psychologist to participate in the conversation to help answer the monitoring team's questions (regarding Individual #301). This was good to see. In response to a recommendation in the previous report, the CMR met with the record clerks to review possible suggestions for the content and order of the active record. A meeting was held in May 2012 and the group determined that the content was appropriate and did not recommend any changes. <u>Individual notebooks</u> SASSLC continued to use individual notebooks. Staff appeared comfortable and knowledgeable about the individual notebooks (e.g., Janet Nash, DSP I). For some individuals, data in the individual notebooks were recorded up to date (e.g., Individual #332, Individual #299, Individual #293) whereas others were a few hours behind or had some missing data entries (e.g., Individual #41, Individual #291). In follow-up to the last report, the monitoring team praised the green sheets that were inserted in front of the observation notes section of the individual notebook, but recommended that it be updated regularly, such as every three months, with new information and perhaps on a new color sheet. That had not yet been done, but should be considered by the recordkeeping department. It appeared that the individual notebooks were not always readily available to staff. Some staff reported that the individual notebooks were in the home, but that staff recorded in them when they had a moment, usually later in the day towards the end of their shift. In one home, 672, the DSP III and the other staff could not find the individual notebooks when asked by the monitoring team. After about a 10-minute search, they were located on a small bookcase in one of the offices. The facility reported that all individual data recording sheets were kept in the individual notebook except for a binder in each home that contained the "medication diet/treatment record." If so, then this aspect of individual data recording needs to be included in the facility's review and audit procedures, too. <u>Master records</u> The master records continued to be managed by the CMR. She initiated a new table of contents in May 2012, based upon suggestions from state office. At this point, she had only put new admissions into the new format; there were four so far. All of the others	

#	Provision	Assessment of Status	Compliance
		remained in what was now the old format. She should continue to update all of the master records, even if it is just a few a week. When doing so, she should ensure that the checkmarks made on the table of contents are correct. For example, the active chart face sheet item was not checked off for Individual #195 even though the document was in the master record. The CMR had not resolved what to do about items that should be in the master record, but were not. As noted in previous monitoring reports, a process is needed and should be delineated. It may be that the staff who manage the master records indicate what actions they've taken to try to obtain the document, or indicate the rationale for why no further action is needed. Even though it wasn't done in any formal manner, some of the master record table of contents pages included some rationales written right on the table of contents. <u>Shared drive</u> The shared drive was described to the monitoring team. The recordkeeping department and the quality assurance department reported that there were no items in the shared drive that were not in the unified record as a hard copy. <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 improved upon its spreadsheet used to list out all 20 provisions of the Settlement Agreement and the corresponding state and facility-specific policies. Also included were the policy #, date of revision and/or revision, and an indication if any of these were new since the last onsite review. This appeared to be a reasonable way to track state and facility policies. As recommended in the previous report, this spreadsheet should be dated because it is likely to be updated regularly. The spreadsheet, it 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 (though this was no longer a DADS requirement). Not all state policies were in place yet, though continued progress was evident. For the next onsite review, the facility should specify for the state and facility policies for each provision of the Settlement Agreement, regarding training: • Notes the list of job categories to whom training should be provided.	Noncompliance

#	Provision	Assessment of Status	Compliance

		• Defines, for each policy
		  o who will be responsible for certifying that staff who need to be trained have successfully completed the training,
		  o what level of training is needed (e.g., classroom training, review of materials, competency demonstration), and
		  o documentation necessary to confirm that training occurred.
		(Some of this responsibility may be with the Competency Training Department.)
		• 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). Some trainings occur only once, while others require annual refreshers.
		• Includes a system to track which staff completed which training.
		• Includes data on the number of staff who are supposed to receive training on each and every policy and the number of staff who did receive training on each of these policies. Then, a percentage can be calculated. A table could be created (or this information could be in columns added to the current spreadsheet) that showed every state and facility-related policy. For example, it might be that 100 employees were required to have training on the state and facility restraint policies and 90 were trained at the time of the onsite review. A simple table could show columns for the number of staff required to be trained (e.g., 100), the number who's training was current (e.g., 90), and the resulting percentage (e.g., 90%). Each row of the table could be a state or facility-specific policy.
		
		While onsite, the monitoring team spoke with the SASSLC CT&D director about the possibility of obtaining these sets of data. Later in the week, she also reported that she made the state office coordinator of CT&D directors aware of this request and that both she and the state office CT&D coordinator were very open to working towards pulling these data sets together.	

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	Continued progress was made towards substantial compliance with this provision item until the time of the veteran URC's retirement. Thus, five reviews were conducted from February 2012 through May 2012. In June 2012, the reviews were done by the QA department. The reviews did not appear to be as complete as those done by the URC, including one of the five being incomplete (i.e., no statewide self-monitoring tool, no master record review, Individual #196). This was not surprising given that the QA staff member was also new to his role and given that he had multiple other responsibilities as well. No reviews were done at all for July 2012 or August 2012. To reiterate from V1 above, the combination of a new URC and a new QA staff member means that the CMR will have to oversee recordkeeping much more than she had to over the past few years.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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 reviews that were conducted, however, were done in a consistent manner. The reviews consisted of (1) the table of contents review of the active record and individual notebook, (2) a checklist review of the master record, and (3) the statewide self-monitoring tool. The IDT V4 interviews were not sent to the monitoring team for all of the unified records reviewed. The typical number of errors found was around four to 10. These were primarily missing documents, out of date documents, or documents that should have been taken out of the active record. The URC maintained an appropriate high standard for legibility, signatures, and written entries. The monitoring team could not determine if errors of legibility, signatures, and credentials were counted. It appeared that they were not counted, but they should be, as noted in the previous monitoring report. Each item scored no on the statewide self-monitoring form could be scored as one error, for example. The URC, as also recommended in the previous monitoring report, worked with the medical compliance nurse to create a list of all medical consultations that went back to the first of the year. A set of emails from June 2012 showed the thoughtful manner in which the veteran and now retired URC approached this topic and the way she worked with the CNE and medical compliance nurse. The new URC should be sure to follow in this path as he assesses the active record for medical consultation documentation. Furthermore, the URC responded to the monitoring team's recommendation to have three columns in the master record review form. That was good to see. The next step, as noted in V1, is to determine a process to document what actions the facility had taken towards obtaining any missing documents. The URC continued with the color-coded way of notifying relevant managers about any corrections that needed to be made. This appeared to continue to be a reasonable way to do this. The URC probably maintained the same system of checking on error corrections as described in the previous report, but given that she was not present during this onsite review, the monitoring team could not be sure. In the provision action information document (which, however, provided good detail on V3 activities since the last onsite review), the URC reported that she was now allowing a two month timeframe for corrections to be made, as recommended in the previous monitoring report. The URC had made progress and created some graphic presentations of data, including: • One graph each month showing the total number of errors, total number that	

#	Provision	Assessment of Status	Compliance
		were corrected, and the total not corrected that needed to be corrected. Unfortunately, there were calculation/addition errors on many of these. • Month to month graph showing the total number of errors, total number of corrections, and percentages. • The addition of more data sets into the QA report beginning in April 2012. • Note that interobserver agreement was obtained on the statewide tool. It should also be obtained on the table of contents tools. As the new URC begins to create graphic presentations of data, he should look at what had been done since the last review and ensure that there is one line graph for each of the following, with one data point per month, with successive consecutive months one after the other: • Number of unified records audited • Average score on statewide self-assessment tool portion of the audit • Average number of errors found per individual • Average number of corrections needed per individual (because not all errors can be corrected) • Percentage of corrections needed that were corrected within a specified time period (e.g., two weeks). In response to some of the findings of the URC, the URC and CMR conducted additional inservices for nursing staff and administrative staff (March 2012). In addition, they created CAPs for nursing and medical departments (primarily for legibility, signatures, and credentials) and for the QDDP and psychology departments (primarily regarding submission of ISP-related documents in a timely manner). They then regularly followed up on these plans with data collection and written feedback. This was good to see and showed the URC and CMR's commitment to moving towards substantial compliance. It is likely that their efforts will lead to improvements and that this will be evident in the data described immediately above, especially if legibility, signatures, and credentials are included in the errors/correction data.	
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.	During the previous review, and in the previous monitoring report, the monitoring team detailed the activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. Unfortunately, no new activity or efforts were devoted to this. The monitoring team and the CMR, new URC, and QA director discussed V4 at length during the onsite review. Below, the six areas of this provision item are again presented, with some comments	Noncompliance

#	Provision	Assessment of Status	Compliance
		regarding SASSLC's status on each. <u>Records are accessible to staff, clinicians, and others</u> SASSLC was not yet self-assessing this. The monitoring team, however, observed that: • Records were maintained in the home areas which clinicians had access to. Physicians continued to report that access to the records was a problem. They had to travel to homes to document information regarding QDRRS, consults, etc. • During the observations, records were consistently not available and accessible to staff, clinicians, and others when needed. This appeared to occur during all times of day – morning, afternoon, and evening. • Records were available during psychiatry clinic and staff referred to them and reviewed documentation. • The habilitation therapists typically included documentation in the IPNs, though this was more infrequent than would be expected. This did not appear to be related to the unavailability of the records, but rather inconsistency in documentation. • As noted in Section F, current ISPs were not found in all individual notebooks for access by DSPs responsible for implementing plans. Risk action plans were not included as part of the ISP. The Risk Action Plans should be included with the ISP and updated when the plan is revised. • As noted in V1, staff appeared comfortable and knowledgeable about the individual notebooks. • The individual notebooks, however, were not always readily available to staff. Some staff reported that the individual notebooks were in the home, but that staff recorded in them when they had a moment, usually later in the day towards the end of their shift. In one home, 672, the DSP III and the other staff could not find the individual notebooks when asked by the monitoring team. After about a 10-minute search, they were located on a small bookcase in one of the offices. • The individual notebooks did not work well for data collection (see K4). <u>Data are filed in the record timely and accurately</u> SASSLC was somewhat assessing this during the monthly audits, that is, when the URC indicated whether a document was in the record, up to date, and in the right place. The information from these reviews, however, should be used to satisfy this requirement, too. • The monitoring team's review of a sample of active records, the monthly URC audits, and the new record clerk audits indicated that ISP-related documents were not filed in a timely manner. • There were missing and conflicting health status information and data, which was recorded in different places and on different forms filed in the individuals' records. Discrepancies in information failed to be reconciled, and widely	

#	Provision	Assessment of Status	Compliance
		fluctuating measures of intake, output, weight, etc. were not identified and addressed. • There were no real data maintained by the habilitation therapists as there were very few programs or interventions provided beyond the communication plans and PNMPs, which were not data driven programs. <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: • For some individuals, data in the individual notebooks were recorded up to date (e.g., Individual #332, Individual #299, Individual #293) whereas others were a few hours behind or had some missing data entries (e.g., Individual #41, Individual #291). • Seizure logs needed improvement. • There were blanks in 16 of 21 individuals' MARs/TARs and many missing entries in individuals' health status information, such as vital signs, weekly weights, etc., which were supposed to be recorded on MARs and/or other tracking logs. This was a significant decline in performance from the prior review when only 4 of 21 individuals' MARs/TARs had missing entries. • Data were not always appropriately graphed, especially in presentation at psychiatry clinic. • The PNMT reported ongoing issues with the IDTs consistent data entry with special tracking and other standard forms, such as the Aspiration Trigger Sheets. <u>IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> SASSLC appeared to be, but wasn't really, self-assessing this. The monitoring team observed: • The URC reported that she reviewed IPNs to check for integration of departments while doing the five monthly reviews, however, the monitoring team could not tell what criteria were used to make this determination. • There were no comments from IDTs related to consult recommendations. • There was little evidence that nurses' reviewed individuals' records to make care/treatment/training decisions. Usually, nurses' made these decisions based upon their assessment or evaluation of a particular situation. • There was not consistent documentation of follow-up once a habilitation support was modified or put in place. It was possible that this occurred, but was not documented. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • The URC continued to conduct a brief, but informative, interview with one IDT	

#	Provision	Assessment of Status	Compliance
		member each month for one of the individuals whom she audited. o Only three of these interviews were given to the monitoring team. None were for the 10 individuals reviewed in V3 above. o There was no summary of her interpretation of these interviews. o Some of the comments were very interesting, but the results were not used in any way by the facility, other than perhaps to assist the URC in scoring the statewide self-monitoring tool question for V4. o The URC should summarize and bring forward any interesting comments or suggestions to the unified records committee and/or the QA department for consideration by QAQI Council. • Some physicians reported that the record was cumbersome to use, particularly the IPNS. They specifically reported that they had to go through several blank IPN pages to get to the most current page. • When a random sample of nurses were asked about how they used the individuals' record to make care/treatment/training decisions, they reported that during their quarterly and annual assessments and during the completion of audit/monitoring tools they reviewed the individuals' records and made decisions (yes/no) regarding whether or not individuals received care in accordance with the Settlement Agreement and Health Care Guidelines. • There was also extensive record review for the OT, PT, and communication assessments. <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item, and data are reported rather than only clinical impressions</u> The monitoring team found the following: • During the annual ISP meeting for Individual #281, his active record was available. It was not used, however, there did not appear to be any time during the meeting when it was needed because important information was presented on other documents and because participants were very knowledgeable about him. • Surprisingly, the clinical pharmacist refused to review record in polypharmacy meeting. She should have used the record to clarify problems that surfaced in the meeting. • The psychiatric documentation was replete with information regarding laboratory review indicating thorough review of the record. • The record was used in the PNMT meeting observed during the onsite review.	

Recommendations:

1. Ensure thorough training and supervision of the new URC (V1, V3, V4).
2. Update facility-specific recordkeeping policies (V1).
3. Replace the term medical records with unified records (V1).
4. Continue to work on the Appendix D requirements, such as legibility, signatures, entries, proper filing, and missing documents (though there had been much improvement since the last review) (V1).
5. Implement state office guidelines regarding content of IPNs once it is disseminated (V1).
6. Update the green sheets in the observation notes section of the individual notebooks; change the color; do so every three months (V1).
7. Ensure individual notebooks are available to staff (V1).
8. Current ISPs including Risk Action Plans should be readily accessible to all staff responsible for implementing any part of the plan (V1, V4).
9. The medication diet/treatment record should be considered to be part of the individual notebook and, therefore, receive the same review, auditing, and policy/procedure as do the individual notebooks (V1, V3).
10. Put master records into the new format (V1).
11. In the master record, document efforts of the URC when a document that is not optional could not be obtained (V1).
12. Expand the spreadsheet to include relevant information from the assistant commissioner's email on 2/15/12 (V2).
13. Create a process for the implementation and training of relevant staff on state and facility-specific policies (V2).
14. Provide data on the number of staff who were supposed to be trained on every Settlement Agreement-related state and facility-specific policy, and the actual number of staff who were trained (V2).
15. Conduct five unified record quality reviews each month (V3).
16. Include findings from the statewide self-monitoring tool for section V in the error/correction data (V3).
17. Graph important recordkeeping outcomes and include in the facility's QA program (V3).
18. Implement and monitor all of the aspects of assessing the use of records to make care, treatment, and training decisions, that is, the six 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
AAUD	Administrative Assistant Unit Director
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
ADD	Attention Deficit Disorder
ADE	Adverse Drug Event
ADHD	Attention Deficit Hyperactive Disorder
ADL	Activities of Daily Living
ADOP	Assistant Director of Programs
ADR	Adverse Drug Reaction
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
APAAP	Alkaline Phosphatase Anti Alkaline Phosphatase
APC	Admissions and Placement Coordinator
APL	Active Problem List
APEN	Aspiration Pneumonia Enteral Nutrition
APES	Annual Psychological Evaluations

APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARB	Angiotensin Receptor Blocker
ARD	Admissions, Review, and Dismissal
ARDS	Acute respiratory distress syndrome
AROM	Active Range of Motion
ASA	Aspirin
ASAP	As Soon As Possible
ASHA	American Speech and Hearing Association
AST	Aspartate Aminotransferase
AT	Assistive Technology
ATP	Active Treatment Provider
AUD	Audiology
AV	Alleged Victim
BBS	Bilateral Breath Sounds
BC	Board Certified
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Twice a Day
BLE	Bilateral/Both Lower Extremities
BLS	Basic Life Support
BM	Bowel Movement
BMD	Bone Mass Density
BMI	Body Mass Index
BMP	Basic Metabolic Panel
BON	Board of Nursing
BP	Blood Pressure
BPD	Borderline Personality Disorder
BPM	Beats Per Minute
BS	Bachelor of Science
BSC	Behavior Support Committee
BSD	Basic Skills Development
BSP	Behavior Support Plan
BSPC	Behavior Support Plan Committee
BPRS	Brief Psychiatric Rating Scale
BTC	Behavior Therapy Committee
BUE	Bilateral/Both Upper Extremities
BUN	Blood Urea Nitrogen
C&S	Culture and Sensitivity
CA	Campus Administrator
CAL	Calcium
CANRS	Client Abuse and Neglect Registry System

CAP	Corrective Action Plan
CBC	Complete Blood Count
CBC	Criminal Background Check
CBZ	Carbamazepine
CC	Campus Coordinator
CC	Cubic Centimeter
CCC	Clinical Certificate of Competency
CCP	Code of Criminal Procedure
CCR	Coordinator of Consumer Records
CD	Computer Disk
CDC	Centers for Disease Control
CDDN	Certified Developmental Disabilities Nurse
CEA	Carcinoembryonic antigen
CEU	Continuing Education Unit
CFY	Clinical Fellowship Year
CHF	Congestive Heart Failure
CHOL	Cholesterol
CIN	Cervical Intraepithelial Neoplasia
CIP	Crisis Intervention Plan
CIR	Client Injury Report
CKD	Chronic Kidney Disease
CL	Chlorine
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMA	Certified Medication Aide
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 Pharmacy Technician
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
DERST	Dental Education Rehearsal Simulation Training
DES	Diethylstilbestrol
DEXA	Dual Energy X-ray Densiometry
DFPS	Department of Family and Protective Services
DIMM	Daily Incident Management Meeting
DIMT	Daily Incident Management Team
DISCUS	Dyskinesia Identification System: Condensed User Scale
DM	Diabetes Management
DME	Durable Medical Equipment
DNP	Doctor of Nursing Practice
DNR	Do Not Resuscitate
DNR	Do Not Return
DO	Disorder
DO	Doctor of Osteopathy
DOJ	U.S. Department of Justice
DPT	Doctorate, Physical Therapy
DR & DT	Date Recorded and Date Transcribed
DRM	Daily Review Meeting
DRR	Drug Regimen Review
DSHS	Texas Department of State Health Services
DSM	Diagnostic and Statistical Manual
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
FLP	Fasting Lipid Profile
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
GIFT	General Integrated Functional Training

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
HOBE	Head of Bed Evaluation
HPV	Human papillomavirus
HR	Heart Rate
HR	Human Resources
HRC	Human Rights Committee
HRO	Human Rights Officer
HRT	Hormone Replacement Therapy
HS	Hour of Sleep (at bedtime)
HST	Health Status Team
HTN	Hypertension
i.e.	id est (In Other Words)
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
IHCP	Integrated Health Care Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development

IM	Intra-Muscular
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IMT	Incident Management Team
IOA	Inter Observer Agreement
IPE	Initial Psychiatric Evaluation
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
LOI	Level of Involvement
LOS	Level of Supervision
LPC	Licensed Professional Counselor
LSOTP	Licensed Sex Offender Treatment Provider
LSSLC	Lufkin State Supported Living Center
LTAC	Long Term Acute Care
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 Plan

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
ORIF	Open Reduction Internal Fixation
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
PAI	Provision Action Information
PALS	Positive Adaptive Living Survey
PB	Phenobarbital
PBSP	Positive Behavior Support Plan
PCFS	Preventive Care Flow Sheet
PCI	Pharmacy Clinical Intervention
PCN	Penicillin
PCP	Primary Care Physician
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

Pharm.D.	Doctorate, Pharmacy
Ph.D.	Doctor, Philosophy
PHE	Elevated levels of phenylalanine
PIC	Performance Improvement Council
PIPRC	Psychology Internal Peer Review Committee
PIT	Performance Improvement Team
PKU	Phenylketonuria
PLTS	Platelets
PM	Physical Management
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
PMRP	Protective Mechanical Restraint Plan
PMRQ	Psychiatric Medication Review Quarterly
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	Personal Skills Assessment
PSA	Prostate Specific Antigen
PSAS	Physical and Sexual Abuse Survivor
PSI	Preferences and Strength Inventory
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Patient
PT	Physical Therapy
PTA	Physical Therapy Assistant
PTPTT	Prothrombin Time/Partial Prothrombin Time
PTSD	Post Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
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
QMS	Quarterly Medical Summary
QPMR	Quarterly Psychiatric Medication Review
QTR	Quarter
R	Respirations
R	Right
RA	Room Air
RD	Registered Dietician
RDH	Registered Dental Hygienist
RML	Right Middle Lobe
RN	Registered Nurse
RNCM	Registered Nurse Case Manager
RNP	Registered Nurse Practitioner
RO	Rule out
ROM	Range of Motion
RPH	Registered Pharmacist
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
SAMT	Settlement Agreement Monitoring Tools
SAP	Skill Acquisition Plan
SASH	San Antonio State Hospital
SASSLC	San Antonio State Supported Living Center
SATP	Substance Abuse Treatment Program
SDP	Systematic Desensitization Program
SETT	Student, Environments, Tasks, and Tools
SGSSLC	San Angelo State Supported Living Center
SIADH	Syndrome of Inappropriate Anti-Diuretic Hormone Hypersecretion
SIB	Self-injurious Behavior

SIDT	Special Interdisciplinary Team
SIG	Signature
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOTP	Sex Offender Treatment Program
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
TCA	Texas Code Annotated
TCHOL	Total Cholesterol
TCID	Texas Center for Infectious Diseases
TCN	Tetracycline
TD	Tardive Dyskinesia
TDAP	Tetanus, Diphtheria, and Pertussis
TED	Thrombo Embolic Deterrent
TG	Triglyceride
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TMax	Time Maximum
TOC	Table of Contents
TSH	Thyroid Stimulating Hormone
TSHA	Texas Speech and Hearing Association
TSICP	Texas Society of Infection Control & Prevention
TT	Treatment Therapist
TX	Treatment
UA	Urinalysis
UD	Unauthorized Departure
UII	Unusual Incident Investigation
UIR	Unusual Incident Report
URC	Unified Records Coordinator
US	United States

USPSTF	United States Preventive Services Task Force
UT	University of Texas
UTHSCSA	University of Texas Health Science Center at San Antonio
UTI	Urinary Tract Infection
VFSS	Videofluoroscopic Swallowing Study
VIT	Vitamin
VNS	Vagus nerve stimulation
VOD	Voice Output Device
VPA	Valproic Acid
VRE	Vancomycin Resistant Enterococci
VS	Vital Signs
WBC	White Blood Count
WFL	Within Functional Limits
WISD	Water Valley Independent School District
WNL	Within Normal Limits
WS	Worksheet
WT	Weight
XR	Extended Release
YO	Year Old