United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: April 29 – May 3, 2013

Date of Report: July 19, 2013

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Monitor

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Background

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

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

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

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

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

Methodology

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

(a) **Onsite review** – During the week of the review, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for offsite 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, supported the work of the monitoring team, was available and responsive to all questions and concerns, and set the overall tone for the week, which was to learn as much as possible about what was required by the Settlement Agreement. The Settlement Agreement Coordinator, Andy Rodriguez, again did an outstanding job, ensuring that the monitoring team was able to conduct its activities as needed.

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, including frequent questions about what it would take to come into substantial compliance. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist SASSLC in doing so.

Third, 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.

<u>Restraint</u>

- There were 29 restraints used for crisis intervention between 10/1/12 and 4/26/13. This was a considerable decrease from the 55 restraints used for crisis intervention the previous six-month period.
- Overall, the facility made progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. Actions taken included:
    - A focus on reducing the number of restraints used for crisis intervention.
    - Crisis Intervention Plans for those individuals historically restrained.
    - Protective Mechanical Restraint Plans for the use of protective mechanical restraint for self-injurious behavior.
    - Desensitization strategies to reduce the need for chemical pretreatment sedation for routine exams.
    - Implementation of the new statewide restraint forms on 3/1/13.

    - Progress on the components of provision C7.
- The facility still needs to ensure that all restraints are correctly identified, documented, monitored, and reviewed.

Abuse, Neglect, and Incident Management

- The facility made progress in addressing compliance with section D. The incident management department was playing an integral role in looking at trends and systemic issues that contributed to incidents and individualized supports and services that placed individuals at risk.
- There was one confirmed case of physical abuse, one confirmed case of sexual abuse, and 20 confirmed cases of neglect. An additional 44 other serious incidents were investigated by the facility, all involving serious injuries. DFPS conducted investigations 113 cases involving 177 allegations at the facility between 10/3/12 and 4/24/13, including 57 allegations of physical abuse, 11 allegations of sexual abuse, 24 allegations of verbal/emotional abuse, 4 allegations of exploitation, and 81 allegations of neglect.
- There were 1017 injuries reported between 9/1/12 and 2/28/13. These 1017 injuries included 20 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive.

Quality Assurance

- The QA program at SASSLC made good continued progress. The QA data list inventory was vastly improved since the last review, and 16 of the 20 provisions were included. Even so, the overall content was not yet complete and adequate.
- The QA plan narrative at the facility was current, complete, and adequate. It could be improved by describing how the most important key indicators are determined. The QA matrix was not yet a useable document.
- Monthly department meetings with the QA director and SAC (called 1:1 meetings) were initiated and were a great addition to the QA program. Other QA-related meetings included unit level QAQI monthly meetings, QA director-facility director meetings, and medical CQI meetings.
- The QA report was much improved. The QA director made many of the changes recommended in the previous monitoring report. Of the 20 sections of the Settlement Agreement, 17 (85%) appeared in a QA report at least once in each quarter. Few contained any break down by program areas, living units, etc. An area for improvement was for there to be more of an analysis of their data.
- QAQI Council met almost every week and included (a) data from the QA plan matrix (key indicators, self-monitoring), and (b) data presented trended over time. There was no indication, however, that (c) comments and interpretation/analysis of data were presented.
- Corrective action plans were tracked by the QA director and appeared to appropriately address the specific problem for which they were created. The monitoring team could not determine how, when, or if the majority of CAPs were or were

not implemented. The QA director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification.

Integrated Protections, Services, Treatment, and Support

- There were some positive steps evident with the new ISP process. At two ISP meetings and two pre-ISP meetings observed by the monitoring team:
    - The IDTs were following the format of the new ISP process, however, the meetings were lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting.
    - There was more integrated discussion among team members.
    - Teams had made some progress with integrating recommendations from various assessments into supports and services.
    - IDTs still need to ensure that deadlines are set and responsibility assigned when additional assessments are recommended by the team. Barriers to implementing recommendations in a timely manner need to be addressed
    - All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress.
- While the planning process was improving, the monitoring team found that plans that teams had spent hours developing were not accessible to staff responsible for implementing the plan. ISPs were out of date in a majority of the individual records reviewed. IHCPs that were a part of the ISP were not available to support staff.

Integrated Clinical Services

- The medical director served as the lead for this provision and was involved in a number of activities related to integration of clinical services. His desire and ability to work with the various clinical and non-clinical disciplines was evident throughout the week of the compliance review. He promoted the concept of a unified organization and the value of teamwork. SASSLC employees appeared to respond well to his leadership and this will be important as he attempts to bring together many departments for the purpose of improving integration of clinical services.
- The monitoring team found some good evidence of integration of clinical services. There were no new major initiatives services, but some meetings were expanded or included more discussions that had the potential to improve integration of clinical services. Some disciplines, such as dental clinic, struggled with integration without any real improvement.
- 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.

Minimum Common Elements of Clinical Care

- No progress was observed in this provision, though at one time, the facility seemed poised to make great strides in this area. The regression was most likely related to the change in the medical director and loss of the medical compliance nurse. There was no facility policy and the monitoring team did not find any specific planning on the part of the facility that would result in any substantive progress. It was also evident that greater involvement from upper facility management was needed to move forward with provisions G and H due to the breadth of the issues.
- The management of assessments needed attention because many key assessments were not completed in a timely manner. While some departments made gains in assessment compliance, others fell out of compliance. Some departments simply just continued as the status quo with no improvement.

At-Risk Individuals

- Progress had been made via an initial attempt to ensure individuals were accurately assessed and action plans were in place to address risks. Adequate plans, however, were not yet in place to address risks for individuals at SASSLC.
- Risk screening was reviewed annually at the ISP planning meeting. There was still a tendency to over-rely on the guidelines for each risk category without factoring in how the various risk factors may compound one another. Good clinical judgment must be used when identifying risks, and developing risk levels, and action plans for high risk conditions.
- The monitoring team observed two teams hold meetings utilizing the new risk discussion format. Meetings were very lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting. Teams were spending a lot of time identifying risks, but little time developing measurable outcomes to address risk factors.
- Teams should be 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 often waiting until a critical incident occurred or until the annual IDT meeting before aggressively addressing the risk.
- A sample of individual records was reviewed in various homes at the facility. IHCPs were not found in any of the 27 individual notebooks reviewed.

Psychiatric Care and Services

- Some progress was noted in this provision. The need for improved integration was identified. Most provision items in this section rely on collaboration with other disciplines.
- Observations of psychiatric clinic showed improvements in the individual's case presentation by the interdisciplinary team, particularly during the quarterly clinics. The current practitioners were making efforts to review and revise diagnoses and adjust medication regimens.
- The psychologists continued to remain the responsible party for the majority of the informed consents for prescription of psychotropic medication. This needs to be changed.

- The Appendix B evaluations were generally of adequate quality although the small percentage of those completed resulted in this provision item remaining in noncompliance.
- The facility reported that 53/55 psychotropic medications were initiated on an emergency basis, therefore, only 4% of these prescriptions were begun with routine orders and procedure. The monitoring team acknowledged that there would be times when the emergency intervention with psychotropic medication were warranted, however it is best to thoroughly review the risk-benefit analysis, when clinically feasible, via the formal consent process.

Psychological Care and Services

- Improvements since the last review resulted in three additional items rated in substantial compliance (K3, K7, K11). Improvements included the number of psychologists with certification as an applied behavior analyst, documentation of internal peer review occurring weekly and external peer review occurring monthly, IOA collection procedures, expansion of the collection of data reliability, and initiation of the graphing of replacement behaviors. There was greater evidence of the use of data based treatment decisions, expansion of monthly progress notes to all individuals with PBSPs, evidence of documentation in the progress note of activity to address lack of progress, and expansion of functional assessments to every individual with a PBSP. There were improvements in the comprehensiveness of annual psychological assessments, expansion of current annual psychological updates to all individuals, improvement in the quality of PBSPs, and initiation of treatment integrity of the implementation of PBSPs.
- SASSLC needs to continue to work to increase the flexibility of the system for collecting both target and replacement data, establish minimal frequencies of data collection reliability and IOA collection and demonstrate that those frequencies of data collection are achieved, establish minimal acceptable data collection reliability and IOA levels and demonstrate that those levels are achieved, and ensure that replacement behaviors are graphed for all individuals with PBSPs. The facility should also ensure that the progress note consistently indicates that some activity occurred in those instances when an individual was not making the progress expected. Psychology staff should improve the quality of the functional assessments, ensure that PBSPs are implemented within 14 days of receiving consent ensure that treatment integrity measures include an observation of the implementation of the PBSP, establish minimal frequencies of treatment integrity per individual with a PBSP, and provide documentation that all staff assigned to work with an individual have been trained in the PBSP.

Medical Care

- The medical department did not make a great deal of progress since the last compliance review. A new medical director was hired in November 2012 following. There appeared to be some level of regression in documentation of many areas, such as acute medical problems and hospital follow-up. This may have been provider specific and the medical director should further explore compliance in this area.
- The management of pneumonia remained a concern for the monitoring team. The facility had ongoing discussions related to the management of osteoporosis. The number of neurology clinic hours was inadequate to meet the needs of

the individuals. The onsite clinic consultation notes did not provide adequate information, and follow-up of complex individuals was often infrequent.

- External and internal audits were completed, but the facility provided no compliance charts and data. Mortality management remained problematic at SASSLC. There continued to be no organized process for ensuring implementation and follow-up of corrective actions.
- This review was impeded by problems related to the provision of the requested documents. Several active records requested were never provided. The Active Problem Lists were not included in the appropriate section of the record and, therefore, were not provided.

Nursing Care

- Some of the systems that were found to be making progress at the last review had slightly regressed.
- The monitoring team was pleased, however, that the new nursing leadership staff were working diligently and were highly motivated to re-establish the Nursing Department progress.
- The Program Compliance Officer was working collaboratively with all nursing staff to enhance compliance with all of the section M provisions. The Nurse Educator was revamping the Nursing Education Program. The RN Case Manager Supervisor was working closely with the RN Case Manager to ensure the timeliness and the quality for the annual and quarterly nursing assessments, as well as their day to day responsibilities. The Infection Control Officer was well underway in strengthening the Infection Control Program.
- The Nursing Department continued to maintain good working relationships with other departments, most notably the pharmacy, medical quality assurance, and psychiatry departments.

Pharmacy Services and Safe Medication Practices

- Progress in this provision was evident in some areas. The lead clinical pharmacist was now under the supervision of the medical director and this appeared to be a beneficial arrangement
- SASSLC faced unique challenges because medications were dispensed at the San Antonio State Hospital (SASH) and not the facility. Even so, the number of documented interventions increased, as did the documentation of the resolution of the problems. The Intelligent Alerts module was implemented in December 2012.
- The monitoring team also noted significant improvements in the QDRR process. There were no timeline deficiencies identified in the documents reviewed. The clinical pharmacists demonstrated even more improvements in content and format. The reviews were robust in content and provided an excellent source of clinically relevant information for the prescribers and the IDTs.
- There were several problems related to completion of the MOSES and DISCUS evaluations.

- The evaluations were completed for those individuals who were enrolled in psychiatry clinic, but individuals who received other medications, such as metoclopramide and AEDs, did not always appear to have timely completion based on record and document reviews.
- The facility was not adequately reporting ADRs. Three Drug Utilizations Evaluations were completed. All were done in a timely manner and presented to the Pharmacy and Therapeutics Committee. Corrective action plans were implemented for identified deficiencies, but minutes did not always indicate closure of identified problems.
- Progress was noted in the medication variance system based on the re-institution of some reconciliation practices. Unfortunately, after more than two years of encouraging the facility to fully reconcile medications, it was discovered that a significant number of medications could not be reconciled.

Physical and Nutritional Management

- Progress was made towards substantial compliance with provision O. The PNMT was fully staffed. Back-ups were identified and attendance at the meetings was generally very consistent. A number of comprehensive assessments had been completed and these were much improved. The meeting observed by the monitoring team was organized and the documentation greatly improved. There appeared, however, to be a significant delay/absence of referrals by the IDT.
- Mealtimes and position and alignment were improved, though some issues positioning continued to be an issue. Significant issues related to availability of PNMPs were noted, though immediate corrections were made once pointed out by the monitoring team. There continued to be some inconsistencies on Dining Plans and PNMPs, some critical to staff accuracy of implementation. Review of these plans is needed in order to make corrections in a more timely manner. There were monitoring systems in place and these errors should not be missed.
- PNM monitoring did not address all areas required, such as medication administration, oral care, and bathing. A system of effectiveness monitoring was not well established and will be necessary for further progress with this provision. Monitoring did not occur across the day. It instead focused on the first shift staff and on a limited number of activities and environments.
- The therapists were encouraged to more objectively evaluate individuals for protective equipment. There are a large number of helmets, gait belts, staff assistance, protective boots, for example. The least restrictive options should be selected.

Physical and Occupational Therapy

- There was continued progress. Improvements in the area of positioning were observed, though staff need more training and prompting to check for optimal pelvic alignment, particularly after transfers. In home 674, staff repositioned everyone right before they entered the dining room, which was excellent practice.
- Improvements in the assessment and design of seating systems will impact the ability of direct support staff to achieve alignment for each individual in a system that fits properly and provides the appropriate supports.

- OT/PT assessment content had improved, but timeliness continued to be a concern. Many, but not all, assessments were completed prior to the ISP. All of the assessments for individuals newly admitted were completed prior to the ISP.
- The system of documentation of therapy interventions appeared to be consistent, though integration into the ISP was not. Many of the assessments identified that effectiveness would be reviewed on an annual basis, but it was not clear how often this occurred in the interim.

Dental Services

- A new dental director was hired in November 2012. This was an important step for the facility because stability in the clinic is essential to moving forward. Due to multiple changes in dental department leadership up until this point, there was minimal progress in the provision of dental services since the last compliance review.
- The number of clinic appointments increased 43% since the last compliance review. The number of off campus appointments and the reasons for these appointments was not clear. Compliance with completion of annual assessments increased, but remained less than desirable.
- Oral hygiene ratings improved slightly. There was no documentation in the assessments that oral hygiene instructions were provided and in home training was discontinued in favor of a weekly toothbrushing clinic. Suction toothbrushing was provided to more individuals, but several problems related to that process were noted as well.
- Informed consent continued to present challenges. The facility's consent policy was revised in October 2012.

Communication

- Continued progress was made. The majority of the most current assessments contained more than 70%, but less than 90%, of the elements considered key by the monitoring team. This was a significant improvement. There was a continued increase in the provision of AAC systems. More work related to the application of AAC to adults with developmental disabilities and physical and cognitive challenges was needed.
- Implementation and integration into the home and day program activities were inconsistent. The therapists and the SLPA should provide real time modeling across environments because doing this is not immediately intuitive for direct support staff.

Habilitation, Training, Education, and Skill Acquisition Programs

- Improvements since the last review included expansion of the number of staff trained in the implementation of SAPs and improvements in the percentage of SAPs reviewed with clear rationales for their selection. There were improvements in individual engagement, and in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans. There was an expansion of the collection of SAP treatment integrity data, initiation of graphing SAP outcomes, modification of the community-training database, and an increase in the number of individuals who were competitively employed in the community.

- The facility needs to ensure that all SAPs are in the new format, and contain all the components necessary for learning discussed in the report, and ensure that dental desensitization or dental compliance plans are consistently written and implemented for individuals that refuse to attend the dental clinic. The facility also needs to expand the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans to all individuals at SASSLC, expand the graphing of outcome data to all SAPS, expand the collection of treatment integrity data to all SAPs, and increase the implementation of SAPs in the community.

Most Integrated Setting Practices

- SASSLC continued to make progress across most of section T. The most notable being the increase in the number of individuals referred and placed, however, there were problems with many of the placements. Twelve individuals were placed in the community since the last onsite review, 18 individuals were referred for placement since the last onsite review, and 15 individuals were on the active referral list.
- Living options were thoroughly discussed during both ISPs observed and an adequate description of a thorough discussion was evident in half of those reviewed. Few ISPs included an action plan to address/overcome obstacles identified. Some, but not all, activities related to the education of individuals, LAR, and staff were occurring.
- The content of discharge assessments needed much improvement, especially regarding the provision of guidance and recommendations for the individual's new community settings, day programs, residence, etc. The list of pre-move and post-move supports had not improved at all since the last onsite review. This must be addressed by the time of the next onsite review. A CLDP meeting did not occur during the onsite review and an audiotape of a CLDP meeting was never sent to the monitoring team.
- Post move monitoring had improved. 29 post move monitorings for 11 individuals were completed. All post move monitoring was documented in the proper format and done correctly and thoroughly.
- Most individuals had some difficulties after moving. Some were relatively minor and addressed by the provider with support from the PMM and facility. A number, however, had serious problems with transition or with receiving the supports that were detailed in their CLDPs. In all cases, the PMM took action, but sometimes waited until the end of the 90-day period before calling an IDT meeting or before doing more than merely asking the provider to follow-up. Going forward, and to maintain substantial compliance, the PMM must demonstrate more immediate action when a support was not provided by a provider.
- The monitoring team was quite disappointed that so many providers in the San Antonio area struggled to provide high quality services to the individuals from the facility.

Guardianship and Consent

- The facility had not yet developed an adequate assessment process for determining the need for guardianship and had not developed a priority list of individuals needing an LAR. IDTs continued to need training to determine each individual's functional capacity to render informed decisions.
- A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need.
- The human rights officer was actively involved with every department at the facility and served as a valuable resource to IDTs.

Recordkeeping Practices

- Progress in many parts of this provision stalled since the last review due primarily to the resignation of the newly hired URC. The active records, however, continued to improve due in large part, to the work of the record clerks. The content of the IPNs was improved. There were fewer items misfiled in the wrong individual's active record. Problems with legibility and signatures continued to be evident. There were still documents missing from many of the active records.
- Individual notebooks continued to be used, however, they were locked in offices, cabinets, or file cabinets and not available to direct support staff. Some of the information in the individual notebooks was not current and some was missing.
- A master record existed for every individual at SASSLC. Not all master records had been converted over to the newest format. There was no progress in resolving what to do about items that should be in the master record, but were not.
- A review of five unified records did not occur each month as required. The tools used by the URC to conduct the audit reviews needed to be updated. The typical number of errors found in a table of contents review was around 15 per record. Data were summarized in a number of graphs that were included in the monthly QA report. No new work was done regarding the requirements of V4.

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 Policy: Direct Care Staff Responsibilities Regarding Use of Restraint
o SASSLC Training Curriculum: Restraint Policy Training for Restraint Monitors
o SASSLC Self-Assessment
o SASSLC Provision Action Information Log
o SASSLC Section C Presentation Book
o Restraint Trend Analysis Report
o Sample of Incident Management Team Minutes
o List of all restraint by Individual 10/1/12 through 4/26/13
o List of all chemical restraints 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 List of all restraint related injuries
o SASSLC “Do Not Restrain” list
o List of all individuals with a Crisis Intervention Plan (8)
o List of individuals with desensitization plans or strategies to reduce the use of restraint
o Desensitization plans for:
• Individual #227, Individual #114, Individual #17, Individual #118, Individual #240, Individual #60, Individual #58, Individual #145, Individual #343, and Individual #32.
o Medical Pretreatment sedation Restraint Documentation and ISPs for:
• Individual #348, Individual #14, Individual #158, Individual #252, Individual #32, Individual #332, Individual #177, Individual #51, Individual #156, and Individual #298.
o Restraint Reduction Committee/QAQI meeting minutes for past six months
o Training transcripts for 24 SASSLC employees
o ISPs, PBSPs, Crisis Intervention Plans (when applicable), and ISPAs for:
• Individual #140, Individual #168, Individual #195, Individual #199, and Individual #304.
o A sample of restraint documentation for crisis intervention including:

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<tr><th>Individual</th><th>Date</th><th>Type</th></tr>
<tr><td>#140</td><td>12/23/12</td><td>Physical</td></tr>
<tr><td>#140</td><td>11/28/12</td><td>Physical</td></tr>
<tr><td>#140</td><td>11/28/12</td><td>Physical</td></tr>
<tr><td>#168</td><td>2/6/13</td><td>Physical</td></tr>
</table>
</td></tr>
</table>

#168	2/5/13	Physical
#195	12/29/12	Physical
#304	11/4/12	Physical
#232	12/22/12	Chemical
#199	3/29/13	Chemical
#138	3/1/13	Chemical

Interviews and Meetings Held:

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

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 4/29/13 and 5/2/13
- Annual ISP meetings for Individual #13 and Individual #259
- Pre-ISP meetings for Individual #88 and Individual #82

Facility Self-Assessment:

SASSLC submitted its self-assessment. 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 reviewed all crisis intervention restraints from 7/1/12 through 3/25/12 (55) to assess compliance with each provision. Additional activities similar to those engaged in by the monitoring team were completed along with the review of restraint documentation. For instance, to assess compliance with C1, the facility also reviewed Protective Medical Restraint Plans. The facility did not, however, review the use of medical restraints or desensitization strategies to reduce the use of those restraints. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings.

The facility assigned a rating of substantial compliance to C1, C2, C3, C5, C6, C7, and C8. C4 was rated as noncompliant. While there had been progress made in developing an adequate self-assessment process, findings were not consistent with the findings of the monitoring team. The monitoring team found substantial compliance with C2, C8, and all but one of the components of C7. The monitoring team continued to evaluate compliance on a number of factors that were not considered by the facility when determining compliance. For example, the facility looked at training data to determine compliance with C3.

The monitoring team verified compliance by reviewing a sample of training transcripts for both completion of training requirements and the timeliness of training.

Summary of Monitor's Assessment:

Based on information provided by the facility, there were 29 restraints used for crisis intervention between 10/1/12 and 4/26/13. This was a considerable decrease from the 55 restraints used for crisis intervention the previous six month period. The monitoring team looked at a sample of the latest restraints to evaluate progress towards meeting compliance with the requirements of section C.

Month	Total Restraints	Month	Total Restraints
April 2012	4	October 2012	8
May 2012	21	November 2012	6
June 2012	2	December 2012	6
July 2012	6	January 2013	2
August 2012	4	February 2013	3
September 2012	18	March 2013	2

There were 103 instances of dental/medical restraint, including pretreatment sedation, from 10/1/12 through 4/26/13, involving 80 individuals. This list included pretreatment sedation prior to medical and dental appointments.

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

- A focus on reducing the number of restraints used for crisis intervention.
- Development of Crisis Intervention Plans for those individuals historically restrained.
- Development of Protective Mechanical Restraint Plans for the use of protective mechanical restraint for self-injurious behavior.
- Development of desensitization strategies to reduce the need for chemical pretreatment sedation for some individuals who historically required the use of pretreatment sedation for routine exams.
- Implementation of the new statewide restraint forms on 3/1/13.
- Progress on the components of C7.

Overall, the facility made progress towards meeting compliance with requirements for documenting and reviewing restraint incidents for crisis intervention. The facility still needs to ensure that all restraints are correctly identified, documented, monitored, and reviewed.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>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.</td><td>The facility provided a list of all restraints used for crisis intervention between 10/1/12 and 4/26/13:

<table>
<tr><td>Type of Restraint</td><td>10/1/12-4/26/13</td></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>23</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>6</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>29</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>10</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a CIP</td><td>4</td></tr>
<tr><td>Medical/dental restraints</td><td>103</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>80</td></tr>
</table>

The facility reported eight individuals at the facility were wearing protective equipment (e.g., mittens) for self-injurious behavior (SIB). Individualized Protective Mechanical Restraint for SIB Plans had been developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.

At SASSLC, there were other individuals who were wearing protective mechanical restraints, but these were classified as medical restraints rather than protective mechanical restraints for SIB. Individualized protective mechanical restraint for medical plans had not been developed for these individuals, but will need to be..

<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 restraints for seven individuals, representing 34% of restraint records over the last six-month period and 70% of the individuals involved in restraints. The sample included seven physical restraints and three chemical restraints. Sample #C.1 included the four individuals with the greatest number of restraints, as well as the individuals who were subject to the most recent restraints. Individuals in this sample were Individual #140, Individual #168, Individual</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		#195, Individual #304, Individual #232, Individual #199, and Individual #138. <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 which included documentation for 10 restraints. The following are the results of this review: • In 10 of the 10 records (100%), staff completing the checklist indicated that the individual posed an immediate and serious threat to self or others. • For 10 restraint records, a review of the description of the events leading to behavior that resulted in restraint found that three (30%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for punishment, for convenience of staff, or in the absence of or as an alternative to treatment. The documentation for the other seven restraints did not indicate what may have triggered the behavior leading to restraint. An example of good documentation was: o The restraint checklist for Individual #140 dated 12/23/12 documented that he became aggressive when his family did not show up for a scheduled visit. Examples where this was not the case included: o The restraint documentation for Individual #304 dated 11/4/12 and Individual #168 dated 2/6/13 offered no clear documentation of events leading to the behavior that resulted in restraint. • In 10 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • Facility policies identify a list of approved restraints. • Based on the review of 10 restraints in sample #C.1 involving seven individuals, 10 (100%) were approved restraints. An example of problematic use of a restraint: • Individual #167 had wrist ties restraining him to his wheelchair and bed to prevent self-injury from involuntary movements. A review of restraint data showed that he had only been out of his bedroom 24 times between 11/1/11 and 5/1/13, including dental appointments, a hospitalization, and a fire drill. On these occasions, he was typically only out of his bedroom for an hour. His ISP	

#	Provision	Assessment of Status	Compliance
		developed on 2/5/13 did not include outcomes to address the opportunity for him to routinely exercise his limbs to prevent further atrophy or contractures. Outcomes were developed for him to participate in activities on campus two times per year and in the community one time per year. His ISP did not ensure that he received activities in a sufficient number of hours to prevent regression and address his many support needs and preferences in the least restrictive manner possible. As noted in section J, the monitoring team found documentation indicating that a number of individuals had been prescribed medication on an emergency basis for the sole purpose of addressing maladaptive behavior not associated with a psychiatric diagnosis. If so, the facility needs to ensure that psychotropic medication administered on an emergency basis be documented as a chemical restraint for crisis intervention. <u>Dental/Medical Restraint</u> There were 93 instances of dental/medical pretreatment sedation from 10/1/12 through 3/31/13 involving 72 individuals. A list of individuals with medical or dental desensitization plans was requested from the facility. The facility reported that desensitization strategies had been developed for 19 individuals. The last 10 desensitization plans developed by the facility were requested for review. All 10 were written training programs addressing dental desensitization. Good progress had been made towards assessing individuals for the need of dental desensitization plans and the development of individualized plans. At ISP meetings observed, both IDTs held integrated discussions to develop desensitization strategies (Individual #13 and Individual #259). In order to gain substantial compliance with C1, the facility will need to continue developing desensitization strategies to address the use of both dental and medical pretreatment sedation for those individuals who have historically required the use of chemical sedation to complete routine exams. Based on this review, the facility was not yet in compliance with the requirements of C1.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The 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 (CIP) 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The restraint records involving the seven individuals in Sample #C.1 were reviewed. Of these, three of the individuals (Individual #140, Individual #168, and Individual #195) had CIPs that defined the use of restraint. 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. • Two of seven (29%) restraints reviewed indicated that the individual was released immediately when no longer a danger. o Three restraints indicated that staff released the individual because they were unable to maintain a correct hold. o One restraint was released when the maximum time allowable (15 minutes) was reached. o The restraint checklist for Individual #168 dated 2/6/13 indicated that he was released due to physical distress. o The longest physical restraint in the sample was 15 minutes. This was the maximum duration allowed by the new state policy before an attempt at release was required. • For three individuals who had Crisis Intervention Plans, three (100%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the CIP. 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	Review of the facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint, • Approved verbal and redirection techniques; • Approved restraint techniques, and • Adequate supervision of any individual in restraint. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that • 22 of 24 (83%) had current training in RES0105 Restraint Prevention and Rules. • 13 of the 16 (81%) employees with current training who had been employed over one year completed the RES0105 refresher training within 12 months of the previous training. • 23 of 24 (96%) had completed PMAB training within the past 12 months. The facility investigator had not completed PMAB training. Although it is unlikely	Noncompliance

#	Provision	Assessment of Status	Compliance
	have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	that she would be involved in restraints, she could be assigned to investigate allegations resulting from restraint. It is recommended that she complete PMAB training. • 14 of the 17 (82%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training. As noted above with regard to Section C.1 of the Settlement Agreement, 100% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. As noted with regard to Section C.2, four (57%) of the seven physical restraints in the sample were released when staff were unable to maintain an approved hold. This can create a significant danger to both staff implementing the restraint and the individual restrained. The facility should always ensure that staff are adequately trained in implementing a restraint correctly and retrained as necessary. PMAB holds are designed to be safely implemented with an individual even if he or she is struggling, so it should rarely happen. If it happens frequently, as indicated in this sample, retraining should be considered. The facility remained out of compliance with C3.	
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 10 restraint records (Sample #C.1), documentation in 10 (100%) indicated that restraint was used as a crisis intervention. In review of three Positive Behavior Support Plans, in three (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. There were 93 instances of medical sedation from 10/1/12 through 3/31/13. This list included pretreatment sedation prior to dental and medical appointments. According to a list provided by the facility, strategies to minimize or eliminate the need for restraints had been developed for 19 individuals who required the use of pretreatment sedation. The facility had identified 80 individuals who had required the use of pretreatment sedation for medical/dental appointments in the past six months. Progress had been made in developing desensitization plans, particularly to address dental treatment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		At both annual ISP meetings observed, the IDT engaged in good interdisciplinary discussion regarding the development of strategies to reduce anxiety over dental treatment. Numerous individuals were observed wearing helmets and other protective restraint at the facility. Plans will need to be developed to address these restraints. IDTs should develop strategies to reduce the amount of time in restraint, eliminate restraint when possible, or consider the least restrictive restraint when possible. The facility had created a "Do Not Restrain" list. There were 90 individuals at the facility identified on this list for which physical restraints would be contraindicated due to medical or physical conditions. In 10 of 10 restraint records reviewed (100%), there was no evidence that the restraint used was in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the facility. In reviewing 10 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Seven (70%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. Examples where this was not the case included: o Individual #158's ISP noted that he was routinely cooperative with medical and dental appointments, therefore, no recommendations for pretreatment sedation have to be given and it was unclear as to why he received pretreatment sedation. o Individual #332's ISP noted that she did not have desensitization strategies in place. She was sedated prior to a dental exam and cleaning on 3/28/13. o Individual #348 required chemical pretreatment sedation for dental cleanings. He did not yet have desensitization strategies implemented. IDTs should develop strategies to reduce the amount of time in restraint, eliminate restraint when possible, or consider the least restrictive restraint when possible. The facility was not yet in compliance with this provision item.	

#	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 10 crisis intervention restraint records (Sample #C.1), a face-to-face assessment was conducted as follows: • In 10 out of 10 incidents of restraint (100%), there was assessment by a restraint monitor. The new restraint policy requires that the Face-to Face Assessment/Debriefing (FFAD) be used in all instances of restraint used for crisis intervention. • In 10 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. • The assessment began as soon as possible, but no later than 15 minutes from the start of the restraint in five (50%) out of 10 instances. Exceptions were: o Individual #168 dated 2/5/13 – late o Individual #168 dated 2/6/13 – late o Individual #195 dated 12/29/12 – late o Individual #232 dated 12/22/12 – late o Individual #199 dated 3/29/13 - late Based on a review of seven physical and three chemical restraint used for crisis intervention that occurred at the facility, there was documentation that a licensed health care professional: • Monitored and documented vital signs at least every 30 minutes from the initiation of the restraint (for a minimum of two hours with the use of chemical restraint) in seven (70%). Records that did not contain documentation of this were: o Individual #140 dated 11/28/12 (x2) – no times listed o Individual #195 dated 12/29/12 – initiated late o Individual #304 dated 11/4/12 – no documentation of monitoring • Monitored and documented mental status at least every 30 minutes from the initiation of the restraint (for a minimum of two hours with the use of chemical restraint) in seven (70%). Records that did not contain documentation of this were: o Individual #140 dated 11/28/12 (x2) – no times listed o Individual #195 dated 12/29/12 – initiated late o Individual #304 – no documentation of monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
		Seven (70%) met the new state policy requirement that a nursing assessment be completed within 15 minutes of the restraint initiation. Based on documentation provided by the facility, no restraints had occurred off the grounds of the facility in the last six months. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 12% of the individuals for whom medical restraint was used. (See Sample C.3 above) For these individuals, the restraint checklists were reviewed. • In 10 out of 10 (100%), the restraint checklist specified the schedule of monitoring required; and • In 10 out of 10 (100%), the restraint checklist specified the type of monitoring required. Based on a review of 10 medical pretreatment sedation restraints, there was documentation that a licensed health care professional conducted monitoring at least every 30 minutes for a minimum of two hours in six (60%) of the instances of restraint. Exceptions were: • Individual #51 dated 3/18/13 – unclear when monitoring was initiated • Individual #32 dated 3/12/13- requirement not met • Individual #348 dated 3/12/13 – did not document time of initial attempt • Individual #14 dated 3/11/13- requirement not met The facility was not compliance with this provision. Monitoring by a nurse should be conducted and documented as required by state policy.	
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	A sample of 10 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 10 (100%), continuous one-to-one supervision was indicated as having been provided on the restraint checklist. • In 10 (100%), the date and time restraint was begun were indicated. • In 10 (100%), the location of the restraint was indicated. • In three (30%), information about what happened before, including the change in the behavior that led to the use of restraint. As noted in C.1, documentation did not sufficiently describe what may have triggered the behavior leading to the restraint. • In 10 (100%), the actions taken by staff prior to the use of restraint to permit	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	adequate review per C.8. • In 10 (100%), the specific reasons for the use of the restraint were indicated. • In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated. • In 10 (100%), the names of staff who applied/administered the restraint was recorded. • In 10 (100%), the observations documented every 15 minutes and at release. • In 10 (100%), the specific behaviors of the individual that required continuing restraint; and • Restraint documentation reviewed did not indicate that restraints interfered with mealtimes or that individuals were denied the opportunity to use the toilet. The longest restraint in the sample was 15 minutes in duration. • In seven (100%) of seven physical restraint incidents, the date and time the individual was released from restraint were indicated. • In seven (100%) of seven physical 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. In a sample of 10 records (Sample C.1), FFADs had been completed for 10 (100%). These forms were generally complete in checking all the required boxes on the form, supplemented with minimal narrative. A sample of 10 individuals subject to pretreatment medical sedation was reviewed, and in six (60%), there was evidence that the monitoring had been completed as required. The facility was not in compliance with documentation and monitoring requirements for restraint incidents.	
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, one individual was placed in restraint more than three times in a rolling 30-day period. This represented a decrease from the three individuals placed in restraint more than three times in a rolling 30-day period reported during the last review. This individual (Individual #140) was reviewed by the monitoring team to determine if the	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		requirements of the Settlement Agreement were met. His PBSP, crisis intervention plan, and individual support plan addendum (ISPA) that occurred as a result of more than three restraints in a rolling 30-day period were reviewed. 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 substantial compliance because the ISPA meeting following more than three restraints in a rolling 30-day period reflected a discussion of Individual #140's adaptive skills and biological, medical, and psychosocial factors. Additionally, to decrease the future probability of restraint, the ISPA minutes reflected suggestions for addressing the factors hypothesized to be contributing to his dangerous behavior. The ISPA indicated that the treatment team believed that Individual #140's psychiatric condition contributed to his aggressive behavior that provoked restraint, and indicated that he had several recent medication changes and that he was to continue to attend psychiatric clinic in an attempt to manage his psychiatric disorder.	
	(b) review possibly contributing environmental conditions;	This item was rated to be in substantial compliance because the minutes from the ISPA meeting following more than three restraints in a rolling 30-day period reflected a discussion of potential contributing environmental factors, and concluded that no environmental conditions affected Individual #170's aggressive behavior that provoked restraints.	Substantial Compliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item was rated as being in substantial compliance because the minutes from the ISPA meeting following more than three restraints in a rolling 30-day period reflected a discussion of potential antecedents to Individual #140's aggression that provoked restraint. Individual #140's treatment team concluded there were no clear antecedents to his physical aggression. The treatment team also identified the use of an antecedent intervention (i.e., distractions) when he engaged in psychiatric behavior that, on occasion, may decrease the likelihood of Individual #140's physical aggression that provoked restraints.	Substantial Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item was rated as being in substantial compliance because the minutes from the ISPA meeting following more than three restraints in a rolling 30-day period reflected a discussion of the variable or variables that may be maintaining the behavior provoking restraints. Individual #140's ISPA reflected a discussion that concluded that his physical aggression that provoked restraint was maintained by automatic variables (i.e., psychiatric condition), and was not consistently affected by environmental consequences.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	Individual #140 had a PBSP to address the behaviors provoking restraint. The following was found: • Individual #140's 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), • Individual #140's PBSP specified the alternative, positive, and functional (when possible and practical) adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, and • Individual #140's PBSP specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint • Individual #140's PBSP contained interventions to weaken or reduce the behaviors that provoked restraint that was based on the functional assessment results Individual #140 had a crisis intervention plan. The following was found: • The type of restraint authorized was delineated, • The maximum duration of restraint authorized was specified, • The designated approved restraint situation was specified, and • The criteria for terminating the use of the restraint were specified.	Substantial Compliance
	(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	This item was rated in noncompliance because, at the time of the onsite review, no data were available demonstrating that Individual #140's PBSP was implemented with a high level of integrity. The facility recently began to collect treatment integrity data (see K10 for a more detailed discussion of treatment integrity at the facility), but no data were available to document that Individual #140's PBSP was implemented as written. In order to achieve compliance with this item, there will need to be evidence that each individual with three or more restraints in a rolling 30 days had a PBSP that was implemented as written (i.e., treatment integrity level of at least 80%).	Noncompliance
	(g) as necessary, assess and revise the PBSP.	This item was rated in substantial compliance because Individual #140's ISPA indicated that the team reviewed his PBSP and a revision was not necessary.	Substantial Compliance
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	According to policy, the review of each incident of restraint began with a Face-to-Face Assessment and Debriefing Form (FFAD) completed by a restraint monitor immediately following the restraint. The newly revised FFAD included an area for recommendations regarding the restraint. The facility had just begun using the new FFAD form. Restraints were reviewed at the daily Unit Meeting and the daily Incident Management Team	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	meeting, within three business days. During the onsite monitoring visit, the Incident Management Team meetings were observed. Discussion of recent restraints was included on the daily agenda. For the 10 restraints in sample C1, • Ten of 10 (100%) were reviewed by a restraint monitor. • Nine of 10 (90%) were signed by the unit director indicating review within three business days. The exception was: o Individual #232 dated 12/22/12 (reviewed 12/28/12) • Eight of 10 (80%) were signed by the IMT designee indicating review within three business days. o Individual #168 dated 2/5/13 was not signed off on. o Individual #232 dated 12/22/12 (reviewed 12/27/12) • The new statewide policy now required a review by the psychiatrist and pharmacist, as well. Both had reviewed the three chemical restraints in the sample. The facility had an adequate review system in place.	

Recommendations:

1. All individuals frequently restrained should have a treatment plan in place to guide staff in addressing behaviors identified by the IDT that might lead to restraint, such as Individual #167 (C1).

2. The use of protective mechanical restraints and the use of medical 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, and/or eliminate the restraint when necessary. IDTs should consider the least restrictive type of restraint necessary to protect the individual from harm (C1, C2, C4, C8).

3. Ensure any psychotropic medications prescribed on an emergency basis are documented to comply with state policy (C1).

4. Ensure all staff responsible for applying restraint techniques have successfully completed competency-based training on approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint at least annually (C3).

5. Ensure that IDTs discuss and approve the use of restraints used for routine medical or dental care for an individual. When determined necessary, the ISP for individual should include treatments or strategies to minimize or eliminate the need for restraint. (C4).

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

7. There should be evidence that each individual's PBSP has been implemented with integrity (C7).

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Section D Presentation Book o SASSLC Section D Self-Assessment o DADS Policy: Incident Management #002.4, dated 11/20/12 o DADS Policy: Protection from Harm – Abuse, Neglect, and Exploitation #021.2 dated 12/4/12 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 24 randomly selected employees o Acknowledgement to report abuse for 24 randomly selected employees o Acknowledgement to report abuse for all employees hired within the last 2 months o Training and background checks for the last three employees hired o Training transcripts for DFPS investigators assigned to complete investigations at SASSLC (11) o Abuse/Neglect/Exploitation Trend Reports FY13 o Injury Trend Reports FY13 o List of incidents 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 A sample of acknowledgement to self report criminal activity for 24 current employees o ISPs for: • Individual #235, Individual #302, Individual #105, Individual #249, Individual #201, Individual #32, Individual #150, Individual #222, Individual #167, and Individual #140. 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 List of all ANE allegations since 10/1/12 including case disposition o List of all investigations completed by the facility since 10/1/12 o List of employees reassigned due to ANE allegations o List of staff who failed to report ANE, or failed to report in a timely manner o Documentation of employee disciplinary action taken with regards to the last three incidents of confirmed abuse or neglect. o Documentation from the following completed investigations, including follow-up:

Sample D.1	Allegation	Disposition	Date/Time of APS Notification	Initial Contact	Date Completed
#42697241	Neglect (10)	Unconfirmed (4) Other (6)	3/29/13 9:03 pm	4/1/13 7:00 pm	4/10/3
#42698853	Neglect	Unconfirmed	4/1/13 5:31 pm	4/3/13 4:06 pm	4/11/13
#42697454	Neglect (3) Physical Abuse (2)	Other (2) Unconfirmed (1) Unconfirmed (2)	3/30/13 1:16 pm	4/2/13 3:00 pm	4/9/13
#42693058	Physical Abuse (2)	Inconclusive (2)	3/26/13 1:54 pm	3/26/13 3:00 pm	4/5/13
#42683181	Emotional/Verbal Abuse Neglect	Unconfirmed Other	3/15/13 6:28 pm	3/16/13 9:21 am	3/22/13
#42672005	Neglect Physical Abuse	Confirmed Unconfirmed	3/4/13 3:42 pm	3/6/13 4:30 pm	3/15/13
#42666578	Emotional Verbal Abuse Physical Abuse	Unconfirmed Confirmed	2/26/13 4:46 pm	2/27/13 12:54 pm	3/15/13
#42666578	Physical Abuse	Unconfirmed	2/20/13 5:19 pm	2/22/13 4:50 pm	3/2/13
#42637544	Neglect (4)	Inconclusive (3) Confirmed (1)	1/29/13 12:47 pm	1/31/13 1:33 pm	2/15/13
#42635016	Sexual Abuse	Confirmed	1/26/13 10:40 am	1/26/13 2:42 pm	2/13/13
#42609886	Emotional Verbal Abuse Neglect (2) Physical Abuse (2)	Unconfirmed Confirmed (2) Other (2)	1/5/13 9:38 am	1/8/13 10:41 am	1/15/13
Sample D.2	**Type of Incident**	**DFPS Disposition**	**Date of DFPS Referral**	**DFPS Completed Investigation**	**Facility Completed Investigation**
#42713605	Neglect	Administrative Referral	4/15/13	4/17/13	4/16/13
#42712164	Neglect	Administrative Referral/Rights Issue	4/13/13	4/15/13	4/13/13
#42692441	Neglect	Referred Back Right Issue	3/25/13	3/26/13	3/26/13

#42562877	Neglect	Referred Back Clinical Issue	11/30/12	11/30/12	4/3/13
#42525644	Neglect	Referred Back Clinical Issue	10/24/12	10/31/12	10/25/12
Sample D.3	**Type of Incident**	**Date/Time Incident Occurred**	**Director Notification**		
#13-043	Unauthorized Departure and Encounter with law	3/18/13 12:12 am	3/18/13 12:12 am		
#13-0410	Serious Injury	2/27/13 6: 49 pm	2/28/13 9:50 pm		
#13-027	Serious Injury	2/20/13 7:20 pm	2/21/13 1:15 am		
#13-038	Serious Injury	2/16/13 3:50 pm	2/20/13 2:45 am		

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs
- Charlotte Fisher, Director of Behavioral Services
- Megan Lynch, Incident Management Coordinator
- Leticia Jaloma, Abuse and Neglect Coordinator
- Kathleen Rocha, Facility Investigator
- Karla Baker, Acting QDDP Coordinator
- Gevona Hicks, Human Rights Officer

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 4/29/13 and 5/2/13
- Annual ISP meetings for Individual #13 and Individual #259
- Pre-ISP meetings for Individual #88 and Individual #82
- Section D 1:1 QA meeting
- Unit III QAQI meeting 4/30/13

Facility Self-Assessment:

SASSLC submitted its self-assessment. Along with the self-assessment, the facility had two other 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. The second document 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, for D1, the facility reviewed the facility's Protection From Harm Policy; employee training transcripts, new employee's signed acknowledgement to report abuse, neglect, and exploitation; and confirmed that disciplinary action was taken following investigations, when appropriate. The facility's review of its own performance found compliance with all 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 18 of the 22 provision items. The monitoring team was unable to confirm compliance with the requirement that • Staff completed competency based training at least annually (D2c); • Investigations were completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the facility director or Adult Protective Services Supervisor, as applicable, grants a written extension (D3g). • The facility implemented action promptly and thoroughly, and tracked actions and the corresponding outcomes following unusual incidents (D3i). • Substantial progress was made in D4. Implementing and completing action plans are also required. The facility is to be commended for its continued focus on developing an adequate self-assessment process to monitor compliance with section D requirements.
	Summary of Monitor's Assessment: According to a list provided by SASSLC, DFPS conducted investigations 113 cases involving 177 allegations at the facility between 10/3/12 and 4/24/13, including 57 allegations of physical abuse, 11 allegations of sexual abuse, 24 allegations of verbal/emotional abuse, 4 allegations of exploitation, and 81 allegations of neglect. Of the 177 allegations, there was one confirmed case of physical abuse, one confirmed case of sexual abuse, and 20 confirmed cases of neglect. An additional 44 other serious incidents were investigated by the facility, all involving serious injuries. There were a total of 1017 injuries reported between 9/1/12 and 2/28/13. These 1017 injuries included 20 serious injuries resulting in fractures or sutures. Injury trends were being generated by individual and made available to IDTs for access on the shared drive. The facility made progress in addressing compliance with section D, though minimal progress had been made in adequately following up on incidents by addressing factors contributing to the large number of incidents and injuries at the facility. The facility will need to make appropriate recommendations with a focus on systemic issues that were identified following investigations, incidents, and injuries.

	The incident management department was playing an integral role at the facility in looking at trends and systemic issues that contribute to incidents and individualized supports and services that place individuals at risk. IDTs now need to ensure that when individuals are at risk, adequate supports are provided.

#	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	According to DADS Incident Management Policy 002.3, staff was 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	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	• Serious injury • Sexual incidents • Suicide threats • Theft by staff • Unauthorized departures. The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a log of all abuse, neglect, and exploitation investigations between 10/3/12 and 4/24/13 provided to the monitoring team, investigations of 113 cases involving 177 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility from these 177 allegations, there were: • 57 allegations of physical abuse including, o 1 confirmed; o 31 unconfirmed; o 12 inconclusive; o 1 unfounded; o 2 administrative referrals; o 1 merged into other cases; and o 9 pending outcomes. • 11 allegations of sexual abuse including, o 1 confirmed; o 9 unconfirmed; and o 1 administrative referral. • 24 allegations of emotional/ verbal abuse including, o 17 unconfirmed; o 2 inconclusive; o 3 administrative referrals; and o 2 pending outcomes. • 81 allegations of neglect including, o 20 confirmed; o 35 unconfirmed; o 5 inconclusive; o 13 administrative referral; o 1 clinical referral; o 5 pending; and o 2 merged into other cases. • 4 allegations of exploitation including,	

#	Provision	Assessment of Status	Compliance
		o 2 unconfirmed; o 1 inconclusive; and o 1 pending outcome. According to a list provided by the facility, there were 44 other investigations of serious incidents not involving abuse, neglect, or exploitation between 9/1/12 and 2/28/13. This included: • 20 serious injuries/determined cause, • 1 serious injuries/undetermined cause, • 5 sexual incidents, • 7 unauthorized departures, • 3 deaths, • 1 suicide threat, • 4 encounters with law enforcement, and • 3 others unspecified. From all investigations since 10/1/12 reported by the facility, 20 investigations were selected for review. The 20 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 (11 cases). • Sample #D.2 included a facility investigation that had been referred to the facility by DFPS for further investigation (5 cases). • Sample #D.3 included investigations the facility completed related to serious incidents not reportable to DFPS (4 cases). Based on a review of the 11 investigative reports included in Sample #D.1: • 10 of 11 reports in the sample (100%) indicated that DFPS was notified within one hour of the incident or discovery of the incident. For three incidents not reported within an hour, there was no evidence that the staff suspected abuse or neglect at the time of the incident. o The facility did not address the fact that staff witnessing another employee leaving individuals on the van to complete personal errands was not reported as a violation of facility policy or possible neglect in DFPS case #42697241. • 11 of 11 (100%) indicated the facility director or designee was notified of the incident. In four cases, notification did not occur within the one hour required by state policy. The exceptions were DFPS case #42697241, DFPS case #42698853, DFPS case #426974454, and DFPS case #42609886. • 11 of 11 (100%) indicated OIG or local law enforcement was notified within the	

#	Provision	Assessment of Status	Compliance
		timeframes required by the facility policy when appropriate. • Nine of 11 (82%) documented that the state office was notified as required. Two UIRs did not document notification of the state office (DFPS case #42697241 and DFPS case #42697454). In reviewing Sample D.3 (serious incidents), documentation indicated: • Four of four (100%) were reported immediately (within one hour) to the facility director/designee when the incident was discovered or deemed serious. • Documentation of state office notification, as required by state policy, was found in four of four (100%) UIRs. 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: • 11 out of 11 (100%) investigation files in Sample #D.1. • Nine of nine (100%) investigation files in Sample #D.2 and Sample #D.3. The facility created a notification log to document when notifications were made for each investigation. New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. All (160) new employees hired since 2/1/13 all signed this form when hired. All employees were required to sign an acknowledgement form annually. A sample of this form was a random sample of 24 employees at the facility. Twenty-three of 24 employees (96%) in the sample signed this form annually as required by state policy. The facility was in substantial compliance with the requirements of D2a.	
	(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	The facility had 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 11 investigation reports included in Sample D.1, in 10 out of 10 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The monitoring team was provided with a log of employees who had been reassigned between 10/3/12 and 3/13/13. The log included the applicable investigation case number, allegation, disciplinary action taken (including retraining), and the date the employee was returned to work. In two cases where the AP(s) was not immediately identified, information regarding employee assignment was not entered into the log (case #426720005 and case #42609886). In both cases, documentation of reassignment was found in the investigation file. All allegations were discussed in the daily IMRT meeting and protections were reviewed. In 11 out of 11 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 gathering evidence, placing the AP in a position of no client contact, an emotional assessment, a head-to-toe assessment by a nurse, and changes in level of supervision when applicable. The facility was in substantial compliance with this provision.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. A random sample of training transcripts for 24 employees was reviewed for compliance with training requirements. This included seven employees hired within the past year. • 24 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 14 (78%) of 18 employees (employed over one year) with current training completed this training within 12 months of the date of previous training. • 24 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 14 (78%) of the 18 employees (employed over one year) with current training completed this training within 12 months of the date of previous training.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. The facility was still not ensuring that all staff completed training annually as required by the Settlement Agreement and state policy. The facility was not in substantial 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. A sample of this form was reviewed for a random sample of 24 employees at the facility. 23 (96%) of 24 employees 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 staff failed to report abuse or neglect as required, however, the investigator for DFPS case #42666578 noted a concern that an employee did not report abuse when the alleged victim reported the abuse to her. The employee was retrained on reporting procedures. The monitoring team assigned a substantial compliance rating to this provision.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report 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 10/1/12 was reviewed for compliance with this provision. The sample ISPs were for Individual #235, Individual #302, Individual #105, Individual #249, Individual #201, Individual #32, Individual #150, Individual #222, Individual #167, and Individual #140. • Ten (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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. In informal interviews with individuals during the review week, most individuals questioned were able to describe what they would do if someone abused them or they had a problem with staff. The facility was in substantial compliance with this item.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of all living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The IMC reported that regular rounds were made of each residential and day site to ensure ANE information and rights posters were in place in all buildings. 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 HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group. 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 11 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and OIG of the allegation in eight (100%), as appropriate. OIG investigated three cases in the sample and criminal activity was substantiated in one of four (25%) cases.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The facility remained in substantial compliance with this provision item.	
	(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 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. No names were submitted. Based on a review of investigation records (Sample #D.1), there was concern related to potential retaliation for reporting expressed in one case (DFPS case #42666578). A witness in the case claimed that she initially made a false witness statement out of fear of retaliation. Staff were retrained on abuse and neglect policies. The facility maintained substantial compliance with this item.	Substantial Compliance
	(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 reported injuries at the morning unit meetings and again at the daily IMT meetings. • Quarterly data reports were compiled to identify trends in injuries. Sample #D3 included investigations completed on a sample of three serious injuries. All three investigations were completed by the facility. The facility investigator investigated all serious injuries. Findings were reviewed by the Incident Management Coordinator at the IMT meetings. The state reported that a new policy had been drafted to offer facilities further direction in developing an adequate injury audit system. The monitoring team will comment further on the new policy during the next round of reviews.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on observations and the sample of documentation reviewed, the facility's audit system was adequate for ensuring that all discovered and/or suspicious injuries were reviewed to rule out abuse or neglect. The facility was in substantial compliance with this provision item.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting investigations and working with people with developmental disabilities. Eleven DFPS investigators were assigned to complete investigations at SASSLC. The training records for DFPS investigators were reviewed with the following results: • Eleven investigators (100%) had completed the requirements for investigations training. • Eleven DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SASSLC had seven employees designated to complete investigations. This included the IMC, Facility Investigators, and Campus Administrators. The training records for those designated to complete investigations were requested, all investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, • Root Cause Analysis, and • Comprehensive Investigator Training. Facility investigators did not have supervisory duties; therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility remained in substantial compliance with this item.	Substantial Compliance

#	Provision	Assessment of Status	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 no indication that staff did not cooperate with any outside agency conducting investigations. The facility investigator reported good cooperation between the facility incident management staff and DFPS.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS, the following was found: • Of the 12 investigations completed by DFPS (Sample #D.1), OIG investigated three 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. The facility log of all DFPS investigations, however, noted that for DFPS case #4267414, it was noted that photographs taken as evidence were lost prior to submission to DFPS. It was recommended that concerns regarding the safeguarding of evidence be discussed	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		with campus coordinators. 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.	
	(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.	<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 with the alleged victim occurred within 24 hours in four of 11 (36%) investigations. DFPS reported that it followed its policy regarding prioritization of alleged victim interviews. Initial interviews with the victim should occur as soon as possible to preserve testimonial evidence. o Eleven (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. • 8 of 11 (73%) were completed within 10 calendar days of the incident. Those not completed within 10 days are below. Three of these had no extension request filed: o Case #42697241 was submitted on the 12th day (no extension filed). o Case #42672005 was submitted on the 11th day (no extension filed). o Case #42666578 was submitted on the 17th day (no extension filed). • All 11 (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 12 of 16 (75%) DFPS investigations reviewed in Sample #D.1 and #D.2, concerns or recommendations for corrective action were included. Four of those cases resulted in a referral back to the facility for further investigation. Concerns were appropriate based on evidence gathered during the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.3: • The investigation began within 24 hours in four of four cases (100%). • Four of four (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Four of four (100%) included recommendations for follow-up action to address the incident.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Substantial compliance was not met with regards the requirement that investigations be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the facility director or Adult Protective Services Supervisor, as applicable, grants a written extension.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	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. <u>DFPS Investigations</u> 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 11 (100%), each serious incident or allegations of wrongdoing; o In 11 (100%), the name(s) of all witnesses; o In 11 (100%), the name(s) of all alleged victims and perpetrators (when known); o In 11 (100%), the names of all persons interviewed during the investigation; o In 11 (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 11 (100%), all documents reviewed during the investigation; o DFPS found in each case that prior case history of principals was reviewed and not deemed relevant. Facility UIRs noted the DFPS finding in each case. None include a summary of review of all previous investigations involving the alleged victim or perpetrator. The facility should review all previous allegations and summarize their findings in regards to relevancy. o In 11 (100%), the investigator's findings; and o In 11 (100%), the investigator's reasons for his/her conclusions.	Substantial Compliance

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		Facility Investigations The following summarizes the results of the review of four facility investigations included in sample #D.3 • The report utilized a standardized format that set forth explicitly and separately, the following: o In four (100%), each serious incident or allegations of wrongdoing; o In four (100%), the name(s) of all witnesses; o In four (100%), the name(s) of all alleged victims and perpetrators when known; o In four (100%), the names of all persons interviewed during the investigation; o In four (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 four (100%), all documents reviewed during the investigation; o In four (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim known to the investigating agency. ▪ UIR #13-027 involved an investigation of a serious injury sustained in a fall. The facility did not include as relevant evidence the 10 falls that she had in the six months prior to incident. o In four (100%), the investigator's findings; and o In four (100%), the investigator's reasons for his/her conclusions. The facility was in substantial compliance with this item.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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. DFPS Investigations The following summarizes the results of the review of a sample of 11 DFPS investigations included in Sample #D.1: • In 11 (100%) investigative files reviewed from Sample #D.1, there was evidence that the DFPS investigator's supervisor had reviewed and approved the investigation report prior to submission.	Substantial Compliance

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		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, • 11 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 9 of 11 (82%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. Exceptions were: o Case #42693058 (submitted 4/5/13, reviewed 4/15/13) o Case #426666578 (submitted 3/15/13, reviewed 3/25/13) 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 three of four (75%) 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 within five working days of completion. o UIR #13-038 was completed on 2/20/13. It was not reviewed by the IMC or facility director until 3/15/13. The facility was in substantial compliance with the requirement for review of all investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. The facility needs to focus on ensuring that review of investigations occurs in a timely manner.	
	(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 20 out of 20 (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. Five of 11 investigations in Sample D.1 included confirmed allegations of abuse or neglect with a known perpetrator named. Documentation provided by the facility indicated that disciplinary action had been taken in five of five cases where allegations were confirmed.	Noncompliance

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	track and document such actions and the corresponding outcomes.	DFPS noted concerns or made recommendations in seven (64%) of the cases in sample #D.1. The facility was doing a better job at tracking and documenting follow-up to concerns and recommendations. • Documentation of follow-up to all DFPS concerns was found in six of seven (86%) of the investigation files in the sample. The cases where evidence was not found that the facility addressed DFPS concerns included: o DFPS case #42637544 regarding staff shortages and exchange of supervision. • The facility documented follow-up in these cases: o In DFSP Case #42697241, the investigator expressed concern that the AP had left individuals on the van while running personal errands. The facility documented a verbal warning to staff for violating facility policy. o In DFPS case #42698853, the investigator expressed concern that the AP was talking on her cell phone while assigned 1:1 supervision duties. The facility issued a verbal warning to staff for violating facility policy. o Following a confirmed allegation of neglect in DFPS case #42672005, the AP was suspended for three days. Documentation of disciplinary action was included in the investigation file. o Following a confirmed allegation of physical abuse in DFPS case #42666578, the perpetrator was terminated from employment. The facility also retrained staff on reporting procedures in response to DFPS's concerns regarding failure of staff to report the incident, false statements made due to fear of retaliation, and evidence that staff discussed the allegation prior to closure of the case. o For DFPS case #42637544, it was recommended that staff be retrained on the victim's PNMP. Documentation of retraining was included in the investigation file. o The AP was terminated in DFPS case #42635016 following a confirmed allegation of sexual abuse. o In DFPS case #42609886, two APs were dismissed following confirmed allegations of neglect, staff were retrained on using blocking pads in behavioral crisis, and the TV in the home was secured to prevent falling. The facility made additional recommendations for follow-up in 2 of the 11 cases in sample #D1. Neither file (0%) adequately documented following up on those additional recommendations. • For DFPS #42693058, the facility Investigation Review Team recommended that the unit director try to locate a fall assessment that the AP allegedly completed, but could not be found during the investigation. The UIR noted that the fall	

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		assessment was submitted, though evidence of the assessment was not included in the investigation file. • For DFPS case #42637544, the alleged victim had three documented injuries from falls within a 90 day period. The IRT recommended follow-up with a neurologist. There was no documentation that this was pursued by the IDT. Sample #D.2 included five investigations that were referred back to the facility for further review. Documentation of adequate follow-up was found in two of five (40%) investigations. DFPS case #42712164 and case ##427136605 included documentation of follow-up by the facility, however, in case #427136605, the investigator noted that follow-up by the IDT was not immediate. Thus, inadequate follow-up was found in the other three (60%) cases: • DFPS case #42692441 was referred back to the facility as a rights issue on 3/26/13. DFPS expressed concerns that the individual involved was unable to contact his guardian and had requested other placement following an incident of peer-to-peer aggression. The individual stated that he did not feel safe in his home following a physical attack by another individual in the home. The UIR indicated that as of 4/22/13, the IDT had still not adequately addressed this. • DFPS case #42562877 was referred back to the facility as a clinical issue. There was an allegation that the individual had a fever that was not treated by the facility nurse. The facility reviewed the case and determined that neglect was not involved because the individual did not have physician orders to treat a fever. There was no follow-up documentation to indicate that physician orders were obtained to prevent a similar incident from occurring. • DFPS case #42525644 was an allegation of neglect referred back to the facility as a clinical issue. A surveyor reported the incident when it was noticed that his oxygen tube was connected but nursing staff had failed to turn on the oxygen pump. Immediate protections were put into place to minimize the risk of reoccurrence, however, there was no documentation that the neglect issue was addressed with staff failing to implement supports. Recommendations for programmatic actions were made in four of four cases reviewed for facility investigations in Sample #D.3. • During the incident that led to UIR #13-043, staff did not follow the individual's crisis intervention plan, which offered specific strategies to be used in the event of an unauthorized departure. There were no concerns noted or recommendations made in regards to staff failing to implement his plan. • UIR #13-0410, UIR #13-027, and UIR #13-038 involved the investigation of serious injuries. Appropriate recommendations were made and follow-up was included in the investigation files.	

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		The facility was not yet following up on all recommendations, documenting follow-up action, and monitoring outcomes of the action for investigations. In an attempt to prevent the likelihood of serious incidents from occurring, the facility needs to ensure that adequate follow-up occurs for all incidents. The facility was not 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 incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility had fully implemented the 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. The facility was compiling data on a monthly and quarterly basis for allegations of abuse, neglect, mistreatment, and other unusual incidents and injuries. • Incidents and injuries trend information was reviewed at weekly unit meetings. • Recommendations for follow-up action were being tracked at the unit level and outcomes were reported in the daily IMRT meetings. • The incident management department submitted data and reviewed data with unit directors in preparation for their monthly unit QAQI meetings and to assist them, their managers, and their clinicians in analyzing these data and coming up with actions. • Trends were reviewed in QAQI Council meetings monthly. • Incident and injury trends were being generated by individual and made available to IDTs for access on the shared drive. • IDTs were using trend information to develop supports during annual IDT meetings. • The incident management department was making recommendations for corrective action when trends were identified both at an individual level and a systemic level.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility had made significant progress in addressing incident trends at the facility. Using trend data to develop supports is a new process for the IDTs. IDTs at SASSLC were still learning how to best use this information to develop and implement supports. IDTs need to aggressively address trends in injuries and implement protections to reduce these incidents and injuries. The monitoring team was pleased to see the incident management department taking a role in the facility's overall approach to addressing the frequency of occurrence of incidents and injuries at SASSLC. The incident management department should continue its positive work. The facility had a good system in place to identify trends and to develop action plans, but this system was new and, therefore, had not yet been implemented long enough for the there to be assessment of the effectiveness of these plans and whether they achieved the expected outcome.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: • Criminal background check through the Texas Department of Public Safety (for Texas offenses) • An FBI fingerprint check (for offenses outside of Texas) • Employee Misconduct Registry check • Nurse Aide Registry Check • Client Abuse and Neglect Reporting System • Drug Testing Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position, also had to undergo these background checks. In concert with the DADS state office, the facility had implemented a procedure to track the investigation of the backgrounds of facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of employees confirmed that their background checks were completed. 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.	Substantial Compliance

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		According to information provided to the monitoring team, for FY13, criminal background checks were submitted for 1122 applicants. There were 54 applicants who failed the background check in the hiring process and therefore was 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 24 employee's acknowledgement to self report criminal activity forms. • Signed acknowledgement forms were submitted for 24 of 24 employees (100%). The facility remained in substantial compliance with this provision item.	

Recommendations:

1. The facility needs to ensure that staff complete training annually as required by the settlement agreement and state policy (D2c).
2. The facility needs to ensure that investigations are completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the facility director or Adult Protective Services Supervisor, as applicable, grants a written extension (D3e).
3. The facility should review all previous allegations and summarize their findings in regards to relevancy in the UIR (D3f).
4. The facility needs to continue to focus on ensuring that review of investigations occurs in a timely manner (D3g).
5. Whenever programmatic action is necessary to correct the situation and/or prevent recurrence, the facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes (D3i).
6. Incident management department should generate action plans based on its data, and follow these plans through implementation and to completion (D4).
7. Data collected by the facility should be used to address systemic problems that are barriers to protecting individuals from harm at the facility. As the facility continues to develop a system of quality improvement, these reports will be critical in evaluating progress towards improvement. The facility needs to frequently evaluate if data are accurate and how data can best be used to evaluate that progress (D4).

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy #003.1: Quality Enhancement, dated 1/26/12 o SASSLC facility-specific policies: • There were six, all were the same as last review; they were: Facility Quality Assurance #200-1A, QAQI Council #400-5, Subgroup team meeting #400-4A, Subgroup calendar #400-4B, QAQI meeting agenda format #400-5A, and QAQI calendar #400-5C o SASSLC organizational chart, undated, but likely March 2013 o SASSLC policy lists, 3/1/13 o List of typical meetings that occurred at SASSLC, undated but likely March 2013 o SASSLC Self-Assessment, 4/12/13 o SASSLC Action Plans, 4/15/13 o SASSLC Provision Action Information, most recent entries 4/12/13 o SASSLC Quality Assurance Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/29/13 o List of all QA department staff and their responsibilities, undated but likely March 2013 o SASSLC QA department meeting notes, monthly September 2012 - April 2013 (7 meetings) o SASSLC data listing/inventory, hard copy (no electronic version), 3/28/13 and 4/30/13 o SASSLC QA plan narrative, 3/25/13 o SASSLC QA plan matrix, 3/25/13 o Set of blank tools used by QA department staff (7, including the new section F tool) o Nursing section M tool assignments, 4/25/13 o New D tools that resulted from 1:1 meeting o Sets of completed tools used by QA department staff (none) o Trend analysis report, for all four components, for last two quarters, through 2/28/13 o SASSLC DADS regulatory review reports, August 2012-March 2013, including annual survey o QAD-Facility Director quarterly meeting notes (first meeting 4/2/13) o Quality assurance department QAD-SAC-section leader meeting summaries • Blank minutes form that will be used • Notes from example 1:1 meeting for section D o Medical CQI meeting notes, 4/30/13 o Unit QA monthly meeting minutes and handouts: Unit III: December 2012-April 2013 (5 meetings), Unit I: September 2012-March 2013 (6 meetings); Unit II: March 2013-April 2013 (2 meetings) o SASSLC QA Reports, monthly September 2012 to March 2013 (7) o SASSLC QAQI Council monthly-quarterly-annual key indicator presentation schedule, 2/20/13 o QAQI Council minutes, monthly October 2012 to April 2013, April (7 months, 28 meetings) • October (4), November (4), December (3), January (4), February (4), March (4), April (5)

	o PIT, PET, work group reports (none, notes were included in the QAQI Council meeting minutes) o SASSLC Corrective Action Plan packet, pending/open CAPs and completed CAPs, 3/28/13 o ICF POC tracking log, undated but probably March 2013 o QA staff training documentation regarding CAPs, 2/26/13 o DADS SSLC family satisfaction survey online, August 2012 - January 2013, 13 respondents o SASSLC phone call interviews with families/LARs, 9 respondents, undated o SASSLC individuals satisfaction survey, January 2013-March 2013, about 40 respondents • Summary graphs of individual satisfaction results o Community/business satisfaction survey, November 2012-March 2013, 12 respondents o Staff satisfaction survey, blank, no respondents o Direct Support Professional Council meeting notes, 2 meetings o List of self-advocacy leadership 2013 o Self-advocacy monthly meeting minutes/notes, monthly September 2012 to March 2013, two meetings per month o Home meetings with individuals (none) o Facility newsletters, The Bridge (3) <u>Interviews and Meetings Held</u>: o Laurence Algueseva, Quality Assurance Director o Andy Rodriguez, SAC, and Kevin Elder, Bill McCarthy, staff of the QA department o Greg Vela, Juan Villalobos, David Ptomey, Residential Unit Directors o Gevona Hicks, Human Rights Officer <u>Observations Conducted</u>: o QAQI Council meeting, 4/30/13 o Unit III QA meeting, 4/30/13 o Medical CQI meeting, 4/30/13 o Sample 1:1 meeting, 4/30/13 o QA department staff meeting, 4/29/13 o Self-advocacy meeting, 5/1/13
	Facility Self-Assessment The self-assessment, written by the new QA director and the SAC, was updated and improved since the last review. The QA director and SAC reported that they referred to previous monitoring reports for SASSLC as well as from other SSLCs in creating this self-assessment. As a result, the self-assessment activities were more in line with the content of the monitoring team's report and were more focused on activities of the QA program at SASSLC. Even so, there remained many aspects of the QA program that the monitoring team regularly reviews that were not reflected in this self-assessment. The monitoring team has provided more of these areas in metrics in the report below. A statewide self-monitoring tool for section E will be helpful in future self-

	assessments for this section. Further, the Monitors and DADS will likely have finalized the expected metrics for each of the five items in this provision in the next few months. This should then result in a statewide self-monitoring tool that can be used by the QA director for future self-assessments. The facility self-rated itself as being in noncompliance with all five provision items of section E. The monitoring team concurred with these self-ratings.
	Summary of Monitor's Assessment: The QA program at SASSLC made good continued progress. There was an increase in the presence of data within most departments and in the expanding role of QA activities and infrastructure across the facility. There were not, however, SASSLC facility policies that adequately supported the state policy. The QA director could consider making the QA plan narrative the facility specific policy. The QA data list inventory was vastly improved since the last review, and 16 of the 20 Settlement Agreement provisions were included. Even so, the overall content was not yet complete and adequate. The items in the inventory would be more useful, if each item was written so that it was evident as to what was being measured. The QA plan narrative at the facility was current, complete, and adequate. It could be improved by describing how the most important key indicators for each discipline are determined. More work will need to be done to make the QA matrix a useable document that helps guide what data are submitted to the QA department, included in the QA report, and presented to QAQI Council. Monthly department meetings with the QA director and SAC (called 1:1 meetings) were initiated since the last review and were a great addition to the QA program. Other QA-related meetings were also occurring, including unit level QAQI monthly meetings, QA director-facility director meetings, and medical CQI meetings. The QA report was much improved. The QA director made many of the changes recommended in the previous monitoring report. Each month's QA report was used during all of the QAQI Council meetings for the subsequent month. Of the 20 sections of the Settlement Agreement, 17 (85%) appeared in a QA report at least once in each quarter. Most contained 12 months or more of data. Some contained some narrative analysis. Few contained any break down by program areas, living units, etc. An area for improvement was for there to be more of an analysis of their data. QAQI Council met at least once each month. In fact, the QAQI Council met almost every week. This allowed for the meetings to be short (one hour) and to be a regular part of management and clinical staff's weekly schedule. All of the QAQI Council meetings included (a) data from the QA plan matrix (key indicators, self-monitoring), and (b) the data presented were trended over time. There was no indication, however, that (c) comments and interpretation/analysis of data were presented (e.g., in the QA report, see above).

	Corrective action plans were tracked by the QA director. Of the 15 CAPs reviewed by the monitoring team, 100 % appeared to appropriately address the specific problem for which they were created. The anticipated outcomes of each action step, however, were not adequately described or determined. Further, the monitoring team could not determine how, when, or if the majority of CAPs were or were not implemented. The QA director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The QA program at SASSLC made good continued progress, again due to the leadership of the QA director, Larry Algueseva, with the assistance of the SAC, Andy Rodriguez. The monitoring team saw an increase in the presence of data within most departments and in the expanding role of QA activities and infrastructure across the facility. <u>Policies</u> There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, titled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QAQI Council, and for statewide discipline QAQI committees. Neither was in place at this time.	Noncompliance

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		Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. There were not SASSLC facility policies that adequately supported the state policy for quality assurance. The QA director reported that the facility followed the state policy, however, the state policy did not provide the procedural detail that would be expected in a facility policy. The QA director could consider making the QA plan narrative (see below) the facility specific policy because it detailed much of the facility specific QA activity. Further, the set of five facility specific policies need to be updated. Two of them referred to subgroup meetings, which were replaced by the 1:1 meetings. Once the facility-specific policy (or policies) is updated, training should be provided to QA department staff. <u>QA Department</u> Mr. Algueseva continued in his role as QA director. He remained present and active at many meetings and presentations throughout the week of the onsite review. An excellent working relationship continued between Mr. Algueseva and the SAC. There was one new program auditor. The other program auditor, the QA nurse, and the data analyst remained the same. As always, the monitoring team enjoyed meeting with them and appreciated hearing about their QA activities. The QA director continued to hold one, sometimes two, staff meetings per month. Topics were announcements, discussion of QA activities, and professional development. During the meeting observed by the monitoring team, the QA director talked about the book The Checklist Manifesto by Atul Gawande. There was good discussion and participation. <u>Quality Assurance Data List/Inventory</u> The QA data list inventory, an important component of a comprehensive QA program, was vastly improved since the last review. Even so, there was not yet a complete and adequate data list/inventory at the facility. The data list inventory was 21 pages long (when printed), contained 20 topic areas (there were two different pages for section D), and was managed in an excel spreadsheet. It appeared that 16 of the 20 provisions of the Settlement Agreement were included. There were no data specifically listed for sections G, H, I, or U, though two lines in the QA data list were about guardianship (page 1, lines 5-6). Some pages included more than one Settlement Agreement Provision (e.g., C and K; O, P, and R). It may be helpful to the facility to have a separate page for each Settlement Agreement provision.	

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		The QA department's data list inventory had 36 items. Many of these items were related to other sections of the Settlement Agreement (e.g., #25 annual/quarterly nursing reviews was section M data). The QA director said that these data were included in that section's QA report and QAQI Council presentation. The monitoring team suggests that, for this page of the data list inventory, a notation be made by each item indicating that it is part of another section. This might be done by adding a column, or perhaps by adding the section letters in parentheses right after the name of the data. Some topic areas had fairly extensive listings (e.g., C, D, J, N, and Q). Some topic areas listed some, but clearly not all, of the data that were being collected (e.g., F, L, M, S, T, and V). Further, some topic areas only listed self-monitoring tools (e.g., K, O, P, and R). That is, no other important data or indicators were included, such as those that would allow for the identification of trends related to program areas, living units, work shifts, protections, supports, and services, and areas of care. Overall, though much progress was seen compared to the last onsite review, not all of the data collected at the facility were included in the data listing inventory. Periodic review during the 1:1 meetings should help, as well as periodic presentations to QAQI Council. The monitoring team and the QAD discussed the possibility of presenting each data list inventory to QAQI Council every six months, perhaps spreading them out over the course of six months. In addition to ensuring that all data types were included, the data list inventory would be more useful to QAQI Council, the QA department, and the reader if each item was written so that it was evident as to what each item was measuring. For example, item #9 on the dental data list said "List of Preventive Care." Instead, the item should, for example, read "Preventive Care: number of individuals treated in dental clinic each month" (if that was what they were measuring). Columns were added to the data list inventory indicating if the data were to be regularly reviewed at QAQI Council, included in the QA report, reviewed at QAD/SAC meetings, and/or reviewed by the QA department. A column also indicated the frequency of use of the tools. This was all very good to see, however, if 100% of what was in the QA report was presented at QAQI Council, there would be no need to have duplicative columns. The data listing was noted to have been updated on 4/30/13, thus, the data list inventory, although not complete, was current. The date of the most recent review/update of each data list inventory page should have its own date because not all will be reviewed and updated on the same day.	

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		Quality Assurance Plan Narrative The QA plan narrative at the facility was current, complete, and adequate. The QA plan narrative was updated in March 2013. It was three pages long and provided a good overview of the components of the QA program at SASSLC. The plan narrative will need to be updated regularly as the QA program develops and evolves (e.g., the unit QAQI meetings were not mentioned in the QA plan narrative). The QA plan narrative could be improved by describing how the most important key indicators for each discipline are determined. As noted above, the QA plan narrative might be considered to be a facility-specific policy. QA Plan Matrix The QA plan matrix was very similar to the previous QA plan matrix with the exception of the removal of a number of items at the beginning of the matrix and the addition of items at the end. More work will need to be done to make the QA matrix a useable document that helps guide what data are submitted to the QA department, included in the QA report, and presented to QAQI Council. For the next review, the QA director should be prepared to demonstrate to the monitoring team that: 1. An adequate set of key indicators is included in the QA matrix for all 20 sections of the Settlement Agreement. 2. These key indicators include both process and outcome indicators for all of the 20 sections of the Settlement Agreement. 3. These indicators provide data that could be used to identify the information specified in E1: 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. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement. The SASSLC QA matrix listed self-monitoring tools for 16 of the 20 sections (80%), however, the monitoring team was aware of recent changes and revisions to many of the self-monitoring tools, and was also aware that many of the tools were no longer being used in the way indicated in the matrix. The QA director needs to update this part of the QA plan matrix. All data that QA staff members collected were not listed in the matrix. QA staff members collected seven different types of data themselves.	

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		Satisfaction surveys were included in the QA matrix. • An individual satisfaction survey was developed with the self-advocacy committee and implemented with about 40 individuals. The results were very positive. The community business satisfaction survey was again completed and was overwhelmingly positive. The results of the family survey across the past few months were also extremely positive. Surveys were done online and via a number of direct phone calls. There were no significant facility-wide findings for which any follow-up needed to be done. • An employee satisfaction survey was not conducted, however, a quarterly direct support professional council meeting was held with one or more unit directors and/or the ADOP. Minutes indicated that some follow-up to concerns was warranted. • Self-advocacy activities can be one way of obtaining satisfaction information from individuals. The self-advocacy group, under the guidance and facilitation of Gevona Hicks, the HRO, had developed into an organized activity for the two dozen or so members. Ms. Hicks was following and drawing upon a variety of curricula, as well as developing her own activities. Recent topics included voting for officers, sharing about community provider tours, exploring apartment living, fund raisers, talking about dreams and goals, and meeting with outside self-advocates. The program had developed nicely over the past two years. The QA matrix is really a subset of the larger data list/inventory. Therefore, all items on the data matrix should also be in the data list inventory. That was the case for many, but not all, of the items. <u>QA Plan Implementation</u> Items in the QA plan matrix should be implemented as written, submitted, and reviewed. Therefore, the QA director should indicate which of the items in the QA matrix were: 1. Submitted/collected/received by the QA department for the last two reporting periods for each item 2. Reviewed or analyzed by the QA department and/or the department section leader 3. Conducted as per the schedule. A percentage can also be calculated, perhaps monthly, bi-monthly, or quarterly, for each of the three items in the list above. Documentation and observation did not indicate that QA staff assisted each discipline in analysis of data, or if there was no assistance provided, there was documentation that it was not needed.	

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		<u>Self-Monitoring Tools</u> The use of self-monitoring tools was an important component of the self-assessment activity at all of the SSLCs and had been so for the past few years. A great deal of importance was placed on these tools and their outcomes. Thus, much attention from the QA department and QAQI Council continued to be directed to self-monitoring tools. Facilities can develop their own tools (or modifications of state-provided tools) for each of the Settlement Agreement sections. As far as the monitoring team could determine, at SASSLC, only the QDDP department had developed any new self-monitoring tools (e.g., for section F). In addition, very recently, the incident management department developed new tools for section D, but was not yet using them. The self-assessment, however, reported that self-monitoring tools existed for 13 sections of the Settlement Agreement and that five of these had been revised. As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that he review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, he should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at SASSLC: 1. Content/validity: A description of how the content of the tools was determined to be valid (i.e., measuring what was important) and that each tool received a review sometime within the past six months. 2. Adequate instructions: A description of how it was determined that the instructions given to the person who was to implement each of the tools were adequate and clear. 3. Implementation: A report or summary showing whether the tools were implemented as per the QA matrix. 4. QA review: A report or summary showing that there was documentation of QA department review of the results, at least once each quarter, for each of the 20 sections of the Settlement Agreement. This, however, appeared to be occurring, for those tools that were being used, primarily during the 1:1 meetings.	
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	Continued progress was seen at SASSLC regarding the gathering and organization of data. Progress was also seen in the analysis of data by many of the departments, as well as at the unit level. Data from the QA plan matrix for 15 of the 19 (79%) sections of the Settlement Agreement (not section E) were summarized and graphed showing trends over time. To make this determination, the monitoring team reviewed the QA reports, minutes from	Noncompliance

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	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.	QAQI Council, and the slides presented at QAQI Council. This was good to see, however, as noted above in E1, there was still a need to: • Review the content of many of the self-monitoring tools and update the tools or create new tools, if needed. • Demonstrate that there was adequate and thorough identification of the important data/indicators for each section of the Settlement Agreement. • When appropriate to do so, for each section, provide an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. <u>Monthly QAD-SAC meeting with discipline departments</u> These meetings were called 1:1 meetings. They were initiated since the last review and were a great addition to the QA program. It had been running for a number of months and, as is the case with any new system, some changes were still being made. One was developing a reasonable way of documenting the topics and outcomes of these meetings. A new format was developed and was going to be implemented going forward, thus, no minutes or other documentation were available for the monitoring team to review. The new format, in addition to documenting discussion, was going to provide data from these meetings regarding topics discussed, section leader completion of tasks, and so forth. The 1:1 meetings occurred once each month. There were 12 of these meetings that covered all 19 of the Settlement Agreement provisions (some meetings covered more than one provision, such as O, P, and R). The QA director was planning to also initiate monthly 1:1 meetings with each of the three unit directors to bring the units even more into the QA program, to review their monthly meetings (see below) and data, and to provide support. This seemed like a very good idea. Numerous department directors and section leaders reported to the monitoring team that they found these 1:1 meetings to be very helpful. This was good to hear. The 1:1 meetings were not scheduled for the week of the onsite review, however, the QA director and SAC set up a meeting with the incident management coordinator to demonstrate their conduct of the meeting. The meeting was efficient and the appropriate topics were covered. The QA director should ensure that the topics listed the four metrics below are always touched upon. Moreover, the 1:1 meeting may also be a forum to address (and document) an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision.	

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		Again, the 1:1 meetings certainly seemed to have occurred, however, there were no minutes or data. Therefore, the monitoring team could not complete the following four metrics, but believes this will not be a problem for the next review. 1. Since the last onsite review, a meeting occurred at least twice for ___ of the ___ (___%) sampled sections of the Settlement Agreement. The five topics below were conducted during ___ of the ___ (___%) meetings that occurred. • Review the data listing inventory and matrix, • Discuss data and outcomes (key process and outcome indicators), • Review conduct of the self-monitoring tools, • Create corrective action plans, • Review previous corrective action plans. 2. Since the last onsite review, during _____ of the _____ (___%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during _____ of the _____ (___%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during _____ of the _____ (___%) meetings, action plans (and/or CAPs) were created for systemic problems and for individual problems, as identified. <u>Other QA-Related Meetings</u> The facility held other meetings that were related to quality assurance. These were likely to help the facility meet the requirements of section E of the Settlement Agreement and demonstrated the facility's increased commitment to data, data review, and quality assurance. • Unit level QAQI monthly meetings: Each unit director ran a monthly meeting for his management and clinical staff. The primary focus was on the analysis of data, primarily from incident management, and to respond to trends identified via the QA department and/or QAQI Council. The unit directors were very positive in their descriptions of it, their goals for this forum, and the outcomes they've achieved. The monitoring team observed unit III's meeting, run by Greg Vela, the unit director. It was a well-run, professionally-conducted meeting with three main presentations. One was a very interesting analysis of injury data, identification of the 7 am to 8 am hour as particularly problematic, and the development of a simple, yet possibly elegant, intervention, which was to set up each individual's clothing and shoes during the overnight shift. The meeting had	

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		many positive aspects to it, including providing the occasion for group discussion and problem solving, making use of data that had been collected for years but not used (i.e., the trend analysis), and allowing staff the opportunity for professional development. • QA director-facility director meetings: The QA director initiated this monthly meeting in April 2013. It seemed like a great way to allow the QA director to bring important issues directly to the facility director and a great way for the facility director to remain informed of QA activities. • Medical CQI meetings: The new medical director recently initiated this activity. It falls under this section of the Settlement Agreement as well as section L3. It was just at the earliest of stages, that is, collecting data. No actions, interventions, or systems changes had yet resulted. <u>QA Report</u> The QA report was much improved. The QA director made many of the changes recommended in the previous monitoring report. The QA report remained a regular and typical part of the QA program and QAQI Council. Each month's QA report was used during all of the QAQI Council meetings for the subsequent month for data review. This was all good to see. Since the last onsite review, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for six of the last six months (100%). Of the 20 sections of the Settlement Agreement, 17 (85%) appeared in a QA report at least once in each quarter (i.e., twice since the last onsite review). Two others (10%) appeared once in the six months, and one (5%) was not in any QA report. Of the 36 sections of the Settlement Agreement that were presented quarterly, four (11%) contained all of the components listed below (sections D and M). Most contained 12 months or more of data. Many did not include any self-monitoring tool data (it may be that the department did not use a self-monitoring tool, per se). Eight included some break down by program areas, living units, etc. (sections C, D, M, and S). Fourteen (39%) contained some narrative analysis (sections D, M, U, N, O, P, and R). • Self-monitoring data o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as appropriate • Other key indicators/important data for the section o reported for a rolling 12 months or more o broken down by program areas, living units, work shifts, etc., as	

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		appropriate • Narrative analysis An area for improvement was for the section leaders to do more of an analysis of their data. This was beginning to occur as noted above and also by the QA director in his opening presentation to the monitoring team. This analysis would best be reflected in a paragraph or two in the QA report. <u>QAQI Council</u> This meeting plays an important role in the QA program and, as required by policy, was led by the facility director. The monitoring team attended a meeting during the onsite review and read the minutes of all QAQI Council meetings from October 2012 through April 2013. There was an adequate description of the QAQI Council in the QA plan narrative. Since the last onsite review, the QAQI Council met at least once each month. In fact, the QAQI Council met almost every week. This allowed for the meetings to be short (one hour) and to be a regular part of management and clinical staff's weekly schedule. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, such as the monthly and quarterly topics, performance improvement team reports, and the Settlement Agreement sections scheduled for presentation. Minutes from all (100%) QAQI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes (and attachments/handouts) from all (100%) of the QAQI Council meetings since the last review documented that (a) data from QA plan matrix (key indicators, self-monitoring) were presented, and (b) the data presented were trended over time. There was no indication, however, that (c) comments and interpretation/analysis of data were presented. The minutes did not, but should, reflect discussion that occurred. If there was no discussion or commentary, this should be indicated in the minutes, too. Similarly, the minutes should reflect if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. During a QAQI Council meeting observed by the monitoring team, there was active	

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		participation of participants other than the presenter for all (100%) of the reports/data for Settlement Agreement sections presented during the meeting (sections N and Q). <u>Work Groups/Performance Improvement Teams</u> Four PITs were in action at SASSLC (consents, active treatment, suction toothbrushing, SAP data) . This was good to see and demonstrated that facility management could target specific important problem areas. Documentation of actions of the PITs were only maintained in the QAQI Council minutes. It might make sense for these PITs to maintain simple minutes/notes of their activities, goals, and accomplishments. <u>Corrective Actions</u> Corrective action plans were tracked by the QA director in two documents. One was for current open CAPs in a 10-page document that contained 59 CAPS. The other was for completed closed CAPs in a seven-page document. This was another improvement in the QA program since the last onsite review. An adequate written description existed that indicated how CAPs were generated, including the criteria for the development of a CAP. Most CAPs addressed broader systemic issues, and some were for individual issues. The facility chose to count each component of a larger CAP as a separate CAP. This increased the number count of CAPs, but it allowed the QA department to track to completion each component of the larger action. When considering the full set of CAPs, they appeared to have been chosen following the written description, policy, or procedure. Of the sample of 15 CAPs reviewed by the monitoring team (25% of the total), 100 % appeared to appropriately address the specific problem for which they were created. Based on this sample of 15 CAPs: • All (100%) included the actions to be taken to remedy and/or prevent the reoccurrence (the actions, however, were not accurately worded). • 0 (0%) included the anticipated outcome of each action step o There were no specific criteria to determine if the CAP was met, or if progress had occurred. • 1 (4%) included the name of the person(s) responsible, however, all included the job title. • 14 (96%) included the time frame in which each action step must occur. Many of the dates had passed. One indicated the timeframe as ongoing.	

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		Lastly, the monitoring team recommends that the QA director maintain and graph some simple data on CAPs. These data can be part of the section E data list inventory (and possibly the QA matrix, too). For example: • Total number of active CAPs • Number of CAPs completed and closed out for the month • Number of CAPs that are active (i.e., not completed) past their due date	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the CAPs tracking document of a sample of 15 CAPs: • 0 (0%) included documentation about how the CAP was disseminated • 0 (0%) included documentation of when each CAP was disseminated, and • All 25 (100%) included documentation of to whom it was disseminated, including the names of the specific persons responsible. o This was indicated by a signature on the CAPs log.	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. The monitoring team could not determine how, when, or if the majority of CAPs were or were not implemented. The monitoring team will be looking for: • Indication that CAPs were implemented fully and in a timely manner. • An adequate system for tracking the status of CAPs that indicates the status of the CAP and any action taken if a CAP had not been implemented. • Summary information/data regarding CAPs and their status that was updated within the month prior to the onsite review • Presentation of this information to QAQI Council at least quarterly. The QA director made a good decision to appoint one of the program auditors to be responsible for following-up on all CAPs, including discussions at 1:1 meetings, and documentation of progress and status. The program auditor should, perhaps along with the QA director, go through the list of CAPs to determine if there are some that can come off of the list. For instance, the some were duplicated, and some were about presentations to QAQI Council.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	SASSLC was not in compliance with this provision item. The QA director did not have a method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes and timely completion	Noncompliance

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		• CAPs are modified when needed • Modifications/results are discussed at QAQI Council. • Modifications are implemented as written fully and timely.	

Recommendations:

1. Given that the statewide policy was disseminated more than a year ago, edits may already be needed (E1).
2. Update or develop facility-specific QA policy (E1).
3. The data list inventory needs improvement as described in E1, including ensuring all data are included, including all departments and sections of the Settlement Agreement, and improving the wording of each data line that better indicates what it is that is being measured (E1).
4. The QA matrix needs improvement as described in E1, including ensuring an adequate set of process and outcome indicators are included, and that the list of self-monitoring tools is accurate (E1).
5. Report on implementation of the items in the QA matrix (E1).
6. Address the recommendations regarding self-monitoring tools that are in E1, including the validity of the content, instructions, implementation, and review of results (E1).
7. For each section of the Settlement Agreement and, when appropriate to do so, conduct a review that provides analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as is required by this provision (E2).
8. Keep minutes/notes from the 1:1 meetings that indicate the content of the four bullets and sub-bullets in E2 (E2).
9. The QA report should include, when appropriate, information regarding program areas, living units, work shifts, etc., as per the wording of this provision (E2).
10. Improve the written CAPs, including description of expected outcomes (with criteria), and name of responsible person (E2).
11. Indicate how, when, and to whom the CAPs are disseminated (E3).
12. Implement, track implementation, and determine status/progress of CAPs (E4).
13. Evaluate the effectiveness of CAPs and, when necessary, make changes and implement the changes (E5).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #004.1: Individual Support Plan Process o SASSLC Policy: Individual Support Plan Process 11/20/12 o DADS Policy #051: High Risk Determinations o Section F Data Report o Curriculum used to train staff on ADA and Olmstead Act o Curriculum used to train staff on the ISP process o SASSLC Section F Presentation Book o SASSLC Self-Assessment o The last 10 section F monitoring tools completed by the QDDP Coordinator o List of all QDDPs and assigned caseload o List of individuals with PBSPs and replacement behaviors related to communication o A list of QDDPs deemed competent in meeting facilitation (13) o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. o List of ISP meetings that occurred or were file over 30 days after the annual date. o A list of all individuals at the facility with the most recent ISP meeting date, date of previous ISP meeting, and date ISP was filed. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans: • Individual #32, Individual #201, Individual #249, Individual #105, Individual #222, Individual #167, Individual #150, Individual #302, Individual #235, and Individual #53. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Charlotte Fisher, Director of Behavioral Services o Megan Lynch, Incident Management Coordinator o Leticia Jaloma, Abuse and Neglect Coordinator o Kathleen Rocha, Facility Investigator o Karla Baker, Acting QDDP Coordinator o Gevona Hicks, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 4/29/13 and 5/2/13 o Annual ISP meetings for Individual #13 and Individual #259 o Pre-ISP meetings for Individual #88 and Individual #82

	o Section D 1:1 QA meeting o Unit III QAQI meeting 4/30/13
	Facility Self-Assessment: SASSLC continued to use the self-assessment format it developed for the last review. It had been updated on 4/12/13 with recent activities and assessment outcomes. The Acting QDDP Coordinator was responsible for the section F self-assessment. The facility had added a number of activities to the self-assessment efforts in regards to section F. The self-assessment commented on findings from a monthly sample of Settlement Agreement Monitoring Tools (SAMTs) completed by the QDDP Coordinator, as well as other activities for each provision. The facility was also observing ISP meetings, reviewing completed ISPs, tracking attendance at team meetings, and tracking completion and submission of assessments prior to the annual ISP meeting. For example, for F1b in regards to team participation in developing the ISP, the self-assessment compared ISP preparation notes (recommended/required attendance) with signature sheets from the annual meeting. These are the same type of activities that the monitoring team looks at to assess compliance. The facility had developed action steps to address deficiencies noted on the self-assessment. This should ensure that progress will continue to be made on developing an adequate ISP process. 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 Since the last monitoring visit, SASSLC QDDPs and other team members had been provided additional training on the new ISP and risk identification process by statewide consultants. IDTs began implementing the newly developed process in October 2012. 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 facility submitted 10 ISPs in the new format for review by the monitoring team. 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. Since a majority of individuals had not had an ISP developed in the new format, the monitoring team concentrated on providing comments regarding areas of improvement and areas that continue to need improvement from the limited sample available rather than offering compliance data in most areas. Compliance will be contingent on both the new plans meeting the requirements, and a sufficient number of individuals having plans that meet the Settlement Agreement requirements.

	There were some positive steps evident with the new ISP process. At two ISP meetings and two pre-ISP meetings observed by the monitoring team: • The IDTs were following the format of the new ISP process, however, the meetings were lengthy and the IDTs struggled with how to integrate the risk discussion into the ISP meeting. • There was more integrated discussion among team members. Some team members understood the new process. • Teams had made some progress with integrating recommendations from various assessments into supports and services. For example, IDTs were developing some outcomes with strategies in place to address communication, health, and behavioral needs. This was good to see. • IDTs still need to ensure that deadlines are set and responsibility assigned when additional assessments are recommended by the team. Barriers to implementing recommendations in a timely manner need to be addressed • All team members need to ensure that supports are monitored for consistent implementation and adequacy. Data collected during monitoring should be used to revise supports when there is regression or lack of progress. While the planning process was improving, the monitoring team found that plans that teams had spent hours developing were not accessible to staff responsible for implementing the plan. ISPs were out of date in a majority of the individual records reviewed. IHCPs that were a part of the ISP were not available to support staff. This needs to be addressed immediately. DSPs should be trained to notify someone when they do not have a current support plan in place to implement. Those assigned responsibility for monitoring implementation should monitor that a current plan is in place and accessible to staff. The new process, thus far, was not resulting in adequate supports and measurable outcomes. Though considerable progress was noted, the facility was not yet in compliance with any of the provisions of section F.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and	During the week of the review, the monitoring team observed two ISP meetings in the new format. The QDDP facilitated both meetings. Both meetings were good examples of facilitation that ensured that team members participated in the meeting and all topics were covered. Progress continued to occur and was evident, with regard to the facilitation of meetings.	Noncompliance

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	supports.	QDDPs had undergone additional training with a state office consultant on the new ISP format. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDPs used this template to draft portions of the ISP prior to the meeting. The QDDPs 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. In both meetings, the risk discussion took a majority of the time. When teams become familiar with this process and more competent at assigning accurate risk ratings, this portion of the meeting should take much less time and then more time can be spent on the other important portion of the meeting, that is, determining if supports in place are adequate and integrated throughout the individual's day. A sample of IDT attendance sheets was reviewed for presence of the QDDP at the annual IDT meeting. QDDPs were in attendance at all annual meetings in the sample reviewed. 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 ensure that meetings result in comprehensive support plans that focus on the individual's strengths and preferences. The plan should then be monitored and revised as needed. The assigned QDDPs remained responsible for ensuring the monitoring and revision. As noted throughout this report, the monitoring team found the QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. The facility did not have an adequate monthly review process in place to ensure that plans were updated when regression or lack of progress towards outcomes was noted.	
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 pre-ISP meeting, as well as professionals dictated by the individual's strengths, needs, and preferences. According to the state office policy, the Preferences and Strength Inventory (PSI) was the document that should have identified the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. PSIs, however, were not completed for individuals in the sample. Instead, the older Functional Skills Assessment was still being used. The QDDP Coordinator had begun to track data on attendance at IDT meetings. Data gathered indicated poor presence and participation by many relevant team members. Review of a sample of ISP attendance sheets confirmed there was key staff missing at	Noncompliance

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		annual meetings in the sample. For example, • At the annual ISP meeting for Individual #32, there was no participation by his family, PT, SLP, dietician, PCP, or dental staff. • For Individual #201, there was no participation at her annual meeting by her family, dietician, or dental staff. • For Individual #150, there was no indication that he participated in his meeting. Other team members not in attendance included his psychiatrist, OT, and dental staff. The facility was still using the Functional Skills Assessment (FSA) to assess daily living skills for a majority of the individuals in the sample. A number of months ago, the state developed a new tool to assess personal preference and support needs, the Preferences and Strength Inventory (PSI). It was similar to the FSA and should serve the same purpose in identifying preferences and support needs, which should be beneficial in determining what staff should be present at the annual IDT meeting. In addition, the facility was holding a pre-ISP planning meeting to gather information and identify assessments that needed to be completed prior to the ISP annual meeting. Note, however, that one might consider that the IDT process was occurring in the psychiatry clinic setting. That is, psychiatry clinic was functioning somewhat like an ISPA given the number of staff in attendance and the collaboration observed. The lack of psychiatry resources did not allow for the routine participation of psychiatry in many of the other IDT processes or meetings. The facility was not yet in compliance with requirements for the IDT ensure input from all team members into the ISP process.	
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. The facility gathered data regarding the timeliness of the submission of assessments prior to the annual ISP meeting. Data gathered regarding the submission of assessments from 9/1/12 through 2/21/13 indicated that assessments were not routinely submitted prior to ISP planning meetings. The overall compliance percentage for the on-time submission of assessments was 39%. 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	Noncompliance

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		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). Newer ISPs reviewed supported the facility's determination that assessments were not being submitted prior to annual ISP meetings in some cases. IDTs did not always have adequate information needed to develop supports. For example, • Individual #32's annual ISP meeting was held on 11/1/12. His psychological assessment and quarterly drug review were completed the day before his annual meeting. His habilitation therapy assessment was completed on the same day as his ISP meeting. • For Individual #302, his habilitation therapy assessment, communication assessment, and aspiration pneumonia/enteral nutrition were not completed and posted to the shared drive for access by team members prior to his annual ISP meeting. All were crucial for developing adequate supports to address his complex needs. Assessments were not functional in adequately addressing individual's preferences related to work, relationships, and community integration. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities. As noted in previous reports, the FSA was not adequate for capturing this information. 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 yet in compliance with this item based on the data available.	
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 not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been progress made in integrating assessment recommendations into support plans when available to the team. 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.	Noncompliance

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		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. Examples where assessment results were not incorporated into the supports and services developed by the IDT included: • Individual #249 had strategies to address his risk for choking and aspiration in his IHCP. These strategies were not incorporated into his communication SAP, which involved activating a switch during snack time. Another SAP to address his mealtime risk by teaching him to eat more independently did not include adaptive equipment listed in his IHCP. • Individual #105's communication assessment indicated that he did not have functional hearing. He used tactile cues for receptive communication. His training instructions for toothbrushing instructed staff to use verbal cues and verbal reinforcement. • Individual #302's rights assessment indicated that he was unable to give informed consent or make decisions regarding his care. The IDT did not discuss his need for guardianship.	
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 mandated that a Living Options discussion 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. As part of the new ISP process, each discipline was asked to include as part of the pre-ISP assessment process a determination on whether or not needed supports could be provided in a less restrictive setting. Discussion by IDT members regarding community placement included preferences of the individual, LAR (if applicable), and family members, along with, opinions offered by each discipline. Any barriers to community placement were to be addressed in the ISP. At both the ISP observed for Individual #13 and Individual #259, team members discussed providing supports in a less restrictive environment. Guardians for both individuals stated that they did not want to consider community placement. The teams did share information with the guardians regarding supports that could be provided in the community. The majority of team members on each IDT agreed that the individuals could be supported in a less restrictive environment. Neither team made a referral to the community. Each team developed some general goals for further exposure to living	Noncompliance

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		options in the community. Both teams stopped short of developing goals that would offer individualized meaningful community integration. The living options portion of the ISP meeting is also of interest to the admissions and placement coordinator and her staff (see section T). The QDDP coordinator might consider working with the APC on this aspect of the ISP meeting. Further, both the APC and the QDDP department monitor the living options discussion. There might be a more efficient way to do so rather than having multiple people observing the same aspect of the same meeting. Community based outcomes in the sample consisted of generic opportunities to visit in the community. For example: • Individual #150 had one outcome to be implemented in the community. The outcomes stated that he "will be offered the opportunity to attend at least one off-campus activity per week." • Individual #167 also had one outcome to be implemented in the community. His outcomes stated, "will have the opportunity to participate in an off-campus activity at least once per year." When outings are planned specifically for greater exposure to the community, documentation should include a means to capture individual's preferences and interests. Those preferences and interest should be used to develop additional action steps that would encourage greater independence and integration into the community. Outcomes should be developed to address communication skills, decision making skills, social interaction, work and volunteer opportunities, and increased exposure to life outside of the facility. As noted in section C, the monitoring team identified an individual who spent very little time out of the bedroom engaged in activities (Individual #167). His ISP outcomes did not provide for meaningful programming with any acceptable frequency. He had an outcome to attend an on-campus activity twice a year and an off-campus activity one time per year. In addition, according to staff, his roommate, Individual #96, also spent a majority of his day in his bed or chair with his arms restrained to his wheelchair. IDTs for these individuals need to meet and develop an interdisciplinary support plan to ensure that a majority of each day is spent out of their bedroom engaged in meaningful activities in the least restrictive way possible to ensure their safety. The facility was not in substantial compliance.	

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F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	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 preferences are integrated into each individual's day. As noted in F1, additional opportunities to try new things should lead to the identification of additional preferences. Observation across the SASSLC campus by the monitoring team did not support that individuals were spending a majority of their day engaged in meaningful activities based on their preferences. Opportunities to explore new interests and develop new skills were limited. Many individuals were working at the facility's sheltered workshop, but it was not evident that doing so would lead to opportunities for supported employment in the community. Good interaction and engagement were observed in some homes, in other homes, engagement was not functional and not based on individual's preferences. Again, there was little opportunity to gain exposure to new activities and learn new skills. As noted in F1e, a majority of plans in the sample offered individuals opportunities to visit in the community, but stopped short of offering opportunities for true integration, such as attending church in the community, banking in the community, joining community groups focused on her interests, or exploring volunteer or work opportunities.	Noncompliance

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		In a review of five recent ISPs (Individual #105, Individual #201, Individual #249, Individual #167, and Individual #150), two (40%) offered specific training to be provided in the community: Individual #201 and Individual #150 had money management outcomes to be implemented in the community. The others had community objectives, however, they were limited to stating the individual would have opportunities to participate in community outings. For many of these individuals, community awareness and participation had been identified as obstacles to living in the most integrated setting, but IDTs did little to develop community integration strategies that would address these obstacles, including use of community settings to teach skills that would support successful community living or integrate preferences identified by and for the individual into SAPs.	
	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, however, there had been considerable progress made at the ISPs observed in IDTs considering what supports would be needed to successfully implement action steps developed by the IDT. A sample of skill acquisition plans (SAP) and integrated health care plans (IHCP) were reviewed to determine if IDTs were developing individualized, observable, and/or measurable goals that included strategies and supports to ensure consistent implementation and monitoring for progress. The monitoring team found that there were still many outcomes not written in a way that staff could measure progress towards completion or did not provide enough information to ensure consistent implementation. For example: • Individual #105 had a SAP that stated, "will be informed by staff that it is time to receive his am medication." It was not clear what training would occur or what would constitute a successful attempt. • Individual #235 had an action step to address her risk for choking. It stated "quarterly observing signs of choking." It was not clear how this would prevent choking. There were no specific supports in place for direct support staff to implement to prevent choking. Her risk for aspiration was addressed with supports that would be needed from nursing staff following an aspiration incident. Again, there were no supports included for direct support staff to implement to keep her safe on a daily basis. • Individual #249 was at high risk for falls. He had numerous recent falls, one resulting in a serious injury. His IHCP referenced following his PNMP and wearing correct footwear. His IHCP did not include specific strategies to address his fall risk. • Individual #201 had an outcome to purchase items from her shopping list. Her	Noncompliance

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		task analysis stated "will independently make a purchase from her list." Methodologies did not specifically state what observable behaviors would be considered a successful attempt (choosing the item, handing the item to the clerk, independently handing the clerk the correct dollar amount, etc.). Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Section M and section I also address the writing of measurable strategies to address health care risks. Section T elaborates on the facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. Little progress had been made in individualizing action plans to overcome obstacles to community transition, and ensuring that they are measurable. For example, at the ISP meeting for Individual #259, the team agreed that there may be ways to reduce barriers to living in the community, but did not clearly define the barriers. The facility had made little progress in developing measurable, meaningful training in the community. All individuals were offered opportunities to take trips in the community, but this still was not resulting in opportunities to integrate into the community. Work opportunities were limited to a few options based on contracts that the facility had for work in the onsite sheltered workshop. Progress had not been made on exploring community employment opportunities for individuals.	
	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. It was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed the individual's array of needs for protections, supports, and services, while approaching this in a person-centered manner and incorporating individuals' preferences and strengths. The development of action plans that integrated all services and supports was still an area with which the facility struggling. At both ISP meetings observed, the team spent more time than before trying to identify areas where measurable outcomes were needed. The teams also engaged in more integrated discussion regarding support needs in relation to preferences, though still struggled with integrating discussion. For example, at the IDT for Individual #13, team members struggled with interjecting relevant supports needed when risk areas were discussed. Each discipline appeared to be more comfortable reading the completed discipline assessment in isolation to other disciplines. He had behavioral and	Noncompliance

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		communication support needs that needed to be considered when reviewing his risks and preferences. When asked for input, the psychologist, psychiatrist, and nurse had difficulty discussing supports that related to the specific topic. 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. Assessment recommendations need to be available when teams are developing action plans for training and interventions. 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. It is expected that progress will continue to be made in developing comprehensive plans as IDT become more familiar with the new ISP process and more adept at developing measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	As discussed in F2a2 and section S, action steps in the sample of ISPs reviewed did not include clear methodology for implementation. Without clear instructions for staff, it would be difficult to ensure consistent implementation and determine when progress or regression occurred. Teams will need to develop methods for implementation of outcomes that provide enough information for staff to consistently implement the outcome and measure progress. IHCPs action steps were generally brief statements of action to address the risk. Most did not include methodology. For example: • Individual #150 had an action step to address his high risk for polypharmacy. It simply stated, "monitoring as needed." The plan should have included what would be monitored, the method for monitoring (lab work, specialist consultation, etc.), the frequency of each intervention, and what the desired outcome should be. • Individual #201 had an action step to address her risk for dental health that stated "staff to encourage him to go to scheduled dental appointments." The plan should have included the frequency of appointments and the method that staff should use to "encourage" him to go. • To address his risk for weight gain, Individual #222 had an action step for staff to encourage him to participate in more activities related to physical exercise.	Noncompliance

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		The action step did not include strategies for encouraging him or list preferred activities. Outcomes in the sample reviewed included either a completion date of 12 months after implementation began or ongoing. Completion dates should be assigned with a realistic expectation of when the outcome may be completed based on each individual's rate of learning. ISPs, SAPs, and IHCPs included designation of which staff would be responsible for implementation of the outcome. It was not always clear who would monitor implementation and how often it would be reviewed and monitored for efficacy. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The new ISP format provided prompts to assist the IDT in considering a wider range of supports and services when developing the ISP. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. IDTs will need to accurately identify needed supports and services through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings. The new ISP process should help teams more accurately identify needed supports. Additional training will be needed by IDTs to effectively integrate those supports into a comprehensive, functional ISP. Teams were still struggling with developing action plans to address all needed supports and services, particularly, in developing outcomes to address identified risks. See section I for additional comments regarding outcomes developed to address risks.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	DADS Policy 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. The new ISP format included columns for person responsible for implementation, type of documentation, and person responsible for reviewing progress. Integrated Healthcare Plans included similar information. The frequency of implementation was found on the SAP. SAPSs, however, were not developed for all outcomes. The frequency of implementation was rarely found for outcomes in the IHCP. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for consistent data collection. IHCPs in the	Noncompliance

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		sample did not include enough information to determine what data would be collected and how progress or regression would be measured. Also see section S of this report for further discussion on the adequacy of data collection. Additionally, see section J of this report for comments regarding the collection and review of data for psychiatric care, section K for the behavioral/psychological data collection and review, sections L and M for the collection and review of medical and nursing indicators, and, sections P and O for data collection relevant to physical and nutritional indicators.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	This provision item will require that psychiatry, psychology, medical, PNM, communication, and most integrated setting services are integrated into daily supports and services. Please refer to these sections of the report regarding the coordination of services as well as G1 regarding the coordination and integration of clinical services. As noted in F1, 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 available to all members of the IDT and 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 7 out of 26 (27%) records reviewed. The facility reported that 15 (17%) of 86 ISPs were filed more than 30 days after the annual ISP meeting from November 2012 through February 2013. The facility needs to ensure that plans are distributed and available to staff implementing the plan. 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.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s)	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. Each discipline was responsible for reviewing specific services and supports. QDDPs were responsible for reviewing the overall plan. It was not evident that the review of supports and services led to timely implementation of assessments or changes in supports when necessary. For example,	Noncompliance

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	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.	• At the pre-ISP meeting for Individual #54, it was reported that he had been hospitalized with pneumonia in January 2013. The team recommended a swallow study following his discharge. The swallow study was not completed until 3/22/13 and his PNMP was not updated to include recommendations from the assessment until 4/24/13. • Individual #259 was hospitalized for a bowel obstruction in March 2013. The PCP recommended a consultation with a GI specialist. It had still not been scheduled. Medical staff failed to monitor the status of the assessment. Nursing staff reported that he received water flushing of his G-tube, but the nurse and dietician were unsure how frequently it occurred, indicating a lack of monitoring. A coordinated system for monthly review of supports was in place. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QDDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. Plans should be updated and modified as individuals gain skills or experience regression in any area. QDDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals'	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 six employees hired within the past year indicated that six (100%) had completed the new training on ISP process entitled Supporting Visions. All staff were required to attend an initial course on the ISP process. The facility had recently been trained by the state office on developing and implementing the ISP. QDDPs were still learning to use the new statewide ISP format. The facility was documenting staff training on individualized specific plans, but as noted throughout section F, staff instructions for many plans did not offer enough information to ensure consistent implementation. Informal interviews throughout the facility indicated that staff were unable to describe supports and services developed through the ISP process. As noted in F2c, plans were not available for reference following development. All departments will need to be involved in training staff on individual specific plans, such as integrated health care plans, behavior support plans, PNMPs, and mealtime plans. An adequate monitoring	Noncompliance

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	plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	system should be in place to ensure that all staff are familiar with plans and provide supports competently and consistently. The facility did not have an adequate system in place to insure ongoing training of individual specific plans.	
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.	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 ISPs were available in 7 (67%) of 27 individual notebooks in the sample. None of the individual notebooks included a current IHCP or Risk Action Plan. Informal interviews with staff indicated that not all staff were adequately trained on the requirements of individual ISPs. Familiarity with plans varied widely from home to home. Without current plans in place, it was not possible to confirm information that staff were able to share regarding supports and services. Section F data compiled by the facility indicated that of six records reviewed, only two (33%) had current ISPs. The facility was gathering data on the submission of documents for the individual records. A list provided by medical records department reported that 15 of 86 (17%) of ISPs were filed more than 30 days after the annual ISP was held. The facility needs to ensure that plans are distributed and available to staff implementing the plan as soon as possible, but no more than 30 days after development.	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 assurance activities with regards to ISPs were still in the initial stages of development and implementation (also see section E above). The facility had just begun to analyze findings and develop corrective action plans based on self-assessment findings.	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. The facility needs to develop an adequate monthly review system so that plans can be monitored and revised as needed (F1a, F2d).

3. 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, F2a3).

4. The facility needs to expand opportunities for individual's to experience new activities and record responses to those activities in order to identify a broader range of preferences. Those preferences should then be used to develop new skill acquisition opportunities (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 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. 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, F2f).

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

13. 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).

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

15. Develop a monthly review system adequate for determining the efficacy of all supports and services. 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).

16. 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 scheduled monthly reviews. 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).

17. 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 David Espino, MD, Medical Director o Yenni Michel, DO, Primary Care Physician o David Bessman, MD, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Family Nurse Practitioner o Mandy Pena, RN, QA Nurse o Soury Phanhthrath, RN Chief Nurse Executive o General discussions held with facility and department management, and with clinical, administrative, and direct care staff throughout the week of the onsite review. Observations Conducted: o Various meetings attended, and various observations conducted, by monitoring team members as indicated throughout this report o Psychiatry Clinics o Daily Clinical Services Meetings
	Facility Self-Assessment: The facility 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 were 17 items listed, including review of committee attendance records and documentation of discussions that occurred. These were all reasonable activities, but they were all process oriented. The monitoring team recommends that the medical director also review the care provided to determine if supports were integrated. This would not require additional work, but would be completed as part of the CQI process of case reviews. The review of such cases should indicate if services were provided

	in an integrated manner. The monitoring team believes that assessment of integration of clinical services requires many to determine if actions occurred and if the actions resulted in the outcome of integration. 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 noncompliance with both provision items. The monitoring team agrees with the facility's assessment.
	Summary of Monitor's Assessment: Throughout the conduct of the review, the monitoring team found some good evidence of integration of clinical services. Some degree of progress was appreciated. There were no new major initiatives specifically related to the integration of clinical services, but some meetings were expanded or included more discussions that had the potential to improve integration of clinical services. The most troubling finding was that the disciplines, such as dental clinic, that struggled with integration continued without any real improvement. The monitoring team had the opportunity to meet with the medical director to discuss integration activities at the facility. He reported working with many clinical areas to help foster the spirit of integration. He also reported that in several instances, he could do no more because the areas requiring attention were not under his purview. The medical director and monitoring team discussed many areas where integration was visible as well as those areas that needed support from the facility administration in order to move forward. 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.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology,	The medical director served as the lead for this provision and was involved in a number of activities related to integration of clinical services. His desire and ability to work with the various clinical and non-clinical disciplines was evident throughout the week of the compliance review. He promoted the concept of a unified organization and the value of teamwork. SASSLC employees appeared to respond well to his leadership and this will be important as he attempts to bring together many departments for the purpose of	Noncompliance

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	psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	improving integration of clinical services. 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. The monitoring team observed a variety of activities designed to foster integration of clinical services. These activities included daily meetings, periodic meetings, and committee meetings. Other activities included the generation of various reports containing clinical information forwarded to the IDTs. There were several ongoing collaborative efforts that targeted integration of services. For the most part, each of the clinical disciplines had considered how they could achieve integration with the other clinical disciplines. The monitoring team observed the following examples throughout the week of the compliance review: • 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 pharmacists, 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 On Duty RN compiled the meetings since the previous meetings. Topics covered in the morning reports were expanded to include, but were not limited to: o Psychology reports on individuals who experienced maladaptive behavioral incidents. o Medical review of individuals with changes in health status, which included treatment and follow-up, if indicated, as well as hospitalization/emergency room visits and disposition of their status. o Individuals who experienced seizure activity were reported and treatment provided, if required. o Respiratory Therapist reports, if any were reported. o Individuals who had clinical issues requiring follow-up were reviewed and discussed. Issues requiring follow-up were identified, as well as action steps required identified, and responsible staff were assigned to follow-up. o Administrative issues requiring follow-up were identified, actions steps were determined, and responsible staff were assigned to follow-up. o Individuals who required urgent consults were identified. o Weekly Enrollment Reports were reviewed, which included daily census, discharges, pending discharges, and admissions. o Community Placement Follow-up Reports were reviewed and discussed when indicated • Integration of nursing services with other departments was demonstrated in	

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		many ways: o The department staff maintained an excellent working relationship with the medical/psychiatry staff and clinical pharmacists. o There was evidence of strengthening of integration with other disciplines through: ▪ Incident Management Teams ▪ Hospital Liaison Nurse communication with other IDTs regarding hospitalized individuals ▪ Providing/training direct care professionals on individuals' health care plans ▪ Collaboration and coordination with the Pharmacy Department on reconciliation of medications ▪ Collaboration with QA/QI Department on Nursing Care Monitoring Tools and Protocol Monitoring Tools ▪ Integration with Home Management Teams ▪ Participation by the RN Case Managers with the IDTs at the annual ISP and ISPA meetings • The habilitation department also made some progress in providing its services in a more integrated format: o The PNMT worked together, in an integrated manner, for assessment and the development of intervention plans in conjunction with the IDTs. o The physicians had attended a few of the meetings held by the PNMT and, based on the observations of the meeting during this onsite review, their contributions were very valuable. The system of the PCP attending during specific discussion about an individual on their caseload appeared to be a good approach to provide integrated supports and services in a timely manner. Needs were identified during the meeting and the physician was able to initiate orders and other directives to ensure timely implementation. • Integration of psychology and psychiatry was improving. Psychologists and psychiatrists appeared to have meaningful interactions during psychiatric clinic meetings observed • The dental department continued activities noted in previous review: o The Daily Dental Report - The 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. o The dental consultation consent was developed for clinical services members to review proposed medications for sedation/TIVA and provide a consensus on the best treatment options.	

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		• The pharmacy department worked closely with the medical staff and nursing on a number of issues: o Quarterly Drug Regimen Reviews were completed by the clinical pharmacists and recommendations made to prescribers. o Clinical interventions included discussions and information forward to prescribers related to medication orders. In addition to the aforementioned examples of integration, 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: • Pharmacy and Therapeutics Committee • Medication Variance Committee • Polypharmacy Oversight Committee • PNMP Committee • Infection Control Committee • Medical Staff Meeting • The Continuous Quality Improvement Committee Details related to the function and activities of these committees are provided throughout the report. Notwithstanding these positive and encouraging observations, the monitoring team identified several opportunities for improvement: • As noted in section J, one concern was that while information about various topics (e.g., polypharmacy; individuals with epilepsy) were discussed with the IDT, it was not always possible to determine the integration of that information via the treatment plan provided for the individual. The integration with regard to the IDT process evident in psychiatry clinic was better spelled out in the psychiatric quarterly evaluations due to various disciplines providing pertinent information in the integrated document (e.g., nursing, psychiatry, psychology, and pharmacy). • The IDT predominantly focused on the review of pretreatment sedation for individuals receiving psychiatric services/prescribed psychotropic medication when dental procedures were necessary, but not equally so for medical treatments. • Improvement was needed in the integration of psychiatry and neurology. The current format did not always result in adequate information for the IDTs and follow-up was not always timely. Furthermore, there was no substantive integration for those who received neurological care off campus. • The development of strategies to overcome barriers to dental treatment was	

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		intended to be collaboration between psychology, dental, and medical. It was clear that integration was lacking in this area. This is discussed further in section Q2. • There was a continued need to ensure that the multidisciplinary clinical protocols issued by state office were fully implemented. 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.	During the August 2012 compliance review, the monitoring team found that SASSLC was making good progress in this area. In fact, 83% of consults reviewed were summarized in the IPN within five working days. The referral to the IDT was the issue of concern. Since the August 2012 review, the facility had lost substantial ground in this area. The database used previously was no longer in use. It had been replace by a standardized state-issued consult-tracking database. During interviews, the medical director expressed concern about the format and data content. The database appeared to house the necessary information, although the facility will need to determine how the information can be sorted. The consults and IPNs for six individuals were requested. A total of 35 consults completed after July 2012 (including those from the record sample) were reviewed: • 20 of 40 (50%) consultations were summarized by the medical providers in the IPN within five working days; most consults reviewed were initialed and dated by the medical providers indicating review of the consults. As discussed in section L1, providers generally summarized the recommendations of the consultants, but usually did not indicate agreement or disagreement with the recommendations. 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. The medical director fully acknowledged during interviews that there were problems with the consult documentation and the facility's self-assessment affirmed those findings. It was reported that these findings were being addressed with appropriate corrective actions. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. Another outstanding issue was related to tracking by case managers. During the August 2012 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. While this appeared to be a reasonable approach and was not intended to replace the database, it had not occurred at the time of the compliance review.	

Recommendations:

1. The facility director or designee must work with the medical director to ensure that the various clinical departments are fulfilling their roles in providing integration of clinical services.

2. 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).

3. 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).

4. The monitoring team recommends the following with regards to documentation of consults:
    a. The IPN documentation should include a statement regarding agreement or disagreement as well as the decision related to IDT referral. Clinically justifiable rationales should be provided when the recommendations are not implemented.
    b. Primary medical providers 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.
    c. The PCPs should always notify the IDT when there is a disagreement with the recommendations of the consultant since further discussion may be warranted.
    d. 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., Surgery Consult, 1/1/12).

5. The medical director should review the functionality of the consult tracking database and determine if changes are needed (G2).

6. DADS should develop and implement policy for Provisions G1 and G2 (G1, G2).

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS draft policy #005: Minimum and Integrated Clinical Services o SASSLC Standard Operating Procedure: 200-5C, Facility Integration of Clinical Services o SASSLC Self-Assessment 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, 2012 -2013 Interviews and Meetings Held: o David Espino, MD, Medical Director o Yenni Michel, DO, Primary Care Physician o David Bessman, MD, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Family Nurse Practitioner o Mandy Pena, RN, QA Nurse o Soury Phanhthrath, RN Chief Nurse Executive 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 While the self-assessment presented a great deal of data and information, the data were sometimes not relevant and, in other cases, did not represent the correct metrics. For example, for H1, it was reported

	that AMAs were completed within the month. The fundamental requirement for AMAs is completion within 365 days of the prior assessment. For other provision items, the selection of metrics was flawed. 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 agreed.
	Summary of Monitor's Assessment: There was really no progress observed in this provision. At one time, the facility seemed poised to make great strides in this area. However, it appeared that little attention was given to this provision. The regression was most likely related to the change in the medical director and loss of the medical compliance nurse. There was no facility policy and the monitoring team did not find any specific planning on the part of the facility that would result in any substantive progress. It was also evident that greater involvement from upper facility management was needed to move forward with provisions G and H due to the breadth of the issues. The management of assessments needed attention because many key assessments were not completed in a timely manner. While some departments made gains in assessment compliance, others fell out of compliance. Some departments simply just continued as the status quo with no improvement. For provision items beyond section H2, the facility appeared to shift focus, which resulted in pathways that did not appear to assist in moving towards substantial compliance. The medical director will need to devote additional time to this provision and seek guidance from state office.

#	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	The state office policy, which remained in draft, required <u>each department</u> 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, he reported that a centralized database, maintained by QA, tracked all assessments. The self-assessment documented compliance	Noncompliance

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	timely detection of individuals' needs.	rates, as reported by the data analyst, for audiology, dental, medical, nursing, habilitation, OT/PT, pharmacy, and psychology. The reporting period was October 2012 to January 2013. Overall, the compliance for most departments was poor with both the nutrition and psychiatry departments having rates of 0% for several months. The only departments that documented 80% compliance for any month were dental and pharmacy. Problems with assessments extended beyond timelines. Discipline heads were required to review the quality of assessments, however, there were no tools provided to the monitoring team as evidence that this occurred. Prior to the February 2012 review, SASSLC drafted a procedure on the Minimum Common Elements 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 was not approved. 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: • Audits of the records and the document sample showed 81% of Annual Medical Assessments were current based on the 365 day requirement. The facility data showed that 31% of AMAs were submitted at least 10 days prior to the ISP. • The facility's requirement to complete Quarterly Medical Summaries was reinstated. However, completion was inconsistent. Those that were completed were nicely done as discussed in section L1. • Quarterly Drug Regimen Reviews were completed in a timely manner and were thoroughly done. This is discussed in further detail in section N2. • Compliance rates for completion of the Annual Dental Assessments improved, but remained relatively low. • The Nursing Department continued completing the Annual and Quarterly Comprehensive Nursing Assessments. The Monitoring Team reviewed 21 individuals' most recently completed annual and/or quarterly nursing assessments and found a regression in the timeliness of completing the assessments according to the annual and quarterly ISP schedule. Only 86% of the annual and quarterly nursing assessments were completed timely. There was, however, an overall improvement in the content and quality of the assessments.. There was significant improvement in assessing all required components, as well as improvements in comparing individuals' past and present health status and response to nursing interventions. However, issues that fell below the 90% criterion were related to the failure of the RN Case	

#	Provision	Assessment of Status	Compliance
		Managers to consistently include all high and medium risk ratings that should require nursing interventions into the nursing problem/diagnosis list. Not all identified nursing problems/diagnosis had a corresponding Health Management Plan (HMP) or an Integrated Health Care Plan. Since the implementation of the IHCP, many of the individuals who did not have an IHCP yet developed had little attention paid to the existing HMPs. Of the individuals who had IHCPs, few of the nursing interventions were sufficient to meet individuals' health care needs.. • The PNMT conducted assessments for individuals referred to the team. Most of the referrals were self-generated. The assessments were generally completed in a timely manner. These assessments resulted in a series of recommendations that required collaboration between the PNMT and the IDT to ensure integration of actions into the ISP for timely implementation. The documentation of completion and of due dates with staff responsible were inconsistent. As such, it was difficult to determine if action steps were implemented in a timely manner. • The OT/PT assessments were generally completed annually for individuals who were provided supports and services, but in the case that there was a change in status in the interim, a comprehensive assessment, or issue-specific assessment was typically completed to document status and specific needs for changes in the PNMP, assistive equipment or other therapy supports and services. These were stand-alone assessments in some cases. or documented in the IPNs for more issue specific concerns. Integration of recommendations was inconsistently evident in the ISPs or ISPAs. • Only 3 of 18 individuals' OT/PT assessments included in Samples P.1 and P.2 (17%) were dated as completed at least 10 days prior to the annual ISP. Additionally, there were 117 assessments listed in the tracking log submitted, for ISPs dated 8/23/12 through 3/7/13. Based on this log, only 26% of the assessments were performed prior to the designated due date. This was a decrease from the previous review, though the monitoring team used 10 calendar days rather than 10 working days as these deadlines were not clearly established in the documentation submitted by the facility at that time. • It was difficult to determine the average of Appendix B Comprehensive Psychiatric Assessments completed each month due to discrepancy in the data presented. There were 49/55 of the CPE's completed according to Appendix B. Given that 174 individuals received psychiatric services, the vast majority of individuals still required a comprehensive assessment. • Not everyone had an initial psychological assessment, but functional assessments were completed for all individuals with PBSPs. Annual psychological assessments were completed for all individuals.	
H2	Commencing within six months of	The medical director reported that medical and psychiatric diagnoses were formulated in	Substantial

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	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.	accordance with ICD/DSM nomenclature. The medical staff received training in ICD/DSM nomenclature in January 2012. The self-assessment noted that the facility's coder found compliance with the appropriate nomenclature. This provision addresses the appropriate use of the nomenclature which cannot be assessed by a medical coder. That is, the proper language must be used, but it must also fit the signs, symptoms, presentation, and findings of the individual. 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. Some documents continued to use non-ICD nomenclature • The psychiatry team mostly addressed maladaptive behaviors instead of requesting the presenting psychiatric symptoms identified in order to establish the diagnosis. The IDT needs to develop combined case formulations in order to provide a cohesive diagnosis consistent with the current version of the DSM and to implement an applicable treatment plan. The revision of diagnostics predominantly occurred during the quarterly psychiatric clinics, not necessarily when it was identified to be inaccurate. The medical director will need to ensure that the diagnoses in the assessments is consistent with disease presentation, symptomatology, and results of diagnostics.	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.	As part of the self-assessment, the medical department reported the number of QMSs due and the number that were completed. Compliance with this requirement was low. The monitoring team was not clear on how this self-assessment would aid in determining the timeliness and appropriateness of treatment intervention. The monitoring team recommends that as a first step, the medical director complete the development of the list of clinical indicators inclusive of those from the other relevant clinical areas. 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.	Noncompliance
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	As discussed in section H3, the facility had not compiled a comprehensive set of clinical indicators across all clinical disciplines. The monitoring team again emphasizes that clinical indicators must be developed for all clinical areas.	Noncompliance

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	interventions shall be determined in a clinically justified manner.		
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 a number of activities used to assess this provision item, including the development of clinical indicators, diabetes tracking, number of emesis episodes, number of seizures, and number of hospitalization. Many of the indicators listed were discussed in the medical quality meeting, but did not necessarily adequately reflect the health status of individuals. For example, assessing the health status of individuals with diabetes mellitus requires more than the HbA1c. Hypoglycemic and hyperglycemic episodes, the development of diabetic nephropathy or diabetic retinopathy would also be indicative of the overall health status. Similarly, tracking the total number of seizures for the facility does not necessarily provide information on the health status of any given individual. The need to link all of the current monitoring systems remained an outstanding need. 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), and the medical quality program. Thus, an individual's care and monitoring could and should be assessed across this continuum of activities. 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 to, the clinical protocols in the development of additional indicators.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The medical department established a set of indictors. As already noted, additional indicators were needed and development was in progress. Practitioners can use these indicators in daily practice through various assessments to determine if treatment is effective for an individual. The facility's medical quality program, external audits and other reviews would assess the care of particular individuals who crossed the threshold for review and would look at overall aggregate data.	Noncompliance
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. The medical director should review the requirements for timelines for assessments to ensure that the audit criteria are accurate.
    c. Interval assessments must occur in a timely manner and in response to a change in status.
    d. All assessments must meet an acceptable standard of practice and the appropriate audit tools developed (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:** <u>Documents Reviewed</u>: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o DADS SSLC Risk Guidelines dated 4/17/12 o List of individuals seen in the ER in the past year o List of individuals hospitalized in the past year o List of individuals with serious injuries in the past year 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 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 constipation o List of individuals with a pica diagnosis 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 individuals with chronic pain. o List of individuals with challenging behaviors. 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, Integrated Health Care Plans, and related assessments for: • Individual #32, Individual #201, Individual #302, Individual #222, Individual #235, Individual #150, Individual #249, and Individual #105. <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Charlotte Fisher, Director of Behavioral Services o Megan Lynch, Incident Management Coordinator o Leticia Jaloma, Abuse and Neglect Coordinator

	o Kathleen Rocha, Facility Investigator o Karla Baker, Acting QDDP Coordinator o Gevona Hicks, Human Rights Officer <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 4/29/13 and 5/2/13 o Annual ISP meetings for Individual #13 and Individual #259 o Pre-ISP meetings for Individual #88 and Individual #82 o Section D 1:1 QA meeting o Unit III QAQI meeting 4/30/13
	Facility Self-Assessment: SASSLC submitted its self-assessment. Along with the self-assessment, the facility submitted an action plan that addressed progress towards meeting the requirements of the Settlement Agreement. For the self-assessment, the facility described, for each provision item, the activities the facility planned to engage 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 not yet implemented an audit process. The self-assessment noted that the audit process would be implemented by 5/15/13. The facility recognized that the risk process was a very new process for the IDTs and it would take some time to develop an adequate system for addressing risks. The facility self-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 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. Adequate plans were not yet in place to address risks for individuals at SASSLC. Since the last review, the state office had made revisions to the At-Risk Individuals policy. The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred since the last review.

	Risk screening was reviewed annually at the ISP planning meeting. There was still a tendency to over-rely on the guidelines for each risk category without factoring in how the various risk factors may compound one another. Good clinical judgment must be used when identifying risks, and developing risk levels, and action plans for high risk conditions. Revisions to the risk identification process included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually. The monitoring team had a chance to observe two teams hold meetings utilizing the new format. Team meetings were very lengthy and the IDTs were struggling with how to integrate the risk discussion into the ISP meeting. Teams were spending a lot of time identifying risks, but little time developing measurable outcomes to address risk factors. IDTs were just beginning to talk about risks in relation to each individual's preferences, strengths, and daily schedule. The facility was moving in a positive direction, though additional training was still needed to help team develop meaningful plans through this process. 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 often waiting until a critical incident occurred or until the annual IDT meeting before aggressively addressing the risk. Plans should be implemented immediately when individuals are at risk for harm. A sample of individual records was reviewed in various homes at the facility. IHCPs were not found in any of the 27 individual notebooks reviewed. The facility needs to ensure that plans are distributed and available to staff implementing the plan. As 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.

#	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 an integrated health care 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. Since the last review, the state office had made revisions to the At-Risk Individuals policy. Changes included regrouping the Risk Guidelines so that the risk factors that were clinically related (regarding outcomes or provision of services and supports) were listed together, and linking each risk factor with specific clinical indicators.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Seven groupings of risk categories were identified. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers, and criteria for IDT review. Updates in status were to be noted on the form, making it easier to track status and determine when the team had met to discuss changes in status. The Risk Action Plans for the identified high and medium risk indicators were to be replaced with Integrated Health Care Plans (IHCP) designed to provide a comprehensive plan that will be completed annually and updated as needed. 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. The consultants had recently provided training and technical assistance to IDTs at SASSLC on the latest revisions in the risk process. The monitoring team was able to observe two IDT meetings using the new style ISP format and new risk rating forms. Progress towards developing an effective process to identify risks was observed in both meetings. Both IDTs followed the newly created IRRF. At the ISP meetings observed for Individual #13 and #259, the team spent a considerable amount of time reviewing each risk category, determining a risk rating, and developing general action plans to address risks. The team engaged in good discussion for some areas but, important data needed to make accurate determination of risk were not available in all cases. The IDTs were more focused on the individual's health history and current diagnosis rather than potential for risk for each category. For example, the psychiatrist noted that Individual #13 was taking medication that elevated his risk of developing diabetes. His family shared concern that there was a family history of diabetes. The team was hesitant to say that he was at risk because he had no current diagnosis of diabetes and showed no symptoms. He in fact was at risk, so the team should have developed supports to monitor his risk and implement preventative strategies when possible. There was still quite a bit of uncertainty over the assignment of risk levels and team members were trying to understand how to use assessment criteria to make risk determinations. The teams stopped short of developing measurable goals and designating who would be responsible for monitoring and ensuring that supports were effective.	

#	Provision	Assessment of Status	Compliance
		At both IDTs observed, team members took a much more integrated approach to assigning risk levels. While much progress had been made in the risk process, additional training is still needed to ensure that team members develop action plans that will reduce the chance of untoward outcomes. The state policy required that all relevant assessments be 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 to track submission of assessments by discipline and attendance at IDT meetings. These databases will be useful 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 and behavioral indicators (e.g., changes in medication, results from lab work, engagement levels, mobility, peer-to-peer aggression). • 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 inter-relatedness of risk factors in an interdisciplinary fashion. • Focus on long term health issues and be more proactive in addressing risk through action plans to monitor for conditions before they become critical. • Guidelines for determining risk ratings should only be used as a guide. Teams should discuss other factors that may not be included in the guidelines. • Monitor progress towards outcomes and share information with all team members frequently so that plans can be revised if progress is not being made or regression occurs. • Ensure that data collected regarding incidents and injuries are frequently analyzed for indication that supports may not be adequate for safeguarding individuals. The facility had taken many positive steps towards ensuring that an adequate risk assessment process was implemented. The monitoring team looks forward to seeing continued progress in identifying risk and developing strategies for monitoring and minimizing those risks.	

#	Provision	Assessment of Status	Compliance
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.	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. Health risk ratings will need to be 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. It was difficult to determine if assessments were obtained and discussed by the team in a reasonable amount of time when recommended. There was no sense of urgency, even following a significant change in status, to ensure that supports were adequate to prevent a serious incident or illness. For example, • At the annual ISP meeting for Individual #259, the team noted that he was waiting for a consultation to be scheduled with a gastroenterologist. The team recommended the consultation following a hospitalization on 3/12/13 for bowel obstruction. The appointment had not been scheduled at the time of his annual ISP meeting on 4/30/13. Similarly, he had over 65 seizures in the year prior to his annual ISP. A neurology consultation had been ordered, but there was no documentation that it was either obtained or discussed further by the IDT. • Individual #302 experienced an increase in seizure activity following a change in medications. His PCP recommended a follow-up consultation with his neurologist in his annual medical review on 12/5/12. The nursing review on 1/23/13 indicated that the follow-up appointment was still pending. The team noted the need for follow-up with the neurologist at his annual ISP meeting, but failed to assign responsibility, discuss barriers for scheduling, or include an action step on his IHCP. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. The process to ensure timely completion and implementation of action plans needs to be refined to meet substantial compliance.	Noncompliance
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,	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. As noted in section F, a comprehensive monthly review process was not yet in place to ensure that plans were being implemented and monitored as needed.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.</td><td>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. For example, 34 (89%) of 38 individuals identified as high risk for aspiration had plans in place to address the risk. Fifty-three (71%) of 75 individuals rated at medium risk had plans in place. The facility reported that individuals would be assessed and action plans developed using the IRRF and IHCPs as annual ISP meetings were held. IDTs had begun using the new forms as of October 2012. Data indicated that there had been progress in developing risk action plans to address all risks.
<table>
<tr><th>Risk Category</th><th># Rated High Risk</th><th># w/ Risk Action Plans</th><th>Previous Percentages</th></tr>
<tr><td>Seizures</td><td>26</td><td>23/88%</td><td>88%</td></tr>
<tr><td>Dehydration</td><td>8</td><td>5/63%</td><td>25%</td></tr>
<tr><td>Polypharmacy</td><td>93</td><td>18/19%</td><td>13%</td></tr>
<tr><td>Diabetes</td><td>5</td><td>4/80%</td><td>50%</td></tr>
<tr><td>Circulatory</td><td>9</td><td>7/78%</td><td>50%</td></tr>
<tr><td>Hypothermia</td><td>2</td><td>1/50%</td><td>33%</td></tr>
<tr><td>UTI</td><td>15</td><td>13/87%</td><td>100%</td></tr>
<tr><td>Dental</td><td>108</td><td>93/86%</td><td>77%</td></tr>
<tr><td>Osteoporosis</td><td>32</td><td>21/66%</td><td>74%</td></tr>
<tr><td>Fractures</td><td>16</td><td>8//50%</td><td>40%</td></tr>
</table>
None of the risk action plans in the sample reviewed, however, included specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an HMP in place or instructions were too general (e.g., follow diet, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. For example,

Individual #201's IHCP included the outcome "will have no complications related to HTN and lipid during the next 12 months." She had an action step to monitor blood pressure and accucheck daily. The plan did not include acceptable parameters and did not specify frequency for monitoring her lipids. Her action step to monitor her diabetes included monthly labwork, but did not include the desired range for labwork.
Individual #235 had an action steps to address her dental risk. Action steps included "assess oral status, as needed and contact PCP." Another action step directed staff to "assure adequate fluid intake." Her plan to address only included one action step, "administer medication prophylaxis for constipation." Her action steps were too general to ensure that staff could consistently provide support and monitor outcomes.
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#	Provision	Assessment of Status	Compliance
		It was not evident that consistent monitoring of those risk indicators was occurring. ISPAs were used to document initial discussion when a change in status was identified. Documentation of follow-up when recommendations were made by the IDT was not found in any of the records reviewed. For example, it was noted at the ISP meeting for Individual #239 that the team met to review his change of status following a hospitalization in March 2012. The team recommended a GI consultation at that time. There had been no follow-up to the recommendation prior to his annual ISP meeting in April 2013. The GI consultation was still not scheduled. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas.	

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 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 PBSP 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 in-service 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: Information Sheet; Consent Section for psychotropic medication; ISP, 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 in-service training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who 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 newly prescribed psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses 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 Appendix B style evaluations for the following 10 individuals: Individual #177, Individual #277, Individual #205, Individual #47, Individual #305, Individual #222, Individual #172, Individual #268, Individual #301, and Individual #129 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 Minutes from the Pharmacy and Therapeutics Committee meeting 4/29/13 o Minutes from the Behavior Therapy Committee meeting 4/29/13 o All data presented, doctor's orders, and Dr. Luna's documentation for psychiatry clinic conducted 4/30/13 regarding the following individuals: Individual #301, Individual #55, and Individual #75 o All data presented, doctor's orders, and Dr. Litton's documentation for psychiatry clinic conducted 4/30/13 regarding the following individuals: Individual #155, Individual #142, Individual #252, and Individual #150 o Documentation regarding facility's request for additional FTE in Psychiatry Department o Minutes from the ISP meeting held 5/1/13 regarding Individual #132 o Most current Statewide Psychiatry Policy and Procedure o Most current SASSLC Psychiatry Policy and Procedure implemented at the facility o Copy of Statewide and Center's Policy for Minimum and Integrated Clinical Services o Adverse Drug Reaction Policy and Procedure o Policy regarding Neuropsychiatric Consults o Copy of Consent Policy, Statewide and Facility, regarding psychotropic medication and pretreatment sedation o Resume of the Psychiatric Assistant o Documentation explaining the role of the Psychiatric Assistant o Resume of the nurse assigned to the psychiatry department o List of completed Comprehensive Psychiatric Evaluations o These documents: • Demographic Data Sheet • Consent Section (last six months) • Individual Support Plan, ISPAs, and signature sheets (last six months) • Social History (most current) • Positive Behavior Support Plan and addendums • Reiss Screen

	• Psychological Evaluation and update • Human Rights Committee review of consent for psychotropic medication, pretreatment sedation, and BSP (most current) for the last six months • Restraint Checklists for the past six months • Suicide Risk Assessment for the last six months • Pretreatment Sedation Assessment-most current • Annual Physician's Summary, Evaluation, Physical Exam • Quarterly Medical Review • Active Medical Problem List • Hospital section for the previous six months • Electrocardiogram, laboratory, and X-ray results 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/Neurology Consults for the past year • Pharmacy Annual Evaluation • Physician's orders for the previous six months • Comprehensive Annual (most current) • Quarterly Nursing Assessment (most current) • Integrated progress notes for the previous six months • Annual weight graph • Seizure graph/Record (Active) last six months • Vital Sign Records for the past six months • Health Management Plan (most current) • Current list of all medications (MAR) • Nurse's note for psychiatry clinic for the past six months • Psychologist's note for psychiatry clinic for the past six months • QDDP note for psychiatry clinic for the past six months • Safety Plan/Crises Plan • Administration of Chemical Restraint Consult for the last six months • SOTP (most current) • Desensitization Plan o For the following individuals: • Individual #90, Individual #39, Individual #301, Individual #55, Individual #75, Individual #254, Individual #155, Individual #142, Individual #252, Individual #150, Individual #132, Individual #115, and Individual #277

	Interviews and Meetings Held: o David V. Espino, M.D., Medical Director; and Sharon M. Tramonte, Pharm. D., Lead Pharmacist o Charlotte Fisher, M.A., LPC-S, BCBA, Director of Behavioral Services o George Zukotynski, State Behavioral Services Coordinator, and Charlotte Fisher, M.A., LPC-S, BCBA, Director of Behavioral Services o Vicky L. Litton, M.D., lead psychiatrist o Vicky L. Litton, M.D., lead psychiatrist with psychiatry team inclusive of Sergio H Luna, M.D., facility psychiatrist; Samantha Denise Duran, R.N, psychiatric nurse; and Teresa Ann Valdez, psychiatry assistant o Samantha Denise Duran, R.N, psychiatric nurse o Teresa Ann Valdez, psychiatry assistant o Alvydas Kukleris, DDS, facility dentist and Amy Jo Hush R.D.H., Observations Conducted: o Behavior Therapy Committee (4/29/13) o Pharmacy and Therapeutics Committee (4/29/13) o Clinical Services Meeting (4/30/13, 5/3/13) o Dr. Luna's psychiatry clinic 4/30/13 regarding: Individual #301, Individual #55, and Individual #75 o Nicole Cupples, Pharm. D., clinical pharmacist, in psychiatric clinics with IDTs throughout visit o Dr. Litton's psychiatry clinic 4/30/13 regarding the following individuals: Individual #150, Individual #155, Individual #303, Individual #142, and Individual #252 o Dr. Litton's clinic 5/01/13 regarding the following individuals: Individual #120, and Individual #195 o Medical Staff Meeting 5/1/13 o ISP regarding Individual #132 (5/1/13) o Dr. Luna's psychiatry clinic 5/2/13 regarding the following individuals: Individual #53, Individual #249, and Individual #80 o Polypharmacy Oversight Committee (POC) meeting (5/2/13) o Observation of individuals in various homes throughout visit
	Facility Self-Assessment: The facility self-assessment listed activities that the department conducted towards each of the provision items, and described what they reviewed in order to assess whether they met substantial compliance in each section of J1-15. The psychiatry staff, including the lead psychiatrist, were new to this process and did not understand the importance of utilizing the findings and recommendations in the previous monitoring report as a guide in 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 each section of the report. This can be utilized to refine their self-assessment. The facility self-rated itself as being in substantial compliance with six of the provision items of section J. The monitoring team agreed with three of these ratings (J1, J2, and J12). The conclusion about J11 was that the facility was in the beginning stage because this provision not only required the implementation of facility-level review system to monitor polypharmacy, at least monthly, but that medications not clinically justified were eliminated. The facility made improvement with this provision item, however, this provision was rated in noncompliance. In regards to J13, the medical staff expressed that there was lack of access to the psychiatrist for the delivery of psychiatry services, when clinically indicated. The current process explained, by the PCPs, supported that a psychology staff must first evaluate an individual prior to securing a requested psychiatric examination for those individuals not already enrolled in the psychiatry clinic. The other issue highlighted in this provision item involved the lack of relevant data presentation, consequently, the facility remained in noncompliance. The review of J15 highlighted that while the monthly neurology clinical consultation was encouraging, the present neurology resources were inadequate to provide needed consultation and follow-up. There were numerous individuals with comorbid seizure disorder and psychiatric diagnoses who did not receive neuropsychiatric coordination of clinical care, therefore, this item also remained in noncompliance. Even though more work was needed, the monitoring team wants to acknowledge the efforts of the psychiatric assistant and nurse assigned to the psychiatry department in gathering pertinent information and data which should allow the lead psychiatrist to review and assign a precise self-rating in future reviews. The second document, detailing the action steps, was written to guide the department in achieving substantial compliance. The action steps did not address similar concerns of the monitoring team (i.e., did not adopt relevant recommendations of the monitoring team).
	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. Since the last monitoring visit, the psychiatry department employed a new lead psychiatrist who was learning the requirements of the position, such as the implementation of Psychiatric Policy and Procedure and appropriate delivery of psychiatric services geared toward meeting generally accepted professional standards of care in psychiatry (e.g., implementation of a suitable consent process for psychotropic medication). There had been challenges due to a turnover in psychiatric clinic staff as well as changes in the psychiatric administrative support staff. The psychiatrist had to become familiar with the individuals assigned to her care in addition to allocate time to tackle the deficiencies in the delivery of facility-wide psychiatric services. A prior lead psychiatrist had developed a game plan to achieve substantial compliance, and it has been previously recommended by the monitoring team that the psychiatry clinic staff follow her lead that was established. In discussions with the director of psychology, dental director, lead psychiatrist, and medical staff, the need for improved integration was identified. Most provision items in this section rely on collaboration with

	other disciplines. The different departments must communicate with one another to allow for appropriate assessment and intervention to take place by the IDT. Psychology could be more integrated with psychiatry (e.g., identification of clinical indicators/target symptoms, data collection, collaboration regarding case formulation). The physician was not reliably provided appropriate data in order to make decisions regarding pharmacology and, per a review of records, made medication additions or adjustments in the absence of data about specific clinical indicators associated with the individual's psychiatric disorder. In order for psychiatry to meet the requirements of the Settlement Agreement, the department will need the ongoing support of facility administration and the leadership of related disciplines. Observations of psychiatric clinic performed during this monitoring review revealed improvements in the individual's case presentation by the interdisciplinary team particularly during the quarterly clinics. These clinics demanded an increased time commitment from the IDT, with fewer individuals scheduled, and amended documentation requirements from various disciplines of the IDT. During the quarterly psychiatric meetings, the current practitioners were making efforts to review and revise diagnoses and adjust medication regimens. Conversely, the monthly reviews were not as helpful in the revision of diagnostics or identification of the specific indications of the selected medication that must be cohesive with the consent process. The psychologists continued to remain the responsible party for the majority of the informed consents for prescription of psychotropic medication. In order for psychiatric services to improve, strong leadership and integration among all the necessary disciplines will need to transpire at SASSLC. During both clinics, 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, but the IDT did not concentrate on this during the clinics observed or in the documentation reviewed. It was time to expand this vital area of clinical intervention to include identification and implementation of non-pharmacological regimens that would be beneficial to the individual instead of a generic plan, present in some of the cited examples. The monitoring team similarly identified paucity of combined assessment and case formulation. Further effort must be made regarding determination of the extent of pretreatment sedation for medical procedures, to develop a clinical consultation process for this similar to that utilized for dental clinic. The attention of the IDT was necessary to implement interdisciplinary coordination for individuals who required numerous pretreatment sedations for procedures, for appropriateness of desensitization plan, without restriction on the receipt of necessary dental and/or medical intervention. 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. The Appendix B evaluations were generally of adequate quality although the small percentage of those completed resulted in this provision item remaining in noncompliance. There was discrepancy of data presented, therefore, it was difficult to determine the average/number of comprehensive assessments completed each month since the last review. The completion of a Comprehensive Psychiatric Evaluation

	may actually be utilized in lieu of a quarterly evaluation if completed during the time frame of when the quarterly is due, as long as the necessary elements capture the up to date data. The lead psychiatrist at SASSLC determined that at least one more FTE was necessary, particularly to address the completion of the comprehensive assessments and to enhance the attendance of psychiatrists in the ISP meetings. Due to the lack of sufficient psychiatric resources as summarized by the facility to ensure the provision of services necessary, this provision item also remained in noncompliance 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). The facility reported that 53/55 psychotropic medications were initiated on an emergency basis, therefore, only 4% of these prescriptions were begun with routine orders and procedure. The monitoring team acknowledged that there would be times when the emergency intervention with psychotropic medication were warranted, however it is best to thoroughly review the risk-benefit analysis, when clinically feasible, via the formal consent process.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications and Experience</u> The psychiatrists at the facility were board certified in psychiatry by the American Board of Psychiatry and Neurology. Sergio H. Luna, M.D. was also board eligible in Child and Adolescent psychiatry. He had numerous years of experience providing assessment and treatment for persons with developmental disabilities and had previously provided services at another SSLC. He was employed at SASSLC since 4/16/12. Since the last visit, Vicky L. Litton, M.D. was designated as the lead psychiatrist. She had work experience in the field of developmental disabilities while practicing in the state hospital system and was employed since 10/16/12 at SASSLC. Although the two psychiatrists were making advances with in the provision of psychiatric services, there had been barriers to the full implementation of policy and procedure that will be necessary for psychiatry services to meet generally accepted professional standards of care. As stated in the previous monitoring report, and in this report, psychiatry will need administrative and interdisciplinary support in order to move forward. <u>Monitoring Team's Compliance Rating</u> 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 reviewed in section J5.	Substantial Compliance

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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, 174 of the 262 individuals (66%) received psychopharmacologic intervention at the time of this onsite review. The limited psychiatric resources (addressed in J5) was one of the factors resulting in the insufficient number of completed Appendix B evaluations (discussed in J6). Evaluation and Diagnosis Procedures The monitoring team observed four psychiatry clinics. It was apparent that the team members attending the clinic were well meaning and interested in the treatment of the individual. The quarterly psychiatric evaluations were well organized, there was also good discussion and documentation of the individual's history and presenting symptoms, however, the monthly reviews observed during the visit were not as helpful in regards to the revision of the diagnostic criteria and identification of the specific indications for the psychotropic medications. In some instances during the monthly review, the team did not know the purpose for the monthly consultation and decided to wait and address further elements of care later at the quarterly review. If the IDT has determined that a diagnosis is not applicable, thus, making the indications of the medication not relevant for the specific condition, then this matter should be addressed no matter what type of meeting is being held at that time. Clinical Justification The facility self-assessment noted there were 487/487 (100%) Quarterly Clinic Addendum-Treatment Plan Reviews done during 7/1/12 to 3/8/13 and were documented by the facility as being performed in a clinically justifiable manner with a rationale for the prescription of psychotropic medications. Psychiatry staff, overall, performed a suitable job of evaluating individuals in a clinically justifiable manner. There was evidence of appropriate clinical documentation, but there was a need to further differentiate psychiatric target symptoms from other maladaptive behaviors, such as self-injurious behaviors and/or aggression that were not necessarily associated with a the assigned DSM diagnosis (reviewed further in J11). The monitoring team discussed the importance of integrating care between neurology and psychiatry via the IDT process for those individuals with a Seizure Disorder, who were prescribed Anti-Epileptic medication, and who also received psychotropic medication (discussed in J15). 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. A good example was cited about Individual #344, when a diagnosis of Depressive Disorder, NOS was changed to Major Depressive Disorder. Per the facility's	Substantial Compliance

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		written justification for this diagnostic addition, the person met "full criteria for this diagnosis" as evidenced by depressed mood, diminished interest, psychomotor retardation, appetite loss with significant weight loss, and loss of energy during sustained episodes. Given this information, and the review of 20 records, it was evident that the psychiatric physicians were making effort to provide clinically justifiable evaluations. In addition, this document gave detailed information regarding the rationale for the prescription of psychotropic medication. <u>Monitoring Team's Compliance Rating</u> This provision was rated in substantial compliance during the previous monitoring period. The facility psychiatric staff must continue their current level of documentation and attend to the number of Appendix B comprehensive assessments that were outstanding in order to maintain this rating. The completion of a Comprehensive Psychiatric Evaluation may actually be utilized in lieu of a quarterly evaluation if completed during the time frame of when the quarterly was due as long as it captures up to date data. This should facilitate further completion of these critical assessments. As discussed in J6, the completion of these assessments was likely hampered by a lack of sufficient psychiatric resources, turnover, and appointment of a new lead psychiatrist.	
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 treatment plan or in the absence of a diagnosis. Per the review of 20 records, all had a psychiatric diagnosis noted in the record. As noted above in J2, some of the psychiatric diagnosis were identified by the psychiatrist as not being supported by the presenting symptoms exhibited by the individual. If the IDT has determined that a diagnosis is not appropriate, thus, indicating that the medication was not being used for the actual illness, this matter should be addressed, including revision of the consent for psychotropic medication. Per this provision item, individuals prescribed psychotropic medication must have an active treatment program. In all records reviewed, individuals prescribed medication did have a treatment program on file. The quality of the content of the PBSP documentation is addressed in section K of this report. There was no indication that psychotropic medications were being used as punishment or for the convenience of staff. Psychology representatives and other staff disciplines were present in psychiatric clinics observed throughout the visit. 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 review of justification of diagnosis and pharmacological interventions. An expansion should include a routine review of non-pharmacological	Noncompliance

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		interventions, either occurring or proposed. It will be important for ongoing collaboration to occur between psychology and psychiatry to formulate a cohesive case formulation, and in the joint determination of psychiatric target symptoms and descriptors or definitions of the target symptoms associated with the assigned DSM diagnosis, inclusive of behavioral data, and in the process generate a hypothesis regarding behavioral-pharmacological interventions for each individual, and that this information is documented in the individual's record in a timely manner. This review period, the facility reviewed integrated progress notes, psychiatry clinic notes, and Restraint Checklists for 100% of the multi-agent chemical restraint orders from 7/01/12 to 3/08/13 to confirm that justification was provided when single-agent chemical restraint was ineffective. This self-assessment practice was good to see and highlighted that, in two of the five incidents of ordering multi-agent restraints, there was previous failure with a single-agent chemical restraint during crisis intervention. The document dated October 2012 to March 2013 indicated that in only two of the five incidents of chemical restraints that the individual received more than one medication to target aggression. This practice pattern of minimal utilization of chemical restraint supported the impression that the facility did not rely on this type of restrictive intervention and that medications were not used as punishment. <u>Emergency use of Psychotropic Medications</u> The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression/SIB (i.e., chemical restraint) had decreased. During the prior monitoring period, there were a total of 17 incidents involving nine different individuals. During this monitoring period, there were a total of five incidents involving five different individuals: Individual #140, Individual #268, Individual #232,Individual #264, and Individual #138. Individual #140 received the multi-agent chemical restraint on 10/3/12 (Haldol 5 mg and Ativan 2 mg IM) in addition to being prescribed an increased dose of a separate neuroleptic on the same date (Risperdal by 1mg to a total dose of 6 mg/day), and required transfer to the hospital on 10/4/12 due to lethargy and an elevated temperature to rule out Neuroleptic Malignant Syndrome. The psychiatrist wrote a thorough summary on 10/5/12 outlining the results of the VPA level (116.6 obtained on 10/4/12), and that Individual #140 experienced a suspected influenza/viral infection instead of NMS. The psychiatrist advised the IDT to continue to monitor for signs of NMS and to remain vigilant about this uncommon side effect of antipsychotics. A review of the documentation regarding the five individuals who required chemical restraint revealed that, in 80% of the examples provided by the facility, a psychiatrist's	

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		clinic note regarding the incident was not included for various reasons. There was not evidence for Individual #232 because this individual was "transferred" in January 2013. Individual #268 appeared to have a dental emergency and was sent to the dentist on the date of the administration of Lorazepam 2 mg IM. The indication of the administration was to calm the individual, however, due to lack of documentation by the psychiatrist, it was not clear if this individual actually needed a pretreatment sedation for the dental examination or if this was for the sole purpose of aggression as documented in the chemical restraint data. The dentist documented that Individual #268 was seen in dental clinic for a possible emergency, was agitated, and did not allow exam. 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 chemical restraint is necessary, particularly involving multiple agents at one time, 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. The IDTs were attempting to monitor the efficacy of the medications utilized for chemical restraint with a goal of single agent intervention, if clinically feasible. <u>Monitoring Team's Compliance Rating</u> The facility self-rated this item in noncompliance due to inconsistent integration between psychiatry and psychology regarding treatment planning, nonpharmacological interventions, and behavior support planning. They did note progress with regard to the reduction in the utilization of multi-agent 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	<u>Extent of Pretreatment Sedation</u> There was a listing of individuals who received pretreatment sedation for either medical or dental clinic. This listing from 7/1/12 to 3/31/13 indicated there were 97 administrations of pretreatment sedation for dental clinic. The summary also included when TIVA was ordered (TIVA reviewed in section Q). Seventy-one individuals received the 97 administrations for dental pretreatment sedation with 65% of these individuals also administered a daily regimen of psychotropic medication, therefore, were at risk for potential drug-drug interactions. Data regarding medical pretreatment sedation listed the names of six individuals who received such intervention, with 80% of these individuals prescribed a daily dose of psychotropic medication.	Noncompliance

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	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.	Some of these individuals received numerous pretreatment sedations, such as Individual #67 who was given Ativan 3 mg on 10/31/12, 1/09/13, and 1/30/13. • Individual #67 also received a routine daily dose of the same medication, Lorazepam (Ativan 8 mg/day). • The Drug Regimen Review Profile noted that Individual #67 actually had allergies to Valium, but Individual #67continued to receive a high daily dose of a benzodiazepine since 1/29/13 for the treatment of an Axis I Disorder. The facility provided data in one comprehensive list of individuals who received pretreatment sedation medication or TIVA for medical or dental procedures that included: individual's name, designation of whether it was medical or dental pretreatment sedation, date the pretreatment sedation was administered, name, dosage, and route of the medication, and date of the IDT review to minimize the need for the use of the medication. Interdisciplinary Coordination There were 10 examples provided of multidisciplinary consultation regarding the utilization of pretreatment sedation for individuals in dental clinic. Unfortunately, there were no examples provided for pretreatment sedation for individuals requiring medical procedures. Upon interview with the medical staff and other members of the IDT throughout the week about this section, the monitoring team received various responses, such as the team does not have to collaborate about pretreatment sedation except for TIVA administration. At a later time in the onsite review, members of the IDT stated that the interdisciplinary coordination was predominantly focused only on dental procedures. For some reason, integration of care via the IDT had not extended to medical pretreatment sedation. Pretreatment sedation chosen for the medical procedure should be reviewed by representatives in primary care, psychiatry, and clinical pharmacy within an IDT process prior to administration to the individual. The dispensing of a necessary agent should not be confused with the topic of the development of a desensitization plan. Although it is important to assess individuals, particularly those who required numerous pretreatment sedations for procedures, for appropriateness of a desensitization plan, this should not restrict an individual who must receive a dental and/or medical intervention from receiving necessary care. Examples reviewed were adequate and included representatives from dentistry, primary care, psychiatry, and clinical pharmacy for dental pretreatment sedation. As recommended in the prior monitoring report, the facility added a section to this document that noted the consensus and plan that was reviewed during the morning clinical services meeting. Some of the consultation reports for pretreatment outlined the potential drug-drug interactions by the Pharmacy staff, in addition to some of the side effects to monitor. This was an important component for individuals who received psychotropic medication, seizure	

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		medication, and other medication for their medical condition and then receive an additional, agent usually of a substantial dose. Desensitization Protocols and Other Strategies A list of all individuals with medical/dental desensitization plans and date of implementation were requested. The monitoring team was provided seven dental desensitization plans, with five being completed since last review. 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 psychology's exclusively. The monitoring team discussed with facility staff 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. 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). 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 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 a staff member to participate regularly. If individuals recovered appropriately from TIVA, they were returned to their home for monitoring by their regular nursing staff. If there were any concerns, the individual would spend the night in a home with 24 hour nursing services. Monitoring Team's Compliance Rating This item remains in noncompliance because further effort must be made regarding determination of the extent of pretreatment sedation for medical procedures, to develop a clinical consultation process for this similar to that utilized for dental clinic. Further, attention to interdisciplinary coordination for individuals who required numerous pretreatment sedations for procedures, for appropriateness of desensitization plan, was needed.	

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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 66% of the census received psychopharmacologic intervention requiring psychiatric services at SASSLC as of 4/29/13. 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 at the facility were board certified in psychiatry. Administrative Support There was a new psychiatry assistant and a newly appointed nurse as of 10/29/12. Each of the psychiatric staff, including the lead psychiatrist were in the process of learning their new roles, acquiring knowledge about the individuals who required psychiatric services, and learning about the Settlement Agreement. Determination of Required FTEs It was questionable whether the current allotment of psychiatric clinical services was sufficient to provide clinical services at the facility. At the time of the review, there were a total of 80 available clinical hours. The calculation of the duties of the lead psychiatrist determined by the facility would require less clinical responsibility than presently delegated, to allow more time to conduct administrative duties. Ancillary psychiatry staff consisted of the psychiatry assistant and the nurse assigned to the psychiatry department. The lead psychiatrist at SASSLC determined that at least one more FTE was necessary, particularly to address the completion of the Comprehensive Psychiatric Evaluations and to enhance attendance at the ISP meetings. SASSLC should engage in an activity to determine the detailed amount of psychiatry service FTEs required. This computation should consider hours for clinical responsibility, obtaining consent for psychotropic medications, documentation of delivered care (i.e., quarterly reviews, Appendix B evaluations), required meeting time (e.g., physician's meetings, behavior support planning, emergency ISP attendance, discussions with nursing staff, call responsibility, participation in polypharmacy meetings), in addition to improved coordination of psychiatric treatment with neurology, primary care, other medical consultants, pharmacy, and psychology. The facility self-assessment included information regarding some of the 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, but did result in a self-rating of noncompliance due to lack of sufficient psychiatric resources needed to provide required services. Monitoring Team's Compliance Rating Due to the lack of necessary psychiatric resources as summarized by the facility to provide the services required, this provision remained in noncompliance.	Noncompliance

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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 provided a list of 25 comprehensive psychiatric evaluations per Appendix B guidelines that were completed as of 4/19/13. The data regarding this section were inconsistent depending on what documents were reviewed (reportedly due to staff changeover and also because some of the evaluations completed by prior treatment providers were not of acceptable quality and not included in the count). • The self-assessment listed 49/55 of the CPEs were completed in the Appendix B format. • Last report, a total of 41 individuals had psychiatric evaluations performed, but eight were not consistent with generally accepted professional standards of care. Given that 174 individuals received treatment via psychiatry clinic, the vast majority of the individuals still required a comprehensive psychiatric assessment. The psychiatrists struggled to focus attention on completion of the comprehensive psychiatric evaluations in the Appendix B format, however, from 7/1/12 to 3/8/13 the evaluations were completed 75% of the time within 30 days of admission or "within 30 days of initial evaluation." 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 #177, Individual #277, Individual #205, Individual #47, Individual #305, Individual #222, Individual #172, Individual #268, Individual #301, and Individual #129. The CPEs 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 diagnostics. All Appendix B evaluations reviewed included case conceptualizations and history 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	Noncompliance

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		level of functioning. Treatment recommendations inclusive of non-pharmacological interventions were included in the documentation, however, the examples for several individuals' illustrated a probable copy and past exercise from another individual's PBSP. • Individual #205's non-pharmacologic interventions listed the name and content of another individual's PBSP within the documentation twice. • The example outlined for Individual #305 did not specify the name of the individual on all of the pages of the evaluation. The gender was listed incorrectly and it and cited what seemed to be a generic summary "PBSP reviewed and the items addressed in "her" PBSP appear to still be relevant…" • The copy and paste exercise was also apparent for Individual #222 in the non-pharmacological intervention stating that items addressed in "her" PBSP appear to still be relevant, but the individual was not a female. • Individual #222 was admitted to SASSLC receiving four psychotropic medications in addition to four medications for seizures, an agent for EPS associated with the psychotropic medication, medication for hypertension, and agents for dyslipidemia. It would be relevant to summarize details of the risk/benefit analysis in the psychiatric evaluation. <u>Monitoring Team's Compliance Rating</u> Although the completed evaluations were generally of adequate quality, the small percentage of those completed resulted in this provision remaining in noncompliance. Per interviews with the psychiatry clinic staff, there were plans to perform more comprehensive psychiatric evaluations each month. The psychiatrists' duties would require the completion of approximately eight evaluations per month, in order to meet substantial compliance with this provision item within 1.5 years.	
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	<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 three new admissions for the previous six months with all of these individuals being administered a Reiss screen within a week following admission. • One of the three newly admitted individuals did not receive a comprehensive psychiatric evaluation according to the document request data for this section (Individual #305). The Reiss screen score (23) was obtained five days after the admission. The monitoring team discovered in the section regarding the completion of CPEs that Individual #305 actually had a Comprehensive Psychiatric Evaluation completed (1/30/13), within 30 days of the admission to the facility,	Noncompliance

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	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.	but this information was not reflected in the documents because there was not a date provided. The monitoring team encouraged the psychiatric department to be attentive to providing relevant documentation in order to point out the positive progress the facility has made. • One of the evaluations occurred almost two months after the individual's admission (Individual #222). The Reiss screen obtained 10/30/12 was zero. • One individual received a comprehensive psychiatric evaluation on the same date of the admission to the facility. <u>Reiss Screen for Each Individual (excluding those with current psychiatric assessment)</u> This was a difficult item to assess due the lack of integration between the psychiatry and psychology department in the presentation and comparison of the data. The total facility census was 262 with 174 individuals (66%) enrolled in psychiatry clinic. Therefore, 88 individuals were eligible for baseline Reiss screening. Reiss screens completed in the previous 12 months, revealed the names of 15 individuals. Of these, all 15 persons were enrolled in psychiatry clinic. Given the data provided, it was difficult to determine which individuals were previously enrolled in the psychiatry clinic, 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. <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> 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 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). <u>Monitoring Team's Compliance Rating</u> The facility self-rated this provision in noncompliance and the monitoring team is in agreement. 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).	

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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 monitoring team was informed that the SSLC statewide policy and procedure for psychiatric services was updated 5/1/13 and should be fully implemented by each state center on or before 7/1/13. For the purposes of this review the SSLC statewide policy and procedure for psychiatric services dated 8/30/11 for psychiatry services will be referenced and 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 four 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, pharmacy, nursing, QDDP, direct care staff, and the individual). Nicole Cupples, Pharm.D., clinical pharmacist, was present in the psychiatric clinics with the IDTs throughout the week of the visit and provided valuable information in reference to drug levels, current medication regimen, and the QDRRs. The monitoring team also encouraged the IDT, inclusive of pharmacy staff, to have discussions about potential drug-drug interactions for individuals who were prescribed numerous psychotropic and nonpsychotropic medications. The pharmacy staff agreed to pay closer attention to the relevant side effects and interactions concerning the individuals who received multiple agents and were receptive to feedback from the monitoring team. There were, however, challenges noted with the receipt of information from psychology with regard to behavioral data. While data were documented in the record as the impetus for medication adjustments, both psychiatry and psychology staff predominantly discussed maladaptive behavior, such as aggression and self-injurious behavior, but did not focus on the psychiatric symptoms that resulted in the assigned psychiatric diagnosis. Medication decisions made during clinic observations conducted during this onsite review regarding quarterly clinics were based on lengthy (minimum 30 minutes) observations/interactions with the individuals, as well as a review of information provided during the time of the clinic. In the four clinic observations, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with him or her, and discussed the plan, if any, for changes to the medication	Noncompliance

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		regimen. 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, one of the psychiatric physicians was relatively new to the facility. While there was discussion among the IDT members, it was somewhat subdued in the monthly clinics that were not as formal or interactive, resulting in the IDT at times not even understanding the reason that the team convened. This is likely to improve over time as the new psychiatric staff members become acquainted with the individuals enrolled in the psychiatry clinic. The goal established should result in the outcome of a more efficient process of delivery of psychiatric services especially due to the limited number of psychiatric practitioners. A review of the psychological and psychiatric documentation for 20 individual records revealed inconsistent implementation of a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. The following example highlighted this: • The psychological evaluation obtained prior to admission to the facility dated 5/1/12 outlined that Individual #222 had a Personality Change secondary to a Seizure Disorder (aggressive type). • The BTC review dated 11/5/12, without psychiatric participation, outlined that Individual #222 had a Psychotic Disorder, NOS, and Intermittent Explosive Disorder. • The ISP for Individual #222 dated 11/16/12 did not have psychiatric participation. All medications (Remeron, Clonidine, Risperdal, and Luvox) were administered for aggression. • Individual #222 had a complicated medical history, including Intractable Seizures, status post brain surgery for resection of the corpus callosum, Hypothyroidism induced by Lithium (by history), extreme Obesity, Obstructive Sleep Apnea, Hypertension, Dyslipidemia, and Anemia (by history). • The CPE dated 12/20/12 concluded the diagnosis was Schizoaffective Disorder, Depressive Type, and Intermittent Explosive Disorder. If the IDT does not have a cohesive combined assessment and case formulation for those individuals with a neuropsychiatric condition, then the integrated plan of care will not be useful for monitoring presenting medical symptoms (i.e., seizure activity). The self-assessment also accurately summarized that psychiatry and psychology recognized the need for continued discussion of non-pharmacologic intervention in the treatment plans. The copy and paste exercise was displayed for Individual #222 concerning the non-pharmacological intervention, and the case example was summarized in J6.	

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		Appendix B evaluations were another opportunity for IDT members, including psychology, to contribute to the collaborative case formulation. Psychology and psychiatry need to formulate diagnoses and plans for the treatment of 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). The requirements of the Case Formulation were outlined in Appendix B, "XIII. Bio-Psycho-Social-Spiritual Formulation." Throughout the onsite visit, particularly in the psychiatry clinics observed, the team did not consistently initiate discussion of some important issues without the prompting from the monitoring team (e.g., frequency of seizure activity, date of last neurology clinic, possible medical contributants, data about hallucinations). There was minimal discussion regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. <u>Integration of treatment efforts between psychology and psychiatry</u> The biggest challenges with regard to integration remained as outlined: a) The presentation of behavioral data was not helpful in determination of the efficacy of the psychopharmacological regimen b) The deficiency in the completion of the collaborative case formulations for each individual enrolled in psychiatry clinic per Appendix B c) The need for the identification and implementation of non-pharmacological interventions specific to the individual's needs. The director of behavioral services and the lead psychiatrist have begun discussion regarding another critical component of care, the topic of consent for psychotropic medications (J14). Interviews with both staff members and information provided in the document request revealed plans to address this issue in order for medical consent to be the responsibility of the prescribing practitioner. <u>Coordination of behavioral and pharmacological treatments</u> As noted in J6 and J9, there was cause for concern with regard to the coordination of behavioral and pharmacological treatments, specifically with respect to the PBSP. There was sporadic documentation of interventions noted in Appendix B evaluations. When interventions were noted, the wording was reflective of nonspecific statements, citing the wrong gender of the individual, and not taking into the account the individual's needs with goal of least restrictive treatment other than psychotropic medication to target maladaptive behaviors. It would be useful for psychiatry to inform the IDT including psychology what	

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		data is necessary to gather and analyze. Monitoring Team's Compliance Rating The monitoring team agreed with the facility that this section remained in noncompliance. The monitoring team identified paucity of combined assessment and case formulation, and insufficiency in the non-pharmacologic treatment interventions.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	Psychiatry Participation in PBSP 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. The facility self-assessment rated noncompliance due to the continued need for PBSPs to be reviewed in collaboration with the IDT by the psychiatrist. There were 90 of 175 (51%) of the PBSPs reviewed by the psychiatrist from 7/1/12 to 3/8/13 to generate a hypothesis regarding behavioral-pharmacological interventions and strategies to reduce the use of emergency medications. During psychiatry clinic, the psychiatrist asked questions regarding behavioral challenges, yet inconsistencies were evident in discussing non-pharmacological interventions. 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, and that the required elements are included in the document. This provision item focuses on the least intrusive and most positive interventions to address the individual's condition (i.e., behavioral and/or psychiatric) in order to decrease the reliance on psychotropic medication. It was warranted for the treating psychiatrist to participate in the development of the behavior support plan via providing input or collaborating with the author of the plan. Given the presence of the IDT in psychiatry clinic, the PBSPs were being reviewed during a regularly scheduled psychiatric clinic, with additional reviews as clinically indicated. It would be helpful in future monitoring reviews for psychiatry clinic staff to indicate where this review was documented in the record and to provide the names of those individuals who were reviewed, so that these records can be selected for review. Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. There were 43 meetings attended by psychiatry this review period, quite a reduction from 105 meetings attended last review period. Of those, there was one categorized as an ISP meeting with psychiatry in attendance on 3/21/13. There were 21 labeled as ISPA meetings that occurred during psychiatry clinic. Training and review of HRC Consent forms were listed in this data, but will be summarized in the consent section (J14). There were no	Noncompliance

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		PBSP meetings included in the listing. If the PBSP meetings occurred in the scope of the psychiatric clinic, the psychiatry department should collect and provide this data germane to this provision item. Treatment via Behavioral, Pharmacology, or other Interventions The following example highlighted difficulties with regard to the coordination of treatment among disciplines, and illustrated how there appeared to be a copy and paste exercise: • The wrong individual's name was cited in the consent for use of psychoactive medication for "Behavior Support" for Individual #131 in the ISP/ISPA dated 9/24/12 on page 8. • The name of Individual #131 was not noted on the header of page 8. The plan listed the name of a different individual, and that the other individual's current diagnosis, behaviors/symptoms would be tracked. • The parent/LAR signed this summary on 10/20/12 for the first plan developed for Individual #131. • The committee members who attended the PBSP on 9/24/12 did not include the name of a psychiatrist for this individual (who was prescribed numerous psychotropic medications). It appeared that the ISP/ISPA dated 9/24/12 was signed by the psychiatrist 2/8/13. The monitoring team recommends for the facility to list the name of the individual, date, and name of the document on each page for medico-legal purposes (i.e., correct identification for chosen treatment to be delivered to the appropriate individual). ISP Specification of Non-Pharmacological Treatment, Interventions, or Supports Non-pharmacological interventions included references to behavioral supports, work programs, and outings. Conversely, a review of documentation revealed that in each psychiatry clinic, for the most part, target behaviors, instead of identified psychiatric target symptoms, were reviewed by psychiatry and the IDT members who were present. The comprehensive psychiatric evaluations noted recommendations for non-pharmacological interventions in a non-specific manner, however, review of the ISP documentation revealed identification of specific activities that individuals were interested in or that would be beneficial in assisting with symptom amelioration. Monitoring Team's Compliance Rating 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. The monitoring team agreed with facility self-assessment that this section continued to be in noncompliance. Psychiatry and psychology must learn how they can assist each other toward the common goal of appropriate treatment interventions	

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		through the IDT, both pharmacological and non-pharmacological. Therefore, this provision item was rated as being in noncompliance with the following comments: a) The psychiatrists were not able to routinely attend annual ISP meetings because of time constraint, but reportedly focused their devotion for individuals deemed high risk with frequent behavioral challenges. b) There was psychiatric review of the PBSP during the chosen psychiatric clinic. The monitoring team, however, had difficulty locating the summary of such data of psychiatric participation in this process. c) The monitoring team recommends the facility to list the name of the individual, date, and name of the document on each page of the individual's plan.	
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.	Policy and Procedure The monitoring team was informed that the SSLC statewide policy and procedure for psychiatric services was updated 5/1/13 and should be fully implemented by each state center on or before 7/1/13. For the purposes of this review the 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. It allowed for documentation regarding the risk versus benefit of treatment with a particular medication. Quality of Risk-Benefit Analysis The self-assessment noted that 55 new psychotropic medications were initiated for 40 individuals. The facility reported that 53/55 psychotropic medications were initiated on an emergency basis, therefore, only 4% of these prescriptions were begun with routine orders and procedure. Data provided for these 55 new medications did not indicate whether the emergency medications were initiated during a regularly scheduled clinic, during a crisis, or due to result of the necessity of an emergency psychiatric consultation. The monitoring team understands that there were probably times when the emergency intervention with psychotropic medication was warranted, however, it is best to thoroughly review the risk-benefit analysis, when clinically feasible, via the formal consent process. A positive finding was that the facility reported that 55/55 of the New Psychotropic Medication Justification forms were signed by IDT members including the "psychiatric provider, primary care physician, and nurse." The facility provided a self-rating of noncompliance for this provision because the currently	Noncompliance

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		implemented form did not specifically address medication side effects. The provision of consent will be addressed in J14. The monitoring team recommends the facility monitor the pattern of initiating emergency psychotropic orders and to ensure that the detailed elements required in the consent process are addressed in a timely fashion. Depending on the indication of the psychopharmacologic regimen, beginning an agent for the sole purpose of maladaptive behavior on an emergency basis, not associated with a psychiatric diagnosis, may better be classified as a chemical restraint, depending on the clinical history. A form was initiated 11/1/10 to document the risk/benefit analysis with respect to new medication prescriptions. The form also included signature lines for the prescribing psychiatrist, psychologist, IDT members present in the clinic, 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 and possible drug-drug interactions. An example was Individual #194, prescribed Zoloft (Sertraline) to treat compulsive destructive behavior, inclusive of property destruction. There was no mention on the "New Psychotropic Medication Justification Form" that Individual #194 also received other psychotropic medications for property destruction, agitation, and aggression. The diagnosis of Obsessive Compulsive Disorder was not formalized and there were several psychotropic medication changes recommended to occur at one time (e.g., increase Seroquel, decrease Risperidone, start consent process to start Zoloft). As discussed 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. Potential drug-drug interactions and side effects on this list were not adequate (in all examples) and, thus, would not suffice for consent. The ISP/ISPA dated 1/15/13 for Individual #106 included the name of another individual indicating the current diagnosis, behaviors/symptoms of the wrong individual will be tracked, again exhibiting a copy and paste exercise in the development of the treatment plan. 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 psychiatric target symptoms be provided to the physician, that these data are presented in a manner that is useful to determine efficacy, that the	

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		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 manner in which the quarterly psychiatry clinics were conducted (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. Documentation should reflect a thorough process that considers the potential side effects of each psychotropic medication along with drug-drug interactions, weighs those side effects against the potential benefits, includes a rationale as to why those benefits could be expected and a reasonable estimate of the probability of success, and compares the former to likely outcomes and/or risks associated with reasonable alternative strategies. <u>Observation of Psychiatric Clinic</u> During some of the psychiatric clinics observed by the monitoring team, the psychiatric rationale for a particular medication regimen was discussed with the IDT and some of the components of the risk/benefit analysis were undertaken during psychiatry clinic with helpful input from the clinical pharmacist. The team should consider reviewing this type of information together via a projector/screen and typing the information <u>during</u> the clinic process. 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 current process involved the psychiatrist writing continuously throughout the clinic and at times did not allow for their ongoing conversation with the IDT due to task of completing handwritten notes. <u>Human Rights Committee Activities</u> A risk-benefit analysis, if authored by psychiatry, but 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). There was additional documentation from HRC about Individual #106 implying that the "patient not seen at time of med change" along with a couple of other illegible handwritten comments that appeared to reference environmental factors with request for clarification of medication history concerning the review of the proposed treatment regimen. The box was checked for approval of the program without revisions for the period ending 12/29/13, but there was a horizontal line drawn across the page with the noted HRC concerns, therefore, the monitoring team did not know if the plan for Individual #106 was actually approved.	

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		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. The psychology department continued to be responsible for the medical consent process for psychotropic medication instead of this being assigned to the prescribing practitioner/psychiatry staff. While the currently implemented form addressed newly prescribed agents, it did not list other prescribed psychotropic agents. The facility reported that 96% of psychotropic medications were initiated on an emergency basis. Depending on the indication of the psychopharmacologic regimen, beginning an agent for the sole purpose of maladaptive behavior on an emergency basis, not associated with a psychiatric diagnosis, may better be classified as a chemical restraint depending on the clinical history. The facility should monitoring the pattern of initiating emergency psychotropic orders and to ensure that the detailed elements required in the Risk-Benefit Analysis of the consent process are addressed in a timely fashion.	
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.	Facility-Level Review System The facility held the inaugural Polypharmacy Overview Committee (POC) meeting on 6/22/12, and since had three additional meetings to outline policy and procedures (10/16/12, 11/13/12, and 2/12/13). The self-assessment outlined that, as of 3/8/13, 134/175 (76%) individuals who received psychiatric services met criteria for being prescribed polypharmacy. The POC 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. There were only three adverse drug reactions reported in the 4/29/13 Pharmacy and Therapeutics Committee meeting with one of these involving Individual #90 (e.g., GI Bleed 4/6/13 while receiving Olanzapine). • The Behavior Therapy Committee reviewed the PBSP of Individual #90 on 4/29/13 immediately prior to the Pharmacy and Therapeutics Committee meeting and discussed recommendations to add Risperdal to replace Zyprexa that was discontinued due to a possible "recurrent GIB." • The monitoring team inquired if there was a medical representative in the BTC meeting at the time of this discussion and it was determined that a medical representative, such as psychiatry did not usually attend these meetings. • The members of the BTC were not aware of the findings of the Adverse Drug Reaction Report dated 4/27/13 that noted the etiology of the GIB could have been	Noncompliance

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		contributed by a high dose of Acetaminophen and the low dose of Aspirin. Individual #90 was on a 90-day course of Acetaminophen 650 mg every six hours (2,600mg/day). • The monitoring team informed the members of the Pharmacy and Therapeutics committee about discussion that occurred regarding Individual #90 in the BTC and the importance of integrating clinical services, especially during this transitory period that psychology managed the consent process. • The IDT should be aware that other psychotropic medication may also contribute to abdominal bleeding and, therefore, risk-benefit must be thoroughly reviewed. The lead psychiatrist stated that Individual #90 definitely needed an agent like Risperdal because of the facial scratching that was displayed upon abrupt discontinuation of the agent. The monitoring team cautioned the members of the committee to consider scratching as a possible sign of a withdrawal discontinuation syndrome and/or akathisia-like symptoms due to immediately stopping the antipsychotic, particularly if antipsychotic medication was prescribed on a long-term basis. • In an emergency medical situation, such as an individual experiencing a GI bleed, it was a reasonable approach to discontinue the medication, but the IDT should be aware that the symptoms of scratching/SIB could actually be the result of the effects of the withdrawal of the medication presenting as physical symptoms instead of an actual psychiatric illness. Fifteen individuals at SASSLC were prescribed Beta Blockers as a psychotropic medication. The monitoring team encouraged the POC to routinely review drug-drug interactions for individuals prescribed numerous medications (psychotropic polypharmacy, numerous nonpsychotropic medications in combination with psychotropic medication) and to ensure adequate monitoring of vital signs, preferably orthostatic vital signs. It was of concern that individuals who were not compliant with allowing vital signs to be taken continued to receive medications for psychotropic indication, such as Propranolol and Clonidine, even in combination with nonpsychotropic medication for indication of Hypertension (i.e., Norvasc). At a later time, after the POC meeting, the medical director informed the monitoring team that orthostatic vital signs were not necessarily warranted according to the review of literature. The facility has to recognize that nonverbal individuals who experience orthostatic changes, dizziness, lightheadedness, falls, and ultimately fractures will not be able to give such descriptors to the examiner. Therefore, objective measures should be obtained whenever possible for adequate monitoring of medication side effects, drug-drug interactions, and/or adverse drug reactions. For additional information regarding adverse drug reactions refer to section N6.	

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		Review of Polypharmacy Data Documentation presented during the POC meeting 4/29/13 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 37. This was a decrease from 41 individuals in August 2012. • The total number of individuals residing at the facility prescribed three or more psychotropic medications was 81. This was a reduction from 92 individuals in August 2012. • 67% of the individuals prescribed psychotropic medications at SASSLC met criteria for polypharmacy. The facility made progress with a 5% reduction of the prescription of polypharmacy since August 2012. • Data regarding the number of individuals prescribed medications within a specific class (outside of those meeting the designation of intra-class polypharmacy) were not provided in the committee meeting. The total number of individuals residing at the facility prescribed any psychotropic medication (174) was provided to the monitoring team from the psychiatry department. The notes provided by the POC dated 3/12/13 stated that since June 2012 the entire psychiatry staff had turned over, so the strategy for prioritizing polypharmacy did not occur. The committee decided to continue discussions based on the most pressing needs and cases identified during meetings or in the morning report, with an emphasis on individuals who had a Comprehensive Psychiatric Evaluation. • POC notation dated 10/16/12 indicated that Individual #140 received Lorazepam for "sedation" to control aggressive behaviors. This was another example whereby the wording of the indication of the medication possibly suggested the intervention was a chemical restraint. There were challenges with the review of these data regarding intraclass polypharmacy for review of individuals prescribed two or more AEDs either due to a seizure diagnosis and/or for psychiatric purposes. The facility should consider reviewing these data and revise the indications, if not accurate, for the medications and update the diagnostics in the document to be consistent across disciplines (i.e., diagnosis per psychiatrist to be cohesive with QDRRs, neurology consultation, etc.) The lead pharmacist reported to the monitoring team about the 100% timely completion of the QDRRs since last review. Pharmacy quarterly drug regimen documents were located in 20 of 20 of individual records. The available documentation revealed timely reviews in 100% of the cases. A new clinical pharmacist joined the staff as of 8/10/12 who was instrumental in remediation of this delinquency and who contributed in dissemination of	

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		the QDRR findings and recommendations in the psychiatric clinics. 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 vigorous discussion regarding reviews of the justification for polypharmacy derived by the IDT in psychiatry clinic. Monitoring Team's Compliance Rating The self-rating by the facility of compliance was not supported by the monitoring team. This element was in the beginning stage as this provision not only required the implementation of a facility-level review system to monitor polypharmacy, at least monthly, but that medications that are not clinically justified are eliminated. The facility made improvements with regard to this provision item, however, given the ongoing challenges (e.g., the POC postponement of relevant discussions due to psychiatric staff changes, skewed data collection regarding AED indications, 67% of the individuals prescribed psychotropic medications that met criteria for polypharmacy), this provision was rated in noncompliance.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	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 October 2012 through March 2013. 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 organized to compare scores over time. A revision in the presentation of data into a spreadsheet may assist with tracking both the completion of the instruments over time and changes in scores requiring further clinical evaluation. The self-assessment indicated that 175/175 (100%) of individuals receiving psychiatric services had a MOSES and DISCUS scale completed on a quarterly basis from 7/1/12 to 3/8/13. In addition, it was reported that as of 11/1/12, the nurse from the psychiatry clinic reviewed MOSES and DISCUS during clinics as defined by the policy for quality of clinical correlation in regards to potential psychotropic medication side effects. The facility provided a self-assessment of substantial compliance for this provision and the monitoring team agreed.	Substantial Compliance

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		Training Per the response to the request for information regarding inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations, there was "no evidence for file" for both this review and the previous monitoring visit. In a prior monitoring report, it was noted that an inservice training occurred 6/22/11 where 21 nurses attended. Additional information previously received noted that the MOSES and DISCUS were included in the annual nursing competency assessment, therefore, it would be best to summarize these findings of training and competency data. Quality of Completion of Side Effect Rating Scales In regard to the quality of the completion of the assessments for the set of scales reviewed (10 examples of each assessment tool), most were completed appropriately and included the signature of the psychiatrist. In the majority of cases, clinical correlation was documented on the evaluation form, but a conclusion was not determined for some assessments. • A conclusion was not listed on the DISCUS dated 12/17/12 for Individual #92 who was prescribed Reglan, had greater than 90 days of antipsychotic drug exposure, and had a total score of five or greater, but was not on an antipsychotic. • Individual #92 had other diagnosis (i.e., Cerebral Palsy) that allegedly accounted for the findings. Individual #92 was noted to exhibit blinking, chewing, lip smacking, thrusting lower lip, tongue thrusting/tongue in cheek, and retrocollis/torticollis. • Individual #92 was listed as having Tardive Dyskinesia in the data provided, however, the Quarterly Clinic Addendum-Treatment Plan Review dated 12/20/12 per the psychiatrist summarized that it was not clearly determined if movements were accounted for by TD and/or Cerebral Palsy. • The MOSES for Individual #92 was also completed 12/17/12 with a score of 24 and the psychiatrist noted findings were likely secondary to the Reglan use, so would confer with medical doctor. It was not clear if this meant that Individual #90 had Tardive Dyskinesia secondary to Reglan. Individual #90 was also listed as having TD, but the DISCUS 1/31/13 (score of five) noted that Individual #90 did not have TD. The issue of the Individual #90's edentulous state was not mentioned on the DISCUS, but the psychiatrist clearly stated this was the cause of the elevated DISCUS score in the Quarterly Clinic Addendum-Treatment Plan Review dated 1/31/13. 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,	

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		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 included in the clinic note, was sometimes not consistent with findings on the MOSES or DISCUS evaluation form itself, and resulted in inaccurate data that could ultimately impact care. Twenty-two individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). This was an increase from nine individuals identified in the previous monitoring report, but as outlined in the examples for this provision, the data were not reliable. Although medications, such as antipsychotics and Reglan (Metoclopramide) may cause abnormal involuntary motor movements, the same medications may also mask the movements (e.g., lowering DISCUS scores). Thirty-two individuals were prescribed Reglan and two (Individual #302, Individual #199) were diagnosed with Tardive Dyskinesia. Medication reduction or the absence of the antipsychotic or Reglan 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. <u>Monitoring Team's Compliance Rating</u> Given the documentation of clinical correlation present in the Quarterly Clinic Addendum-Treatment Plan Review about the findings 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 establishing integrated findings, ensure and review the conclusion of the DISCUS and MOSES evaluations so that this practice is reinforced. Data were inconsistent depending on what document was reviewed, therefore, should be reorganized 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	<u>Policy and Procedure</u> The new SSLC statewide policy and procedure for psychiatric services should be fully implemented by each state center on or before 7/1/13. 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	Noncompliance

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	behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	characteristics to be monitored, and the expected timeline for therapeutic effects to occur. 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 assessed and the findings were variable as reflected in the following example. The record of Individual #277 was reviewed upon request by the medical staff at SASSLC. • The ISP 1/16/13 did not include the signature of a psychiatrist or a PCP for this individual who underwent multiple medication changes in response to SIB and had experienced peer related attacks due to his "compulsive grabbing behavior." There was a generic statement indicating that the IDT reviewed, updated, and approved the Psychiatric Treatment Plan to ensure that all appropriate services and supports were included, but there was no mention of the date of the Psychiatric Treatment Plan and it was difficult for the monitoring team to identify the components of the Psychiatric Treatment Plan that were included in the ISP. Psychiatry was not mentioned as one of the parties responsible for review for progress and effectiveness in the ISP. • A medication variance occurred regarding Individual #277 as noted by the psychiatrist (e.g., Zyprexa was decreased by 7.5 mg on 1/22/13, but in error the Zyprexa was accidentally discontinued when the list of medications were transferred to a new sheet). • The psychiatrist noted on 1/31/13 that Individual #277 was not receptive to behavior modification and the PBSP would be implemented upon stabilization of medication. The rationale for prescription of psychotropic medication was included the pharmacological hypothesis. Copious information was included in this document regarding medication side effect monitoring and lab results. • One of the established goals set in the plan for Individual #277 was to exhibit <u>zero</u> incidents of SIB per week for 26 weeks. This seemed like an unreasonable goal for this individual. The PBSP reviewed 6/18/12 with a date of expiration of 2/18/13 did not include the signature of a psychiatrist. • The psychiatrist completed a CPE 1/31/13 that thoroughly identified Clozaril was not a good choice because of the recurrent problems experienced by Individual #277 with Clozaril (e.g., frequent toxic levels accompanied with puffiness of the face), however, on 3/15/13 Clozaril was to be restarted on an emergency basis due to Individual #277 being assigned a Psychotic Disorder, NOS. Individual #277 had not improved with other medication trials such as Zyprexa and Invega. • The monitoring team had difficulty interpreting the handwritten note about whether the LAR was in agreement or opposed during the teleconference meeting with the IDT/psychiatrist and signed by the psychiatrist on 3/15/13.	

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		• The typed Quarterly Clinic Addendum-Treatment Plan Review dated 3/15/13 revealed the assignment of a new psychiatric diagnosis and the discontinuation of a prior diagnosis that was positive progress with updating chosen diagnostics. 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 outlined in the "New Psychotropic Medication Justification Form." Individual #115 was also reviewed upon request by the medical staff at SASSLC. • The medical staff informed the monitoring team that psychiatric consultation was not available unless psychology first screened the individual. One of the components for this section of the Settlement Agreement is 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. • Individual #115 received a sleep aid for "Primary Insomnia." He also received numerous medications for Epilepsy. To diagnose primary insomnia, one must ensure that it is not due to the direct physiological effects of a medication or a general medical condition, does not occur exclusively during the course of another mental disorder, or during the course of other sleep disorders. • The Drug Regimen Review Profile dated 12/4/12 noted that Individual #115 had diagnoses inclusive of Manic-Depressive Psychosis, Psychoses with origin specific to childhood, Bipolar Disorder, Infantile Autism, Intractable Epilepsy…The QDRR completed 12/10/12 summarized comments about active problems for Individual #115 including Bipolar Disorder, Autism, and Primary insomnia, however Individual #115 had been discharged from psychiatric care since September 2011. The monitoring team informed the facility that psychiatric services should be directly available to the medical staff, preferably in concert through the IDT and without the mandate of first obtaining a psychological consultation, particularly for an individual with history, such as Individual #115, with probable medical, psychiatric, and pharmacological contributants. The IDT also needed to review diagnostics and if not relevant, update diagnostics, and establish indications for prescribed medications. <u>Psychiatric Participation in ISP Meetings</u> The information for psychiatric participation in ISP meetings was summarized in J9. At the time of the onsite review, there was limited psychiatry participation in the ISP process. Given the manner of the data, it was not possible to determine what percentage of the total	

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		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 allowed for improvements in overall team cohesion, information sharing, and collaborative case conceptualization. <u>Psychiatry Clinic</u> During this monitoring review, four psychiatry clinics were observed. 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 information in the record. During clinic, the psychiatrist made attempts to review behavioral data. In general, the data were up to date. In section K4, the monitoring team pointed to a very good example of the use of data in the case of Individual #255's psychiatry clinic. Sometimes, however, were not provided to the IDT, and the data graphing were variable. In only 11/70 (15%), the individual's behavior data were presented in graph form. This variability made data based decision making difficult for the psychiatrist because medication changes and other events that may affect psychiatric symptoms were not consistently noted. In observed clinical encounters, the individual's weights and vital signs were discussed, but the facility did not routinely obtain orthostatic vital signs for those individuals prescribed psychotropic medication that was known to cause orthostasis, not even during the time period of initial dosing titration, or when prescribed in combination with other medications used to treat Hypertension, and/or with polypharmacy regimen. The individual's record and laboratory examinations were reviewed during the clinical encounter and documented in clinic notes. This was consistently noted in documents. The individuals enrolled in psychiatry clinic were seen at a minimum within a quarterly time frame. This was an improvement from the last visit whereby there were a total of 26 individuals (of a total caseload of 189) who were delayed with regard to psychiatric follow-up that may have been due to the 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 and a review of appropriate	

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		target data (both pre and post the medication adjustment), the physician can determine the benefit, or lack thereof, of a medication adjustment. A medication taper should be considered to also reflect one dosage change a time, IDT to collect data, and then consider another dosage change depending on results of the information. Some individuals may be nonverbal and not be able to explain exactly when the presenting symptoms occurred during an ongoing medication taper across several weeks or months. It was common for the taper of medication at SASSLC to be ongoing, such as reduction of a medication every several weeks, instead of only one reduction of the medication and then collect further data before the next reduction. This process may be helpful for those prescribed long-term psychotropic medication to prevent withdrawal symptomatology and to assess for the possible emergence of abnormal motor movements and/or Akathisia. <u>Monitoring Team's Compliance Rating</u> Per a review of the facility self-assessment, this provision was rated in substantial compliance. The monitoring team rated this provision in noncompliance. The psychiatric department should revise the facility policy and procedure regarding the delivery of psychiatric services. The medical staff highlighted concern about the lack of access to the psychiatrist when clinically indicated. The facility psychiatry staff made advancement with regard to development of a treatment plan for psychotropic medication that identified the expected timeline for the therapeutic effects of the medication to occur and the behavioral characteristics that would be monitored to assess the treatment's efficacy. The IDT must also focus on the establishment of a current clinically justifiable diagnosis across disciplines to be reflected in documentation (e.g., psychiatric diagnosis consistent with diagnostics in QDRRs, physician's assessments, psychology assessments, nursing assessments, IDT assessments) and identify psychiatric target symptoms associated with the diagnosis in order to determine efficacy of the chosen treatment. Given these deficiencies, 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	<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	Noncompliance

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	medications or restrictive procedures and shall identify associated risks.	days thereafter…attempts to reach the LAR need to be documented in the integrated progress notes…" <u>Current Practices</u> Per the facility self-assessment, 28/55 (51%) of individuals prescribed a new psychotropic medication did not have a LAR, therefore, consent was obtained from the SASSLC director and the HRC/BTC. The facility provided a self-rating of noncompliance because psychiatry services was in the process of revising the "SASSLC Psychiatry Clinical Services Policy and Psychotropic Medication Consent Form" to address the need for the prescribing practitioner to disclose to the LAR the risks, benefits, side effects, alternatives to treatment, as well as ensure the LAR's understanding of the information. It was reported that psychiatry did not participate in the annual consent process for utilization of psychotropic medication. This process remained inappropriately delegated to psychology staff. In an effort to address the issue of consent, the lead psychiatrist spent time with psychology regarding HRC Consent forms (12/19/12 for one hour, 1/16/13 for one hour), and provided training to the HRC (1/24/13 for 90 minutes). A review of information provided regarding the five individuals enrolled in psychiatric clinic who were most recently admitted to the facility revealed that all were prescribed psychotropic medications. The example of Individual #305 highlighted the need for the IDT to determine the limitations on the use of the medications in the terms of consent and identify associated risks. • The psychiatry clinic documentation indicated a meeting was held for the purpose of an ISPA for Individual #305. • Individual #305 informed the IDT that medication for sleep was not being administered. The psychiatrist wrote that the medication "for sleep (Ambien) was somehow discontinued, but can be restarted today." There was no mention if this was a medication variance of if another medical staff discontinued the agent. • Ambien was cited as a current psychotropic medication with indication for Insomnia and the team agreed with this plan. The data did not support that Individual #305 warranted a sleep aid; conversely, Individual #305 was documented to "sleep excessively." • The monitoring team was not able to locate a consent form for the Ambien that was restarted on 2/20/13. • The typed portion of the Quarterly Clinic Addendum-Treatment Plan Review noted that this was the first quarterly since admission to the facility. The facility documented that there was no psychotropic polypharmacy at this time even though he was prescribed Olanzapine (Zyprexa), Sertraline (Zoloft), and Zolpidem (Ambien).	

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		• The 180-Day Medication Orders valid 3/27/13 through 9/20/13 listed both Olanzapine Zydis and Sertraline for "aggression." The 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. This document did not include the signature of the person providing the information to the individual's LAR. A review of records for the last 10 individuals most recently prescribed a new psychotropic medication revealed that the documentation included the "New Psychotropic Medication Justification Form." Information was typically 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. <u>Monitoring Team's Compliance Rating</u> Even though there were improvements, current facility practice was not consistent with generally accepted professional standards of care that require that the <u>prescribing practitioner</u> 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.	<u>Policy and Procedure</u> 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. <u>Individuals with Seizure Disorder Enrolled in Psychiatry Clinic</u> A list of individuals participating in the psychiatry clinic who had a diagnosis of Seizure Disorder included 69 individuals. At the time of the previous review, there were 75	Noncompliance

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		individuals listed. Data provided for this monitoring visit were confusing, as per the facility self-assessment, it was noted that there were only seven individuals receiving psychiatric services diagnosed with a seizure disorder who were prescribed medications to treat both seizures and a mental health disorder. These seven individuals were not identified in any other data set. Individual #75 was reviewed in the psychiatric clinic during the onsite visit. The name of this individual was not provided with the names of individuals who had a Seizure Disorder currently receiving psychiatric services, but throughout the documents reviewed, it was noted that Individual #75 had Epilepsy. The monitoring team requested review of the record, including neurology consultation for the past year and no neurology assessment was provided. The team informed the monitoring team that Individual #75 had Status Epilepticus when undergoing a Lorazepam taper. • The QDRR dated 2/26/13 noted Individual #75 had a history of Seizure Disorder. Status Epilepticus occurred August 2002, apparently related to Lorazepam withdrawal "…currently no medications are being utilized for Seizure control, however, Oxcarbazepine and Lorazepam are being used for psychiatric purposes and are also effective anticonvulsants." • The Quarterly Medical Review dated February 2012 noted an active medical diagnosis of Seizure Disorder. This individual also had a temperature of 107 in the past and the IDT was not able to provide information if this was possibly associated with Neuroleptic Malignant Syndrome. • The IDT were receptive to feedback during the onsite visit. Upon review provided from the psychiatric clinic dated 4/30/13, the psychiatrist outlined that pharmacological management will be discussed with the neurologist and that polypharmacy and indications of all medications needed to be reviewed. This was progression in identifying areas and implementing recommendations in order to enhance care. • Individual #75's case highlighted that the individual experienced difficulties related to the lack of the neurologist and psychiatrist coordinating the use of medications. The team must thoroughly review and document decisions made between the neurologist and psychiatrist in regards to taper of medications, such as Lorazepam and/or Oxcarbazepine in individuals with a Seizure Disorder and/or history of Seizure Disorder. It is preferable for the neurologist and psychiatrist to review these tapers in order to go slowly, with one dose change at a time, then review data, instead of an ongoing taper that may result in withdrawal seizures and potential Status Epilepticus. Individual #301 was reviewed in the psychiatric clinic during the onsite visit. The guardian was present and the team was well prepared. Documentation from the 4/30/13 psychiatry	

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		clinic noted that the plan was to discuss treatment with the neurologist, specifically the use of Keppra (that can cause agitation and severe irritability), and Clonazepam (disinhibitory), prior to the consideration of adding a new psychoactive medication. This was a good example of integrated treatment where clinical information obtained via consultation in the psychiatric clinic discussion resulted in such recommendations for consultation between psychiatry and neurology. <u>Adequacy of Current Neurology Resources</u> The neurologist was scheduled to evaluate individuals at SASSLC the second Tuesday and last Tuesday of every month starting at 10:00 am. The schedule from 7/17/12-2/26/13 included 11 neurology clinics (only one clinic in August, September, and January, 2012, and no clinics in December, 2012). A review of the document "Seizure Disorder Diagnosis Currently Receiving Psychiatric Services" included the date of the last neurology consultation for the 69 individuals, but there were no data regarding the most recent neurology clinic evaluation provided for two individuals. In other cases, notations such as "no AED" indicating that the individual was not currently treated with antiepileptic medications were present in 10 instances. Twenty-three of the individuals [non-inclusive of the 10 individuals without AED] had not been seen in neurology clinic in the previous year. One individual was last seen in 2005, two individuals were last seen in 2008, two individuals were last seen in 2009, five individuals were last seen in 2010, and 11 individuals were last seen in 2011. Given these data, it was evident that additional clinical neurology consultation was needed, and for the neurologist and psychiatrist to coordinate the use of medications. It would be beneficial for the IDT to review the cases of the individuals requiring neurology follow-up to ensure that they received annual neurology clinical consultation and neuropsychiatric consultation as outlined in this provision. 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 69 individuals who had a seizure disorder and psychiatric disorder [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, exploring consultation with local medical schools and clinics, and considering telemedicine consultation with providers currently contracted in other DADS facilities. The facility was also accessing care for individuals with refractory seizures from the Comprehensive Epilepsy Center. Documents received revealed that SASSLC had submitted	

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		a contract for on-campus services from the Comprehensive Epilepsy Center and this contract was pending approval. <u>Monitoring Team's Compliance Rating</u> Because 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 the neurology clinic. The neurology resources, however, were inadequate to provide needed consultation and follow-up. As such, this item remains in noncompliance.	

Recommendations:

1. Integrate psychiatry into the overall treatment program at the facility. This would include the continued involvement of psychiatrists in decisions to utilize emergency psychotropic medications and, more importantly, their increased involvement in discussions regarding treatment planning, non-pharmacological interventions, and behavioral support planning (J3, J8).

2. 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).

3. 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 pretreatment sedation (J4).

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

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

6. Monitor psychiatrist's workload in order to objectively determine the need for additional clinical contact hours. This can better be performed once a baseline is established for meetings/clinical coordination with other disciplines. Do an adequate assessment of the amount of psychiatry FTE needed at the facility (J5).

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

8. 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).

9. 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).

10. Improve coordination between psychiatry and psychology, specifically with regard to case conceptualization, identification and justification of diagnoses, the identification and definition of specific target symptoms for monitoring, the monitoring of the response to treatment with psychotropic medications, and the identification/implementation and monitoring of non-pharmacological interventions (J8, J9).

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

12. 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).

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

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

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

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

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

18. 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).

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

20. 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).

21. 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).

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

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

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

25. Continue clinical consultation clinic for psychiatry and neurology. Documentation for both psychiatry and neurology participation as well as the communication of information through 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:** Documents Reviewed: o Functional Assessments for: • Individual #140 (1/11/13), Individual #222 (11/28/12), Individual #306 (1/29/13), Individual #145 (11/2/12), Individual #249 (2/13/13), Individual #204 (1/17/13), Individual #128 (10/2/12), Individual #149 (2/12/13), Individual #167 (1/17/13), Individual #53 (1/7/13), Individual #193 (1/15/13) o Positive Behavior Support Plans (PBSPs) for: • Individual #140 (1/22/13), Individual #249 (3/11/13), Individual #204 (2/11/13), Individual #149 (3/4/13), Individual #128 (2/4/13), Individual #264 (2/25/13), Individual #167 (2/11/13), Individual #193 (2/19/13), Individual #306 (2/19/13), Individual #53 (12/17/12), Individual #145 (11/19/12), Individual #13 (5/1/13) o Annual Psychological updates for: • Individual #222 (10/22/12), Individual #140 (12/21/12), Individual #167 (1/17/13), Individual #264 (1/7/13), Individual #249 (2/11/13), Individual #193 (1/15/13), Individual #128 (10/1/12), Individual #204 (1/17/13), Individual #149 (2/12/13), Individual #306 (1/29/13) o Six months of progress notes for: • Individual #140 (1/22/13), Individual #249 (3/11/13), Individual #204 (2/11/13), Individual #149 (3/4/13), Individual #128 (2/4/13), Individual #264 (2/25/13), Individual #167 (2/11/11), Individual #193 (2/19/13), Individual #306 (2/19/13), Individual #53 (12/17/12), Individual #145 (11/19/12), Individual #13 (5/1/13) o Psychological treatment plans and progress notes for: • Individual #39, Individual #85, Individual #350, Individual #16, Individual #304, Individual #83, Individual #140 o PBSP assessment-guided staff training sheets for: • Individual #9 (12/27/12), Individual #191 (12/14/12), Individual #191 (12/27/12), Individual #51 (12/6/12), Individual #55 (12/20/12), Individual #166 (7/3/12), Individual #256 (7/19/12) o Abbreviated PBSP for: • Individual #132 o SASSLC Quality Assurance Report, March 2013 o Comparison of IOA and data collection for August 2012 and March 2013 o IOA and data Integrity data sheet, undated o Section K presentation book, undated o Status of enrollment in BCBA coursework for each psychologist, undated o For the past six months, minutes from meetings of the psychology department

	o Internal and external peer review minutes from August 2012 to April 2013 o SASSLC self-assessment, 4/12/13 o SASSLC action plan, 4/12/13 o Target behavior data documentation graph dated 7/12-3/13 o A list of all individuals for whom a functional assessment has been completed, undated o A list of all individuals who have a PBSP, including dates of the last plan revision, undated o A list of all individuals receiving psychological services other than a PBSP, undated o PBSP Assessment-Guided Staff Training, dated 11/12 <u>Interviews and Meetings Held</u>: o Charlotte Fisher, Director of Behavioral Services o Tiffany Nash, Associate Psychologist o Ashley Pleasant, Associate Psychologist o Melanie Rogers, Associate Psychologist o Melissa Steerman, Associate Psychologist 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 #199 and Individual #39 o Internal Peer review • Individual presented: Individual #336 o Individual Support Plan (ISP) meeting • Individual discussed: Individual #13 o Psychiatric Clinic meeting: • Psychiatrist: Dr. Luna • Individual presented: Individual #301 o Psychiatric Clinic meeting: • Psychiatrist: Dr. Litton • Individual presented: Individual #120 o PBSP staff training: • Psychologist conducting the training: Charles Obi • Individual's PBSP trained: Individual #132 o Psychiatric Clinic meeting: • Psychiatrist: Dr. Linton • Individuals presented: Individual #255, Individual #77, Individual #164 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. Generally, the self-assessment appeared to be based directly on the monitoring team's report. SASSLC's self-assessment consistently included a review for each provision item, a list of 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 allowed the psychology department 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 the psychology department in completing the self-assessment, and believes that the facility continued to proceed in the right direction. SASSLC's self-assessment indicated compliance for items K2, K3, K5, K7, and K11. The monitoring team's review of this provision found K2, K3, K7, and K11 to be in substantial compliance and noncompliance for all other provision items. The reasons for this discrepancy for K5 are discussed below. Finally, 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 discussed in detail in this section of the report.
	Summary of Monitor's Assessment: There were several improvements since the last review, resulting in three additional items rated in substantial compliance (K3, K7, and K11). These improvements included: • Improvement in the numbers of psychologists with certification as an applied behavior analyst (K1) • Documentation of internal peer review occurring weekly and external peer review occurring monthly (K3) • Improvement in IOA collection procedures (K4, K10) • Expansion of the collection of data reliability (K4) • Initiation of the graphing of replacement behaviors (K4, K10) • Evidence of the use of data based treatment decisions (K4) • Expansion of monthly progress notes to all individuals with PBSPs (K4) • Evidence of documentation in the progress note of activity to address lack of progress (K4) • Expansion of functional assessments to every individual with a PBSP (K5) • Improvements in the comprehensiveness of annual psychological assessments (K7)

	• Expansion of current annual psychological updates to all individuals (K7) • Improvement in the quality of PBSPs (K9) • Initiation of treatment integrity of the implementation of PBSPs (K10) • Improvement in DCP's report that they understood PBSPs (K11) 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) • Increase the flexibility of the system for collecting both target and replacement data (K4) • Establish minimal frequencies of data collection reliability and IOA collection, and demonstrate that those frequencies of data collection are achieved (K4, K10) • Establish minimal acceptable data collection reliability and IOA levels, and demonstrate that those levels are achieved (K4, K10) • Ensure that replacement behaviors are graphed for all individuals with PBSPs (K4, K10) • Ensure that the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred in those instances when an individual is not making the progress expected (K4) • Improve the quality of the functional assessments (K5). • Ensure that PBSPs are implemented within 14 days of receiving consent (K9) • Ensure that treatment integrity measures include an observation of the implementation of the PBSP (K10) • Establish minimal frequencies of treatment integrity per individual with a PBSP, and ensure that those frequencies are achieved (K10) • Establish minimal acceptable treatment integrity levels, and demonstrate that those levels are achieved (K10) • Provide documentation that all staff assigned to work with an individual (including float staff) have been trained in the implementation of their PBSP prior to PBSP implementation, and at least annually thereafter (K12)

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the psychologists at SASSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as applied behavior analysts (BCBAs). At the time of the onsite review, three (27%) of the 11 psychologists that wrote PBSPs were BCBAs. This represented an improvement from the last review when none of the psychologists that wrote PBSPs were certified as applied behavior analysts. Additionally, nine of 11 psychologists who wrote PBSPs (82%) were either enrolled, or completed coursework, toward attaining a BCBA. This represented another improvement from the last review when 70% of the psychologists that wrote PBSPs were either enrolled in, or	Noncompliance

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	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.	completed, BCBA coursework. 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.	
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 continued to be in substantial compliance with this item. At the time of the onsite review, the director of psychology had a master's degree in psychology, was a certified applied behavior analyst, and had over 15 years of experience working with individuals with intellectual disabilities. 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 provided documentation that internal peer review meetings consistently occurred weekly, and external peer review meetings consistently occurred monthly. Therefore, this provision is rated in substantial compliance. The facility continued to conduct Behavior Therapy Committee (BTC) meetings that contained many of the elements of internal peer review, however, these meetings only reviewed PBSPs that required annual approval. The peer review meetings, by design, provided an opportunity for psychologists to present cases that were not progressing as expected or were new to the facility. The peer review meetings also allowed more time to discuss cases. The internal peer review meeting observed by the monitoring team reviewed a draft of a functional assessment and PBSP for Individual #336. The internal peer review meeting included active participation from all of the department's psychologists, and included representatives from the rehabilitation department. The meeting appeared to be very productive and resulted in the identification of several new treatment strategies to address Individual #336's target behaviors. Review of minutes from internal and external peer review meetings indicated that the majority of psychologists in the department regularly attended peer review meetings. Meeting minutes also indicated that internal peer review meetings consistently occurred weekly, and that once a month these meetings included a participant from outside the facility, thereby achieving the requirement of monthly external peer review meetings.	Substantial Compliance

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		Finally, operating procedures for both internal and external peer review committees were established. In order to maintain substantial compliance, SASSLC needs to ensure that internal peer review consistently occurs weekly, external peer review consistently occurs at least monthly, and evidence of follow-up/implementation of recommendations made in peer review exist.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The monitoring team noted several improvements in this provision item. In order to achieve substantial compliance, however, the facility needs to ensure that the data collection system is flexible, improve the collection of replacement behaviors, and ensure the graphing of replacement/alternative behaviors for all individuals with a PBSP. Additionally, SASSLC needs to establish acceptable interobserver reliability (IOA) and data collection reliably frequencies and levels, and demonstrate that those frequencies and levels are achieved. Finally, the facility needs to ensure that progress notes consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred when individuals are not making expected progress, and that all treatment decisions are data based. The facility continued to utilize 30-minute target behavior data collection in all residential and day programming sites. Several psychologists indicated that some individual's target behaviors were difficult to "fit" into the current data system. For example, target behaviors that occurred at very low rates (e.g., once a week or once a month) were still required to be recorded as not occurring every 30 minutes. Additionally, the current data system was not designed to measure the frequency per interval or duration of target behaviors; both measures that could be important in more accurately representing and, ultimately, understanding target behaviors. It is recommended that the facility ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors. In SASSLC's current data collection system, direct care professionals (DCPs) were required to record a zero 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 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).	Noncompliance

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		As reported in the last review (August 2012), the facility had begun data collection reliability, and performance feedback to DCPs, to ensure that data were recorded in a timely fashion. The facility reported that target data were recorded within 30 minutes of occurring for 43% of the data sheets sampled in March 2013. The monitoring team did its own data collection reliability by sampling individual data sheets across several treatment sites, and noting if data were recorded up to the previous 30 minutes. The target behaviors sampled for nine of 20 data sheets reviewed (45%) were completed within the previous 30 minutes. Of the remaining 11 data sheets not competed within the previous internal, six were not filled out for the entire shift, and five did not contain data for the entire day. This was consistent with the data collection reliability reported by the facility, and represented an improvement from the last review when only 11% of data sheets reviewed were completed within 30 minutes of the behavior occurring. Although an improvement, 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. As discussed in the last two reports, one possible reason that data collection reliability was poor could be that the individual notebooks (which contained data sheets) were not always readily available to DCPs. The majority of individual notebooks reviewed by the monitoring team remained behind locked doors. In order to improve data collection reliability, it is recommended that SASSLC ensure that data sheets are more accessible to DCPs so that they can record target and replacement behaviors as soon as possible after they occur. 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. Finally, SASSLC needs to establish minimum frequencies for the collection of data collection reliability (i.e., how often it is collected), and ensure that those frequencies occur. Additionally, data collection reliability levels should be established (i.e., what are acceptable data collection reliability scores), and ensure that those levels are achieved. The monitoring team found only two of 20 individual records (10%) reviewed contained data sheets (or replacement behavior skill acquisition plans) 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	

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		new behaviors, writing replacement behaviors as SAPs is recommended (see K9). SAPs, however, are typically only implemented at specified times of the day and, therefore, they might not be recorded when they occur at other times of the day. Additionally, several psychologists reported difficulty accessing and graphing the SAP 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. Another possible reason that replacement behaviors were found in only 10% of the individual records reviewed is that 10 of the 20 abbreviated PBSPs in the individual records (50%) did not contain any reference to the replacement behaviors. It is recommended that all abbreviated PBSPs contain a description of replacement behaviors. As discussed in the last report, while data collection reliability assesses whether data are recorded in a timely fashion, interobserver agreement (IOA) assesses if multiple people agree that a target or replacement behavior occurred. The facility recently began the collection of IOA. The monitoring team reviewed the IOA procedures and believes that they represented an adequate method for IOA collection. Now SASSLC needs to ensure that IOA is collected for each PBSP, establish the minimum acceptable frequency of IOA collection, establish specific IOA goals (i.e., how high does IOA need to be), and ensure that these frequencies of IOA collection and levels are attained. The majority of graphs of target behaviors utilized simplified graphs (i.e., reduced number of data paths and addition of phase lines to mark medication changes and/or other potentially important events). The monitoring team did, however, encounter a few graphs in PBSPs (e.g., Individual #204, Individual #145) that were very difficult to interpret because they included several target behaviors and/or medication dosages on the same graph. It is recommended that all graphs at the facility be simplified by reducing the number of data paths and adding phase lines to mark medication changes and/or other potentially important events. Finally, although the monitoring team encountered a few graphs of replacement behaviors (e.g., Individual #259, Individual #255), none of the PBSPs reviewed included graphs of replacement behaviors. It is recommended that replacement behaviors be graphed for all individuals with PBSPs. The routine use of data to make treatment decisions had improved at SASSLC. For four of five (80%) individual's psychiatric clinics observed, current graphed data were available for the treatment team to review. For example, in Individual #255's psychiatric review, the psychologist presented graphs that were current (the graphs represented data that occurred up to one day prior to the clinic meeting) and simple to understand. They clearly showed the effects of Individual #255's medication changes on his target behaviors. The clear and current graphs contributed to a very productive discussion by Individual #255's treatment team, and resulted in data based decisions concerning his	

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		use of medications and various treatment interventions. In reviewing six months of PBSP data for 12 individuals, six (50%) indicated improvement, or stable and low levels, of severe target behavior, such as aggression or self-injurious behavior (i.e., Individual #13, Individual #306, Individual #149, Individual #128, Individual #193, and Individual #204). This represented a slight decrease from the last review when 60% of the PBSP data reviewed indicted decreases or low stable levels of severe target behaviors. An improvement from the last review was that all individuals with a PBSP had monthly progress notes, and there was some evidence that when progress was not occurring, action to address the lack of progress was occurring (e.g., modification of the PBSP, or retraining of staff). For example: • Individual #140's PBSP was modified prior to the annual review due to an increase in physical aggression. • Individual #249's 2/13 progress note indicated his increase in physical aggression was likely related to staff not complying with his PBSP, resulting in a plan to retrain staff on this plan. There was, however, no indication of systematic action to address the lack of progress in all individuals reviewed that did not demonstrate progress (i.e., Individual #145, Individual #264, Individual #167, and Individual #53). The monitoring team expects that an analysis of the potential reasons for the lack of progress will consistently 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) should be documented in the progress note. 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. Clearly SASSLC's work on this provision item resulted in many improvements that are documented above. There remains, however, much more to do in this area. The monitoring team believes that this is a provision item that needs the facility to continue to focus on over the next six months.	
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	SASSLC rated this item as being in substantial compliance in the self-assessment. One reason for the discrepancy between the facility's and the monitoring teams rating of this item is that the facility assumed this provision item addressed annual psychological assessments, rather than full psychological assessments. Although there were improvements noted below, this provision item was rated as being in noncompliance due to the absence of complete full psychological assessments for each individual, and the	Noncompliance

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	for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	absence of complete functional assessments for each individual with a PBSP. Psychological Assessments 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 a full psychological assessment. Additionally, these full 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. Functional Assessments A list of functional assessments and PBSPs indicated that all individuals with a PBSP had a functional assessment. Additionally, 177 of the 186 individuals with a PBSP (95%) had current (i.e., revised/reviewed within one year) functional assessment. This represented a dramatic improvement in the percentage of individuals with PBSPs that had current functional assessments compared to the last two reviews (i.e., 71% and 82%). Two of the revised functional assessments reviewed (Individual #149 and Individual #193), however, appeared to be identical copies of last year's functional assessment. The monitoring team does not believe that direct and indirect assessments need to be repeated each year if they are determined to continue to be current. The monitoring team does expect, however, that a statement be included stating that the assessments from the previous year are believed to be current, and attempts are made to ensure that all information is updated (e.g., reference to current PBSP, etc.) A list of all functional assessments completed in the last six months indicated that 105 were completed since the last review. Eleven of those functional assessments (10%) 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 judged to be 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 occurred by conducting/administering questionnaires, interviews, or rating scales. As found during the last review, all of the functional assessments reviewed included	

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		appropriate indirect assessment procedures. Seven (i.e., Individual #249, Individual #204, Individual #306, Individual #149, Individual #167, Individual #222, and Individual #13) of the functional assessments reviewed (64%) utilized direct assessment procedures that were rated as complete. This was comparable to the last two reviews when 60% and 62% of direct observations were rated as complete. An example of a complete direct assessment procedure was: • Individual #306's functional assessment described direct observations of her engaging in self-injurious behavior (SIB) that suggested antecedents (i.e., the absence of attention) to the target behavior. This direct observation revealed that Individual #306's SIB likely functioned as a way for her to attain staff attention. The remaining four functional assessments (Individual #145, Individual #193, Individual 53, and Individual #128) 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. 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 consequent events affecting the target behavior. All of the functional assessments reviewed (100%) identified potential antecedents and consequences of the undesired behavior. Several functional assessments reviewed, however, also included antecedents that appeared to be precursors to the target behavior (e.g., Individual #306 moving in her seat). Additionally, some consequences appeared to include interventions from the behavior support plan (e.g., Individual #222's functional assessment included that as consequence of his target behavior, he was to be	

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		redirected to an alternative area to calm down). The functional assessment should only include environmental antecedents to the target behavior (e.g., noisy environments, placing demands, absence of staff attention), and consequences hypothesized to maintain the behavior (e.g., getting staff attention, escaping demands, obtaining tangible items). 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. Ten of the 11 functional assessments reviewed (91%) included a clear summary statement (Individual #13's functional assessment did not include a summary statement). This represented a slight decrease from the last review when 100% of the functional assessments reviewed were judged to have a clear summary statement. Six (i.e., Individual #249, Individual #204, Individual #306, Individual #149, Individual #167, and Individual #222) of the 11 functional assessments reviewed (55%) were evaluated to be comprehensive and clear. This represented a slight decrease from the last review when 60% of the functional assessments were determined to be complete. SASSLC made much progress in this provision item by ensuring everyone with a PBSP now had a functional assessment, and that 97% of those were current. It is recommended that, over the next six months, the facility now focus on improving the quality of the functional assessments.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	There was no evidence that full psychological assessments were current and, therefore, this provision item was rated as being in noncompliance. The facility did not have a spreadsheet of individual's full psychological assessment dates. The director of psychology, however, indicated that no full psychological assessments had been conducted in the last year, and that she believed that the majority were more than five years old. SASSLC should maintain a list of individual's full psychological assessments and dates. Additionally, all psychological assessments (including assessments of intellectual ability) should be conducted at least every five years.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later,	The majority of individuals at SASSLC had a current annual assessment, 100% of the annual assessments reviewed were judged to be complete, and there was evidence that all of the individuals admitted to the facility in the last six months had a psychological update within 30 days of admission. Therefore, this provision item was rated in	Substantial Compliance

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	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.	substantial compliance. 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 243 of the 262 individuals at SASSLC (93%) had current annual assessments. This represented a dramatic improvement from the last review when 76% of individuals had a current annual assessment. The monitoring team reviewed 10 of the 97 annual psychological assessments (10%) that were completed in the last six months. All 10 of the annual assessments reviewed (100%) contained all of the components described in K5. This represented another sharp improvement from the last review when 50% of the annual assessments reviewed for comprehensiveness were judged to be complete. Finally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility in the last six months indicated that this component of this provision item was also in substantial compliance.	
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	There were no substantial 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 10 individuals at SASSLC. Therapists outside of the facility provided psychological services to seven of these individuals. Treatment plans and progress notes were reviewed for seven individuals to assess compliance with this provision item. None of the treatment plans and progress notes were judged to be complete. In order to achieve substantial compliance with this provision item, the facility needs to ensure that all individuals that need psychological services (other than PBSPs) receive them, the services are provided by qualified staff, and that all treatment plans/progress notes include: • Services that are goal directed with measurable objectives and treatment expectations	Noncompliance

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		• 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.	SASSLC continued to make very good progress in K9. This item was rated as being in noncompliance, however, because PBSPs were not consistently implemented within 14 days of receiving consent and because the PBSPs reviewed did not consistently contain all the required components. A list of individuals with PBSPs indicated that 186 individuals at SASSLC had PBSPs. A list of all PBSPs and the date of last revision indicated that 179 of these 186 PBSPs (96%) were current (i.e., revised in the last 12 months). Forty-nine PBSPs were completed in the last six months, and 12 (25%) of these were reviewed to evaluate compliance with this provision item. All 12 of the PBSPs reviewed had the necessary consent and approvals, however, there was no evidence that they were implemented within 14 days of receiving consent. Additionally, the facility's self-assessment and the director of psychology indicated that many PBSPs were not implemented within 14 days of receiving necessary approvals and consents. SASSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. As reported in the last review, all PBSPs reviewed (100%) included operational descriptions of target behaviors. Additionally, all 12 of the PBSPs reviewed described antecedent and consequent interventions to weaken target behaviors, but one (i.e., Individual #264) of these (8%) identified consequences that appeared to be inconsistent with the stated function of the behavior and, therefore, was not likely to be useful for weakening undesired behavior. This represented an improvement in the effectiveness of antecedent and consequent procedures reported in the last review when 27% of the PBSPs reviewed were judged to be inconsistent with the stated function. Individual #264's consequent intervention was rated to be incompatible with the hypothesized function of her target behavior because her PBSP hypothesized that her aggression was maintained by negative reinforcement (i.e., a way to escape or avoid unpleasant activities) and social attention. Individual #264's PBSP prescribed that following the occurrence of self-injurious behavior (SIB), DCPs should ask her to go to a quiet area to talk about what upset her. If, however, avoiding undesired activities and getting staff attention was reinforcing for Individual #264 (as hypothesized in the PBSP), then this intervention would likely increase the likelihood of her physical aggression.	Noncompliance

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		Encouraging (and allowing) her to indicate that she wanted to talk to staff and/or leave an area BEFORE she engaged in physical aggression would potentially be an effective antecedent intervention. After the targeted behavior occurred, however, Individual #264 should not be provided additional staff attention or 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. Additionally, although some staff attention would likely be necessary to safely address Individual #264's aggression, the PBSP needs to clearly state that attention should be minimized immediately following aggression, and removal of the undesired activity should be avoided, whenever possible and practical, because it encourages future undesired behavior. An example of a PBSP where both antecedent and consequent interventions appeared to be based on the hypothesized function of the targeted behavior and, therefore, were likely to result in the weakening of undesired behavior is described below: • Individual #193's PBSP hypothesized that the function of her SIB was escape from undesired activities and social attention. Antecedent interventions included staff consistently interacting with her if she attempted to communicate with them. Additionally, antecedent approaches included giving Individual #193 several breaks from work (her replacement behavior was learning to sign for breaks). Her intervention following SIB included minimizing attention, and attempting to prompt her back to work. 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 #264's and Individual #13) of the 12 (17%) PBSPs reviewed, replacement behaviors that could be functional were not functional. This is similar to the last report, when 18% of replacement behaviors that could be functional were not functional. An example of a replacement behavior that was not functional was: • Individual #264's PBSP hypothesized that her physical aggression was maintained by maintained by negative reinforcement and social attention. Her replacement behaviors were to participate in preferred scheduled activities. It	

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		may be important for Individual #264 to participate in preferred activities, 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 negative reinforcement would be to learn to request a break. An example of a functional replacement behavior for a target behavior maintained by social attention would include teaching/reinforcing another way to get obtain staff attention, such as earning the opportunity to meet with preferred staff and obtain desired items. When the replacement behavior requires the acquisition of a new behavior, it should be written as a skill acquisition plan (see S1). If, however, the replacement behavior is currently in the individual's behavioral repertoire, the replacement behavior does not need to be written in the skill acquisition plan (SAP) format. In any case, as discussed in K4, replacement behaviors should be collected on a data sheet separate from the SAP. Replacement behaviors are an area ripe for collaboration with SLPs and the communication/language department. As noted in section R1 of this report, 4 of 9 PBSPs in that sample (44%) included some communication strategies recommended in the communication assessment. Section R1 also points out that an SLP attended BTC about half of the time. Overall, 10 (Individual #249, Individual #204, Individual #193, Individual #145, Individual #128, Individual #306, Individual #149, Individual #167, Individual #53, and Individual #140) of the 12 PBSPs reviewed (83%) 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 sharp improvement over the last two reviews when 64% and 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.	
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	There were improvements in this area, however, it was rated as being in noncompliance because minimal acceptable frequencies of interobserver agreement (IOA) and treatment integrity data collection were not established and attained. Additionally, at the time of the onsite review, replacement behaviors were not consistently graphed. As discussed in K4, the facility recently began the collection of IOA. Now SASSLC needs to ensure that IOA is collected for each PBSP, that minimum acceptable frequencies of IOA collection are established, that specific IOA goals (i.e., how high does IOA need to be) are	Noncompliance

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	efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	established, and that these frequencies of IOA collection and levels are attained. All of the DCPs asked about PBSPs indicated that they understood them (see K11). The most direct method, however, to ensure that PBSPs are implemented as written is to regularly collect treatment integrity data. This represented another area where the facility had improved since the last review. SASSLC recently began the collection of treatment integrity of the PBSPs. The monitoring team reviewed the treatment integrity data sheet used at SASSLC, and believes it represented an adequate measure of treatment integrity. It included several relevant questions concerning the implementation of PBSPs (e.g., what are the target behaviors, what are the antecedents to the target behaviors) and a direct observation component where the psychologist/psychology assistant observes the DCP implementing the plan. A review of seven completed treatment integrity data sheets, however, indicated that four (57%), did not include the direct observation component. It is recommended that the facility ensure that all treatment integrity sessions include an observation of DCPs implementing the PBSP. The self-assessment indicated that the average integrity score was 66%. There were no data concerning the frequency of assessing treatment integrity. It is recommended that the facility ensure that treatment integrity is collected for each PBSP, that minimum acceptable frequency of treatment integrity collection is established, and specific treatment integrity goals (i.e., how high does treatment integrity need to be) are established. Finally, SASSLC needs to ensure that these frequencies of treatment integrity data collection and levels are attained. Target behaviors were consistently graphed, and the graphing of replacement-alternative behaviors was recently begun, however, was not graphed for all individuals with PBSPs (see K4). The majority of graphs reviewed contained horizontal and vertical axes and labels, condition change lines/text boxes, data points, and a data path. The quality and usefulness of these graphs continued to improve at SASSLC.	
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.	All of the PBSPs reviewed appeared simple, clear, and allowed for staff understanding. Additionally, all DCPs interviewed, indicated that they understood the PBSPs. Therefore, this provision item was rated as being in substantial compliance. SASSLC utilized an abbreviated behavior support plan that was located in the individual books, and was written so that DCPs could understand them. As an objective measure of the readability of these, SASSLC monitored the reading level (using the Flesch-Kincaid Readability score) of 10 abbreviated plans and determined that they averaged (when medical diagnoses were removed) an 8th grade reading level.	Substantial Compliance

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		The monitoring team also asked several DCPs across all treatment sites if they could understand the PBSPs, and they all indicated that the plans were simple and clear. Finally, review of the plans indicated that they were written in a manner that DCPs were likely to understand. None of the PBSPs reviewed, for example, contained more than four target behaviors, and technical language appeared to be kept at a minimal.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	This item was rated as being in noncompliance because, at the time of the onsite review, SASSLC did not have documentation that every staff assigned to an individual was trained on his or her PBSP. As reported in the previous review, the psychology department maintained logs documenting staff members who had been trained on each individual's PBSP. Psychologists and psychology assistants conducted the trainings prior to PBSP implementation and whenever plans changed. The monitoring team observed the training of DCPs on Individual #132's PBSP. The training included a review of the PBSP by the psychologist that wrote the PBSP, an opportunity for DCPs to ask questions, and written questions pertinent to Individual #132's PBSP. The monitoring team found the training to be very positive and thorough. There was, however, no system in place to ensure that all staff (including float/relief staff) implementing PBSPs had been trained. The facility's self-assessment indicated that not all of staff implementing PBSPs were trained prior to PBSP implementation. 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 (including float/relief staff) has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	This provision item specifies that the facility must maintain an average of one BCBA to every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SASSLC had a census of 262 individuals and employed 11 psychologists responsible for writing PBSPs. Additionally, the facility employed five psychology assistants, and one psychology technician. Three of these psychologists had obtained BCBA certification (see K1). In order to achieve compliance with this provision item, the facility must have at least nine psychologists with BCBAs.	Noncompliance

Recommendations:

1. Ensure that all psychologists that write PBSPs have BCBAs (K1).

2. The data system should be flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors (K4).

3. Ensure that data sheets are accessible to DCPs (K4).

4. Establish minimum frequencies for the collection of data collection reliability (i.e., how often it is collected), and ensure that those frequencies occur. Additionally, acceptable data collection reliability levels should be established (i.e., what are acceptable data collection reliability scores), and documentation that those levels are achieved provided (K4).

5. Replacement behaviors should be collected on a data sheet separate from the SAP (K4).

6. All abbreviated PBSPs should contain a description of replacement behaviors (K4).

7. Ensure that IOA is collected for each PBSP, establish the minimum acceptable frequency of IOA collection, establish specific IOA goals (i.e., how high does IOA need to be), and ensure that these frequencies of IOA collection and levels are attained (K4, K10).

8. All graphs should be simplified by reducing the number of data paths and adding phase lines to mark medication changes and/or other potentially important events (K4).

9. Replacement behaviors should be graphed for all individuals with PBSPs (K4, K10).

10. In those instances when an individual is not making expecting progress, the progress note should consistently indicate that some activity (e.g., retraining of staff, modification of PBSP) had occurred (K4).

11. All individuals should have a 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 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).

13. Maintain a list, and most recent administration, of full psychological assessments for each individual (K6).

14. All psychological assessments (including assessments of intellectual ability) should be conducted at least every five years (K6).

15. Ensure that all individuals that need psychological services (other than PBSPs) receive them, the services are provided by qualified staff, and that all treatment plans/progress notes include (K8):
    - 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.

16. Ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents (K9).

17. 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).

18. All treatment integrity sessions should include an observation, and feedback, of DCPs implementing the PBSP (K10).

19. Ensure that treatment integrity is collected for each PBSP, establish the minimum acceptable frequency of treatment integrity collection, establish specific treatment integrity goals (i.e., how high does treatment integrity need to be), and ensure that these frequencies of treatment integrity collection and levels are attained (K10).

20. The facility needs to present documentation that every staff assigned to work with an individual (including float staff) has been trained in the implementation of his or her PBSP prior to PBSP implementation, and at least annually thereafter (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: o SASSLC Policies/Guidelines • Aspiration Pneumonia Guidelines, 7/12 • Anaphylaxis Protocol, 12/11 • Bowel Management, 10/10 • Guidelines on management of Clostridium difficile, 12/11 • Guidelines for care in diabetes, 12/11 • Osteoporosis Guidelines, 11/11 • Urinary Tract Infection Guidelines, 12/11 o Seizure Management, 12/10 o SASSLC Facility Medical Services Policy, 12/28/11 o SASSLC Pneumonia Review Committee, 4/10/12 o SASSLC Medical Continuous Quality Improvement Committee, 4/17/12 SASSLC Lab Matrix 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 Mortality Review Documents o Avatar Pneumonia Tracking Forms o Clinic Tracking Log o 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 #198, Individual #35, Individual #341, Individual #23, Individual #267, Individual #259, Individual #32, Individual #342, Individual #325, Individual #126 o Annual Medical Assessments the following individuals: • Individual #45, Individual #217 Individual #226, Individual #287Individual #136, Individual #36, Individual #73, Individual #342 Individual #203 Individual #129, Individual #156 Individual #9, Individual #220 Individual #177, Individual #141 o Neurology Notes for the following individuals: • Individual #110 Individual #146, Individual #230 Individual #344 Individual #135, Individual #195, Individual #241, Individual #53, Individual #142 o Consultation Referrals and IPNs and for the following individuals: • Individual #348, Individual #257, Individual #213 Individual #135, Individual #10, Individual #133 <u>Interviews and Meetings Held</u>: o David Espino, MD, Medical Director o Yenni Michel, DO, Primary Care Physician o David Bessman, MD, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Family Nurse Practitioner o Mandy Pena, RN, QA Nurse o Soury Phanhthrath, RN Chief Nurse Executive o Mandy Pena, RN, QA Nurse o Robert Zertuche, RN, <u>Observations Conducted</u>: o Daily Clinical Services Meetings o Medical Staff Meeting o Observations of homes o Medical Continuous Quality Improvement 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. The medical director acknowledged that although he served as lead, much of the content of the self-assessment was not done by him. For Provision L1, the assessment of several areas was completed including timelines for AMAs, documentation of integrated discussions in the daily meetings, and data on the percentage of individuals who did not receive preventive care. The criteria used for assessment of the AMAs were not clear because the findings were not consistent with the findings of the monitoring team. The presentation of negative data for prevention compliance was not helpful because the facility did not actually have a grasp on how many individuals successfully completed screenings. 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. Self-assessments should include a mix of process, outcome, and structural data similar to those used by the monitoring team. 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 did not make a great deal of progress since the last compliance review. A new medical director was hired in November 2012 following the retirement of the long term medical director. A second medical compliance nurse worked for a short time in the department. These changes resulted in a loss of data and the decision to start over with data collection. During the last review, it was clear that the medical compliance nurse was playing a very significant role in the progress that was occurring through close work with the medical staff, data maintenance, and auditing. The medical staff reported that these efforts were extremely valuable to them and the care they provided.

	There appeared to be some level of regression in documentation of many areas, such as acute medical problems and hospital follow-up. This may have been provider specific and the medical director should further explore compliance in this area. The management of pneumonia remained a concern for the monitoring team. There was still no compelling evidence that the state-issued guidelines were used or effective at SASSLC. The facility had ongoing discussions related to the management of osteoporosis. The provision of neurological care continued to be a cause for concern. With regards to neurological services, the number of neurology clinic hours was inadequate to meet the needs of the individuals. The onsite clinic consultation notes did not provide adequate information, and follow-up of complex individuals was often infrequent. External and internal audits were completed, but the facility provided no compliance charts and data. The monitoring team was provided with more than a hundred pages of individual audits. Moreover, the facility did not seem to generate adequate data for its own use because the medical director was not aware of the compliance data. Mortality management remained problematic at SASSLC. There continued to be no organized process for ensuring implementation and follow-up of corrective actions. Emails indicated that follow-up on corrective actions occurred just a few weeks prior to this compliance review. Furthermore, the self-assessment documented a lack of implementation of corrective actions. The facility continued the medical quality program, but the format appeared to change. The previous format provided a review of aggregate data and individuals who were not meeting expected outcomes or who crossed a critical threshold for review. The current iteration of the process did not seem to produce any actionable plans. Finally, this review was impeded by problems related to the provision of the requested documents. Several active records requested were never provided. The Active Problem Lists were not included in the appropriate section of the record and, therefore, were not provided. Documents in the original record that were double sided were submitted incomplete. Post-review, unsigned copies of the APLs were submitted, but APL assessment is based on the documents being current, signed, and dated. Several of the documents requested onsite were not submitted and no explanation was provided. Several weeks after the review, the SAC indicated in communication to the monitoring team that the information was being gathered. Information, such as the compliance data for the medical audits, is typically provided at other facilities. During recent reviews, SASSLC has not been able to provide medical department documents without numerous requests from the monitoring team. For example, a request for a copy of the medical department's policy and procedure was fulfilled with a few documents and many articles from the literature. Such information may be included in the presentation book if desired, but the document requests should be fulfilled in accordance with the requests. This lack of attention to the document request was reflected throughout the review as an overall lack of attention to data management.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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, two full time primary care physicians, and a full time advanced practice registered nurse. The medical director carried a caseload of 22 while the APRN's caseload was about 69. The primary care physicians carried an average caseload of 88. There was no medical compliance nurse at the time of the compliance review. 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. All providers maintained current CPR certification. CME information provided indicated that all providers completed CMEs in accordance with the Texas State Board of Medical Examiners. **Physician Participation In Team Process** The facility continued its daily clinical services meeting. The medical director, all PCPs, psychiatrists, chief nursing executive, clinical pharmacists, 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. Many issues, such as consults were also now being addressed during the meetings. The monitoring team requested documentation of PCP attendance at the annual ISP meeting. Data for the months of August 2012 through March 2013 indicated that there were 10 ISPs. PCP attendance was 90%. This did not appear to be a complete list of ISPs for the facility. Attendance by PCPs at the annual planning meetings is a vital component of the process and is necessary for adequate integration of clinical services at the annual planning level. A lack of attendance by primary medical providers at annual planning meetings is a serious and fundamental barrier to the integration of clinical services and appropriate delivery of health care services. The primary medical	Noncompliance

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		providers should play an integral role in the planning process in terms of determining how the individual's health will impact goals, barriers, transitioning, etc. The PCP may not be capable of attending every meeting. Even so, the facility must develop a strategy to have improved attendance by the PCPs. This will be required to achieve substantial compliance in integration of clinical services. **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. The medical director reported that individuals were now admitted to Nix Hospital. This was a 90-bed full service hospital and could address all needs with the exception of neurosurgery. The SASSLC medical staff met with the Nix hospitalists and ER staff to discuss the special needs of the individuals supported by the facility. Individuals with true medical emergencies were transported to the closest most appropriate facility. Labs were drawn and processed at the facility and sent to Austin State Hospital. Beginning 9/1/12, stat labs were sent to Mission Trails Hospital. A 24-hour mobile x-ray service began providing services on 9/1/12. For the most part, individuals received care and physicians responded to their needs. Routine annual assessments were completed, although many were not completed within the appropriate timeframes. Individuals were assessed as problems arose and they 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. Follow-up evaluations for some individuals remained problematic. Compliance rates for some cancer screenings remained low. 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. Discussions 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	

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		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. For the Annual Medical Assessments included in the record sample: • 9 of 10 (90%) AMAs were completed in a timely manner • 10 of 10 (100%) AMAs included comments on family history • 10 of 10 (100%) AMAs included information about smoking and/or substance abuse history • 10 of 10 (100%) 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. • 15 of 15 (100%) 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. The fundamental requirement for this assessment was completion within 365 days of the previous assessment. The facility had an additional requirement of completion prior to the annual ISP. The format of the assessments was revised prior to the August 2012 review and this was an improvement. The interval history, preventive care, and immunization status were documented. Many of the AMAs continued to lack through assessments and plans. In some cases, important diagnoses were not included. In other cases, the plans were inadequate. For example, the record sample included two individuals with chronic Hepatitis B. Both AMAs included statements, such as continue treatment with GI involvement. An assessment of the problem should have included additional information, such as a very brief statement on the treatment provided and the efficacy of the treatment as well as the results of the hepatocellular carcinoma surveillance. Inclusion of the information would require only one or two sentences and would be	

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		helpful to anyone who needed to quickly obtain information about the individual. The AMAs also continued to lack information on complex medical problems. 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. <u>Quarterly Medical Summaries</u> During the August 2012 review, it was reported that Quarterly Medical Summaries were not being completed as required by the Health Care Guidelines due to the increased workload caused by the increase in the number of annual assessments that needed to be completed. During this compliance review, it was reported that QMSs were resumed. However, record audits revealed that compliance with this requirement was inconsistent. For the records contained in the record sample: • 5 of 10 (50%) records included current QMSs The QMSs completed were done using a state issued template. The content of these reviews was vey good and included information on recent hospitalizations, medication changes, and recent consults. <u>Active Problem List</u> For the records contained in the record sample: • 0 of 10 (100%) records included an APL The facility's record index listed the Active Problem Lists under the Health Data Tab. This component of the record was requested for the record sample. However, the APLs were not found in any of the records submitted. Documents were submitted following the review, but the unsigned version was submitted. A second set of documents was later submitted for review. Even so, very few of these documents were appropriately updated. Updating of the APLs appeared to be an ongoing problem. The QDRRs reviewed included many recommendations by the clinical to update the APL with the active problems. For some individuals, the clinical pharmacists made the recommendation to update the APL several times prior to the APL being updated. In other instances, the APLs were never updated. The problem lists should be updated as problems arise and/or resolve. This document is a key component of the medical	

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		transfer packet and should include accurate information on the medical problems of the individuals. Integrated Progress Notes 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 required improvement. In many cases, IPN entries were identified for two consecutive days following hospital return, but compliance with this requirement was provider specific. State issued policy required that documentation continue until the problem was stable or resolved. That level of documentation was very inconsistent. Physician Orders Physician orders were usually dated, timed, and signed. There were many concerns related to medication orders at SASSLC, including incomplete orders, orders written with incorrect routes, doses, etc. Medication orders are discussed further in section N1. Consultation Referrals The medical director indicated that state office issued a database to track consults. He believed that the database was not adequate to meet the needs of the facility. The monitoring team requested to view the content of the database and found that it included the essential information and could probably be sorted as required. The consults and IPNs for six individuals were requested. A total of 35 consults completed after July 2012 (including those from the record sample) were reviewed: • 20 of 40 (50%) consultations were summarized by the medical providers in the IPN within five working days; most consults reviewed, however, were initialed and dated by the medical providers indicating review of the consults. Providers usually summarized the recommendations of the consultants. Very few of the IPN entries reviewed indicated agreement or disagreement with the recommendations and none stated if the recommendations were being referred to the IDT for review. The observation of poor compliance with the requirements for documentation of consultations was a marked regression from the observations noted in the August 2012 review. The medical director indicated during interviews that compliance with requirements for this area was poor. This was also reflected in the self-assessment. The monitoring team suggests that IPN documentation of consultations include a brief summary of recommendations of the consultants, contain a statement regarding agreement or disagreement, and include a decision about referral to the IDT. The	

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		primary providers should also indicate the consult 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. A small improvement was noted in the rate of colorectal cancer screening while compliance with breast cancer screening seemed to decrease. Cervical cancer screening remained essentially unchanged. The facility removed the requirements to complete PSA testing. This, however, was a blanket removal and did not appear to take into consideration family history, risk stratification, or the discussions with the individual/LAR. The medical director reported that all preventive care databases were maintained on the computers of the former medical director and medical compliance nurse. With their departure, the data were lost. New databases for preventive care and cancer screenings were developed and data had to be re-collected. 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 appropriately 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 be 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 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> • 10 of 10 (100%) individuals received the influenza, hepatitis B, and	

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		pneumococcal vaccinations • 8 of 10 (80%) 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> • 9 of 10 (90%) 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 The facility suspended PSA testing and, therefore, provided no facility-wide data. <u>Breast Cancer Screening</u> • 3 of 3 females met criteria for breast cancer screening • 2 of 3 (67%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 80 females, the date of the last mammogram, and explanations for any lack of testing: • 22 of 80 (28%) females completed breast cancer screening within the past year • 53 of 80 (66%) females completed screenings more than 1 year ago • 5 of 80 (6%) females did not have documentation of breast cancer screening <u>Cervical Cancer Screening</u> • 3 of 3 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 100 females, the date of the last pap smear, and explanations for lack of testing: • 72 of 100 (72%) females completed cervical cancer screening within the past three years • 12 of 100 (12%) females completed cervical cancer screening more than three years ago • 5 of 91 (5%) females had no documentation of cervical cancer screening due to refusal	

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		Colorectal Cancer Screening • 6 of 10 individuals met criteria for colorectal cancer screening • 1 of 6 (17%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 129 individuals: • 68 of 129 (53%) individuals had completed colonoscopies • 16 of 129 (12%) individuals were listed as "will not do" secondary to increased risk • 39 of 129 (30%) individuals did not complete colonoscopies and no explanation was provided Additional Discussion Clinical guidelines related to the provision of medical care are in a constant state of flux with many recommendations being generated by numerous professional organizations. State office generated guidelines based on several organizations. Some, but not all, cancer screenings were based on the recommendations of the Unites States Preventive Task Force. This governmental agency recently changed many recommendations and these changes have not been without controversy nor have they been universally accepted by all major professional organizations. What is clear about the approach of the USPTF is that the organization emphasizes appropriate risk classification and shared decision-making between providers and patients. Additionally, practitioners must take into consideration that many individuals supported by the facility lack adequate family history and are not able to provide information related to symptomatology. Thus, risk stratification becomes more difficult. 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. Diabetes Mellitus 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: • 0 of 1 (0%) individuals had adequate glycemic control	

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		• 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 This individual is discussed further below as Individual #35 <u>Pneumonia</u> The facility reported that 17 individuals had pneumonia over the past year. The Avatar data submitted appeared incomplete and consisted of only 7 reports. The facility continued to conduct pneumonia reviews. The committee reviewed clinical information, including chest roentgenograms, lab data, and history. A determination was then made about the type of pneumonia that occurred and recommendations were made. During the February 2012 review, it was reported that J-tubes were not used at SASSLC. 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 rationale. Even with the oversight process, the monitoring team was not clear on the management of pneumonia at SASSLC. Several individuals had recurrent pneumonia and some of these individuals had gastric enteral tubes. There was no documentation in the records regarding the discussion on why aspiration continued to occur or what the suspected source of aspiration was, such as upper airway secretions or enteral meals. Such discussions must occur. State-issued guidelines provided some guidance for the management of individual with recurrent aspiration. **Case Examples** Individual #35 • This individual had an HbA1c of 6.8 and was noted to have elevated glucoses on several CMPs indicating poor glycemic control. • The individual also had the diagnosis of nephrotic syndrome, but the nephrology consult dated 2/18/13 indicated that the individual lacked other criteria to confirm the diagnosis. • The individual was also treated at one time with iron supplementation and the AMA documented that a referral would be made for a colonoscopy. There was no evidence that the appropriate screening was completed. • The PCFS was not updated with AMA. • The individual was on monotherapy with Dilantin for management seizure	

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		management. The last documented seizure was in 2000. The last neurology evaluation was in 2008. Dilantin was continued because attempts to wean had failed in the past. Individual #267 • This individual had a history of chronic Hepatitis B infection. Surveillance for hepatocellular carcinoma was not documented in the AMA, but is required for this chronic condition. • This individual also had a history of Downs Syndrome and hypothyroidism. The last TSH in June 2012 was slightly elevated, however, no follow-up TSH was recorded. The Intelligent Alerts module did not appear to impact the medical management. o The AMA stated for the assessment and plan – "hypothyroidism, continue medical management." The assessment should provide additional information, such evidence that the individual is clinically and biochemically euthyroid, if appropriate. • There was no documentation of a colonoscopy in the records reviewed. • The APL was not updated. Individual #32 • This individual received topiramate and metoclopramide. The metabolic profiles documented low normal to low CO2 levels. Topiramate is associated with development of a metabolic acidosis, but the low CO2 levels were never addressed nor was there any monitoring for side effects that are associated with the metabolic acidosis, such as kidney stones. The package insert for topiramate provides recommendations for this. There was no record of a report of a suspected ADR with topiramate use. • The MOSES and DISCUS evaluations lacked provider conclusions, and were therefore, incomplete. • The APL was not updated with the diagnosis of constipation. • The PCFS was last updated in 2011. • The individual had documented ferritin level of 15. This was essentially pathognomonic for iron deficiency, but there was no discussion related to this in the records reviewed. Individual #198 • This individual had the diagnosis of refractory seizure disorder and was reported to be worked up for a VNS. The last appointment with the epileptologist was in March 2013 and follow-up was to occur in April 2013. There was no documentation of follow-up.	

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		• There was no documentation of breast cancer screening in the past. Due to age, it was now listed as "N/A." • The QDRRs cited hyponatremia associated with carbamazepine, but no ADRs could be located in the tracking spreadsheets. • On 3/24/13, the individual fell from the shower chair, sustained a facial laceration, and was seen in the ED. The PCP wrote for neurology checks but did not document baseline findings upon return to the facility. There was also no MD follow-up for the injury. Individual #325 • This was seen in neurology clinic on 1/31/12 with abnormal motor movements and a history of epilepsy. The was no neurology follow-up. • There was no documentation of completion of a colonoscopy. • The APL and PCFS were not updated. o There was no documentation of the status of the individual's Hepatitis B infection. • There were multiple MOSES evaluations that were never completed by a primary provider. • Vitamin D was 21 Individual #259 • The individual was at risk for osteoporosis due to the use of AEDs, but there was no documentation of a DEXA scan. • The individual received Topamax, but lab monitoring was not adequate. • The individual was hospitalized for 16 days with small bowel obstruction. The AMA stated that the individual had a history of a small bowel obstruction that required surgery. According to the hospital Discharge Summary, the individual had a SBO possibly due to adhesions. The individual was made NPO and was treated with suctioning from the PEG tube. The obstruction resolved with bowel rest. • The medical assessments did not adequately describe a plan for the management of recurrent pneumonia in this individual with a PEG tube. The etiology of the aspiration was not clear. • The PCFS was not updated. Individual #126 • The individual was not listed on the refractory seizure list even though the diagnosis was clear with a history of 16 seizures within a year. • Lab documentation showed abnormal LFTs. The AMA did not discuss a differential diagnosis but stated simply stated "ultrasound pending."	

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		• The APL did not list intractable seizure disorder as a diagnosis. • The individual had recurrent aspiration pneumonia with a PEG tube. The etiology and management of the recurrent aspiration was not documented in the records reviewed. • The neurology clinic note dated 8/12/12 appeared un-reviewed based on the number of comments that were not clear. For example, "the individual had a history of recent hyponatremia, but now results suggest that this is not a medication effect and was probably related to fluid of lobe." This individual with worsening seizure disorder had prn follow-up documented. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 138 individuals. The following data regarding AED use were summarized from the list provided: • 18 of 138 (13%) individuals received 0 AEDs • 62 of 138 (45%) individuals received 1 AED • 28 of 138 (20%) individuals received 2 AEDs • 19 of 138 (14%) individuals received 3 AEDs • 7 of 138 (7%) individuals received 4 AEDs • 4 of 138 (2%) individuals received 5 AEDs The number of individuals seen in the on-campus clinic is summarized in the table below. The on-campus clinic was conducted by a general neurologist 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 visits for the general neurologist. Neurology Clinic Appointments 2012 - 2013 Aug: 9 Sep: 8 Oct: 15 Nov: 10 Dec: 2 Jan: 8 Feb: 13 Total: 65 The total number of appointments was not adequate given the number of individuals with the diagnosis of seizure disorder who actually received medications. For the seven	

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		months listed, there was an average of nine clinic appointments each month The facility supported 138 individuals with a diagnosis of seizure disorder: • 120 of 138 (87%) individual with seizure disorder received AEDs • 58 of 120 (48%) individuals received two or more drugs • 14 of 138 (10%) individuals had refractory seizure disorder o 10 of 138 (7%) individuals had a VNS implanted o 10 of 14 (7%) refractory individuals had a VNS implanted o 1 of 14 (7%) refractory individuals was in the process of a VNS workup o 4 of 138 (3%) individuals had a recent episode of status. The database tracking off-campus appointments did not list any neurology clinic appointments. The records reviewed indicated that some individuals were seen by an epileptologist. The medical director reported that a new agreement was being made to have the epileptologist conduct an onsite clinic. This arrangement was also discussed during the August 2012 review, but at the time of the compliance review, the campus clinic had not started. Individuals with a psychiatric diagnosis in addition to seizure disorder were seen in the SASSLC neuropsychiatry clinic. The treating psychiatrist and primary providers attended this 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: • 7 of 15 (46%) individuals were seen at least twice over the past 12 months • 8 of 15 (53%) individuals had documentation of the seizure description • 11 of 15 (73%) individuals had documentation of current medications for seizures and dosages • 6 of 15 (40%) individuals had documentation of recent blood levels of antiepileptic medications • 6 of 15 (40%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 11 of 15 (73%) individuals had documentation of recommendations for medications • 0 of 15 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The facility revised the template used for SASSLC neurology clinic notes. The template included vital signs, MOSES/DISCUS evaluations, labs, and medications. Although the	

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		templates included the MOSES and DISCUS scores, there was very little information related to side effect monitoring. The monitoring team was concerned about many issues related to the provision of care to individuals with seizure disorder: • Follow-up care did not appear adequate. Many individuals were experiencing difficulties, had increasing seizures, and the neurologist recommended prn follow-up rather than having recommended a definitive timeframe. . • The medication recommendations were at times very vague. • Documentation of medication side effects and even monitoring was not always adequate. The monitoring team noted that some individuals receiving topiramate did not have monitoring as recommended by the drug manufacturers. • Consult notes did not always even indicate why the individuals required evaluation. • Several consults were unsigned, so it was not clear that the neurologist reviewed them and some contained errors that the IDT should have questioned. • The notes almost never included any information on the findings of a neurological examination. The health sciences clinic notes were aftercare instructions for patients. These summaries did include a significant amount of information, such as seizure classification, medications, vital signs, and aftercare instructions. The recommendations for medication changes were quite detailed. Even though they were not the actual consult, they provided more information about the management of seizure disorder and the plan of care than the notes generated at the onsite clinic. The medical director will need to address outstanding needs related to provision of neurological care and work with the consultants (both clinics are scheduled to be onsite) in remediating these deficiencies. **Do Not Resuscitate** The facility submitted a list of individuals who had DNR orders in place. The list included 13 individuals with Level II or III DNRs. The dates of implementation ranged from 2003 to 2010. The qualifying conditions included phenylketonuria and hypertension with diastolic dysfunction. No additional information was provided. The monitoring team discussed the facility's policy for implementation of DNRs with the medical director, including the requirements to adequately justify long term DNRs. The medical director acknowledged the need to provide better documentation for the DNRs, such as those related to PKU and hypertension.	

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		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.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	Medical Reviews Two external medical reviews were completed since the last compliance review. Round 6 was conducted in October 2012 and Round 7completed in April 2013. As part of the original document request, the facility submitted information for the general internal audits and associated corrective action plans for Round 6. No data were submitted for the external audits (general and medical management) completed during Round 6. During the onsite review, the monitoring team requested complete data for the Round 6 external audits as well as the results of the Round 7 audits. This information was requested again two weeks following the compliance review and the monitoring team was informed that the data were not available. Although the graphs and data usually submitted by the QA Department were not submitted for Round 6 external audits, the self-assessment listed two compliance ratings. The medical director was not familiar with this set of data because the review occurred in October 2012, prior to his arrival. The monitoring team was provided with the individual evaluations/audits for each review, but no compliance data were received. The lack of data for overall compliance with the essential and nonessential elements, compliance with medical management, and compliance by question was compelling evidence that the facility failed to maintain an effective medical review system. The Settlement Agreement Coordinator communicated two weeks after the compliance review that the QA nurse and medical director were working on these data. Thus, it was evident that no review and analysis of this data had occurred for Round 6 or Round 7. Round 6 was completed in October 2012 and data should have been available for several months. Similar findings were noted during the August 2012 review. The facility had failed to conduct the reviews in accordance with state guidelines. Moreover, the appropriate data were not generated and provided to the monitoring team until the final day of the review. The monitoring team has previously commented on the need to develop a more robust review with greater focus on clinical outcomes in addition to processes. However, this was the second consecutive occurrence in which the facility could not demonstrate that it properly executed the existing review system. The facility director must ensure that the QA department submits the appropriate data to the medical department for review and analysis in a timely manner. Corrective actions	Noncompliance

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		targeting individual, systemic, and provider issues should be implemented. Achieving substantial compliance in this provision will require state office to address several issues with the medical reviews: • The current review should be expanded to include greater focus on clinical outcomes. • Reviews should be completed in accordance with state-issued guidelines. • The sample size must be adjusted for the external reviews because audits are completed twice a year instead of quarterly. • Compliance data should be provided to the medical department for review in a timely manner. • In addition to correction of individual specific issues, the aggregate data should be used to determine the presence of systemic issues and appropriate corrective actions implemented. <u>Mortality Management at SASSLC</u> Eight deaths occurred at SASSLC in 2012. There were five deaths since the last compliance review. Information for those deaths is summarized below: • The average age of death was 50 years with an age range of 34 to 63 years. • The causes of death were: (1) aspiration pneumonia (2) seizures, cardiac arrhythmia, and hypoxia (3) metastatic colon cancer, (4) acute congestive heart failure, and (5) pending cause of death • One autopsy was performed. • Three individuals died during hospitalization. The other two individuals were receiving hospice services. The monitoring team met with the facility director, medical director, QA nurse, and QA director to discuss mortality management at SASSLC. During the August 2012 review, there were significant concerns about mortality management at the facility, including problems related to the accuracy of the reviews and the lack of a system to ensure that recommendations were implemented. There appeared to be little progress in this very important process. The monitoring team was provided mortality documentation for onsite review and noticed a series of emails in which the QA nurse requested to be informed of the status of corrective actions. These emails were dated a few weeks prior to the review and clearly indicated that this information was required to avoid problems with the upcoming compliance review. The monitoring team was concerned with this finding because there was little evidence that the corrective actions were managed in an ongoing manner. Follow-up should have occurred in a systematic manner and not just prior to the review.	

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		Finally, there continued to be no organized format for mortality management once the various reviews were completed. There was also no analysis of longitudinal data to determine if there were trends, patterns, or systemic issues. The result was a system that was ineffective and failed to utilize information to effect changes that had the potential to positively impact care. Just as in the August 2012 meeting, facility staff indicated that these issues would be addressed. The monitoring team recommends that the facility director and medical director develop a plan to improve the process by which recommendations are implemented and followed-up.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	During the August 2012 compliance review, the monitoring team noted good progress in the development of the medical quality program through the development of the Medical Continuous Quality Improvement Program Committee. The committee was reviewing a mix of structural, process, and outcome indicators and four meetings had occurred. In addition to review of aggregate data, the committee was beginning to discuss individuals with specific problems, such as weight loss and actions relevant to specific individuals were documented. Although the process was in its infancy during the August 2012 review, there was evidence that a review of aggregate data was occurring in addition to providing a level of oversight and review for individuals who met the threshold for a more in depth assessment of medical care. The committee did not meet for several months, but was reinstated in February 2013. The monitoring team attended this meeting during the week of the compliance review. According to the medical director, the facility was still in the process of establishing the framework for this process. Several indicators were discussed, including emesis episodes, ER visits, hospitalizations, seizures, and weights. Other proposed indicators, such as 30-day re-hospitalization and osteoporosis were also discussed. Unlike the meeting attended during the August 2012 review, this meeting did not result in a clear actionable plan for any individual or system of care. This was discussed with facility staff during the review. Data collection and analysis are essential for any medical quality program. New databases for tracking care, such as preventive screenings and seizure disorders were implemented since the last review. Unfortunately, these data did not appear to be used in any meaningful manner. The medical director was not familiar with much of the data included in the self-assessment. He reported that the information was compiled by the former medical compliance nurse. The self-assessment presented information on individuals who lacked care, but the true compliance rates were not presented. As part of the overall quality efforts, the medical quality 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.	Noncompliance

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		The end goal of data collection and analysis is to have a positive impact on health care services. Data analysis should be an ongoing process and not just part of the preparation for compliance reviews. In addition to the CMQI program and medical audits, the facility completed a review of the 18 individuals diagnosed with diabetes mellitus. The quality of care provided to the individuals was assessed through the review of the HbA1c levels. For the individuals reviewed, it was documented that 72% had HbA1c within target range. The monitoring team encourages an expansion of this review to include additional process and outcome indicators that reflect the quality of medical care provided to the individuals. There should also be a plan for how deficiencies will be corrected and care will be improved. State-issued guidelines provided a number of indicators, as recommended by the American Diabetes Association, that could be useful in such a review. The committee will need to continue its efforts in developing a quality program. Such a program will require a mix of process and outcome indicators and include reviews of individual-specific data as well as aggregate data. The state-issued guidelines provided important indicators that should be considered for inclusion in the medical quality program. 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 development of such a program will assist the facility in monitoring and improving the services delivered. There was evidence that these efforts were ongoing at the time of the compliance review.	
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	State office issued a series of clinical guidelines and protocols on several medical conditions. Several of the guidelines were multidisciplinary and provided guidance to physicians, nurses, and direct care professionals. The facility medical services policy was revised and approved. The medical staff received training related to this policy. The presentation book included minutes from the medical staff meetings, which indicated that staff was present for discussions related to several issues, such as medical documentation, pneumonia, diabetes care, and the preventive care guidelines. The monitoring team requested evidence that all members of the medical staff had received training/inservice on all medical policies, procedures and protocols and was informed that no separate documentation existed. The monitoring team recommends that attendance records with signatures and training content be	Noncompliance

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	accepted professional standards of care with regard to this provision in a separate monitoring plan.	maintained for all training and inservices. During discussions with the medical director, he indicated that this provision required attention and policies were being reviewed along with clinical guidelines. Additional clinical indicators were also in development. The plan was to push this information out to the various disciplines once the various policies, procedures, and guidelines were developed and/or revised. This provision was found to be in noncompliance. 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. The monitoring team continues to encourage collaboration 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 work with the PCPs in streamlining the content of the AMAs and providing better plans for medical management. (L1).

2. Quarterly Medical Summaries should be completed by the primary care physicians in accordance with state issued medical policy (L1).

3. 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).

4. 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).

5. 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).

6. 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).

7. All individuals with refractory seizure disorder should be referred to a qualified epileptologist for evaluation. The facility should proceed with plans t implement an onsite seizure management clinic with a qualified epileptologist (L1).

8. 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).

9. 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)

10. The medical director should continue efforts in revising the clinical guidelines for the management of osteoporosis (L1).

11. 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).

12. The facility needs to address mortality management at SASSLC under the direction of state office:
    a. A through medical review should be completed by an outside physician. That review should produce a written report of the findings that is included in the Clinical Death Review.
    b. Recommendations should be made for any deficiencies that are identified.
    c. Committee members should meet periodically, perhaps quarterly, to formally review the status of all recommendations.
    d. The facility should conduct a periodic analysis of the longitudinal data looking for patterns, trends, and opportunities for improvement (L2).

13. 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).

14. 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).

15. 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.
    d. There should be a process for ensuring regular updates of all policies and procedures (L4)

16. The facility director or 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:** Documents Reviewed: o SASSLC Section M, Self-Assessment, Updated: 4/12/13 o SASSLC Section M, Action Plans, Updated: 4/15/13 o SASSLC Section M Presentation Book o SASSLC Nursing Organizational Chart o SASSLC Map of Campus o DADS Medication Reconciliation Guidelines, Revised: 2/26/13 o DADS Medication Variances Policy, Policy Number: 053 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 DADS Emergency Response Policy, Policy Number: 044.2, Effective Date: 9/7/11 o DADS Physical Nutritional Management, Policy Number: 012.3, Effective Date: 3/4/13 o SASSLC Nursing Coverage Guidelines, Standard Operating Procedure: 200-9-A (SSLC Policy Number 00.1), Revised: 3/6/13 o SASSLC Transfers for Medically Enhanced Supervision Guidelines, 300-7A, no date o SASSLC Direct Support Staff – Skin Integrity Guidelines, no date o SASSLC Pass Medication Guidelines, Revised: 12/18/12, and training roster of nurses trained, no date o SASSLC Facility Medical Services Policy, Standard Operating Procedure: 200-5A, Revised 12/28/11, and training roster for nurses, Date: 3/1/13 o SASSLC Medication Reconciliation Guidelines: Revised 2/26/13, and training roster for nurses trained, Dates: 12/20/12 and 2/27/13 o SASSLC Psychiatric Medication Guidelines – Side Effects Monitoring Instructions for Direct Support Personnel, Date: February 2013, and training roster of nurses trained, Date 2/27/13 o SASSLC Medication Variance Committee Training and training roster of nurses trained, Date: 2/28/13 o SASSLC Alphabetical list of individuals with current ISP, annual nursing assessment, and quarterly nursing assessment (due) dates o SASSLC 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 SASSLC List of individuals admitted within the last six months and dates of admission o SASSLC Nursing Department agenda for new nurse orientation o SASSLC Nursing Department curricula for new staff orientation, including training materials used o SASSLC Nursing Department schedule for ongoing in-service staff training o SASSLC Nursing Department curricula for ongoing in-services staff training, including training materials used, and signed training rosters

	o SASSLC List of Sample Monitoring Tools for: Nursing Care Monitoring, Protocol Monitoring Tools, and Medication Administration Practices Monitoring Tools o SASSLC Copies monthly raw data for the six Nursing Monitoring Tools and Medication Administration Observations, October 2012 through 2013 o SASSLC Section M, Quality Assurance Data Reports, October 2012 through January 2013 o SSLC Emergency Drill Instructor Training Curriculum o SASSLC Emergency Equipment Walkthrough Checklists, Emergency Drill Schedules, completed Emergency Drill Checklists, and Corrective Action, September 2012 through February 2013 o SSLC At Risk Training Curriculum for Integrated Risk Rating For and Integrated Health Care Plan Processes o SSLC Pre-ISP Meeting and Follow-up Training Curriculum, Dated: 10/30/12 o SASSLC Root Cause Analysis "The Basics" Training Curriculum for Analyzing Medication Variances, Revised: 8/3/12 o SASSLC Fishbone Cause and Effect Diagram in Response to a Medication Error, Modified: 8/6/12 o SASSLC Medication Administration, "Things to Remember" o SASSLC Medication Variance Committee Reports for: 10/19/12, 11/30/12, 2/28/13,and 3/25/13 o SASSLC Red Lining Procedure for 24 Hour Checks on Physician Order's o SASSLC Morning Report, Date: 4/30/13 and 5/1/13 o SASSLC for the Nursing Department: 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 SASSLC Lists identifying each individual who was identified "At Risk" utilizing the state's risk categories o SASSLC List for the past six months of individuals who were seen in the Emergency Room, including date seen and reason o SASSLC List for the past six months of individuals admitted to the hospital, including date of admission, reason for admission and discharge diagnosis(es), and date of discharge from hospital o SASSLC List for the past six months of 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 SASSLC List of individuals who were diagnosed with a decubitus/pressure ulcer during the past year, including date of onset, stage, location, and date of resolutions o SASSLC Nursing staffing reports/analysis generated in the last six months o SASSLC Minutes of the Infection Control Committee for: 3/28/13 o SASSLC Minutes of the Skin Integrity Committee Meeting for: 8/23/12 and 11/9/12 o SASSLC Minutes for the Quality Assurance and Nursing Meeting Minutes, 4/2/13 o SASSLC Minutes of Nursing Scheduling Meeting for: 11/13/12 o SASSLC Minutes of the Nursing Operations Meeting for: 11/8/12, 11/20/12, 11/27/12, 2/1/13 o SASSLC Minutes of the Nurse Manager Meeting for: 10/17/12, 11/12/12, 11/27/12, 12/6/12, 12/14/12, 1/15/13, and 3/28/13 o SASSLC Minutes of the RN Case Managers Meeting for: 11/14/12 (Sign-in Rosters for: 11/27/12,

	12/14/12, 2/11/12, 3/4/12, and 3/18/12 but no minutes were included.) o SASSLC Minutes of the Nurse Managers Medication Variance Committee Meeting for:11/30/12 o SASSLC Minutes of the Continuous Quality Improvement (CQI) for: 2/22/13 and 5/1/13 o SASSLC Minutes of the Morning Report – Clinical Services Meeting for: 4/3/13, 4/5/13, 4/15/13, 4/30/13, and 5/1/13 o SASSLC Minutes of the Pharmacy and Therapeutics Committee meetings for: 10/16/12, 11/13/12, 12/11/12, 1/8/13, 2/12/13, and 3/12/13 o SASSLC Minutes of the Medication Variance Committee meetings: 10/19/12, 11/30/12, 2/28/13 o SASSLC training curriculum, implementation of emergency procedures, including training materials o SASSLC Documentation of annual consideration or resuming oral intake for each SASSLC individual receiving enteral nutrition o SASSLC training curricula on Infection Control, including training materials for Scabies and MRSA contact precautions o SASSLC for the past six months, list of individuals who died at the facility or after being transferred to a hospital or other care setting o SASSLC for the past six months, mortality reviews and recommendations prepared by the Quality Assurance Department o SASSLC Nursing Department: Corrective Action Plans to address QI Death Review of Nursing Recommendations o SASSLC Nursing Department: Nursing Coverage Guidelines, Revised Date: 3/6/13 o SASSLC Nursing Department: Deployment of Nursing Staff Guidelines, Dated: 3/21/13 o SASSLC Environment of Care (EOC) Inspections Reports for: 2/20/13, 2/21/13, 2/22/13, 2/25/13 o SASSLC Hand Hygiene Surveillance Monitoring for March 2013 o SASSLC Employee Health Surveillance Reports for March 2013 o SASSLC Infection Data for the past six months o SASSLC Infection Control: Monthly Infection Control Report Guidelines, Draft, Dated: 5/2/13 o SASSLC Infection Control: Real-Time Monitoring of Communicable Disease Guidelines, Draft, Dated: 5/2/13 o SASSLC Power Point Presentation for Mock Medical Emergency Drills, Date: February 2013 o SASSLC Curriculum for New Employee Orientation Training - "Observing and Reporting Clinical Indicators" o SASSLC Nursing Administrative/Leadership Functional Job Descriptions, Draft, Dated: 5/2/13 o SASSLC Review of eight Acute Care Plans for six individuals recently or currently diagnosed with various types of active infections for: Individual #40, Individual #59, Individual #197, Individual #235, Individual #77, and Individual #311 o SASSLC Review of Records for Individuals Currently Hospitalized: Individual #60, Individual #254 o SASSLC Review of Community Living Discharge Plan Packets for five recently discharged individuals: Individual #123, Individual #131, Individual #245, Individual #51, and Individual #11 o SASSLC Comprehensive record reviews, including MARs/TARs, selected from the facility's At Risk List for high/medium risk rated individuals from across campus: Individual #87, Individual #239, Individual #36, Individual #164, Individual #99,Individual #384, Individual #69, Individual #134,

	Individual #198, Individual #235,Individual #254, Individual #93, Individual #256, Individual #277, Individual #15, Individual #318, Individual #325, Individual #311, Individual #300, Individual #197,Individual #225, and #40 People Interviewed: o Chief Nurse Executive, Soury Phanhthrath, RN o Nursing Operations Officer, Tasha, Oglesby, RN o Quality Assurance Nurse, Armandina Pena, RN o Program Compliance Nurse, Robert Zertuche, RN o Infection Control Nurse, Qiuhua "Ellen" Li, RN o Nurse Educator, Joe Gomez, RN o RN Case Manager Supervisor, Roseanne Boyd, RN o Hospital Liaison/Nurse Manager, Gayindria Collier, RN o Nurse Manager, Lola Faulkner, RN o Nurse Manager, Gabriella Szettella, RN o Physical Nutritional Management Nurse, Pat Delgado, RN o Medical Director, David V. Espino, MD o Pharmacy Director, Sharon Tramonte, PharmD o Informal interviews with numerous direct care nurses (LVNs and RNs) and direct support professionals (DSPs) Meeting Attended/Observations o Visited individuals residing on all units o Medication Administration Observations on selected units o Enteral Feedings Administration on selected units o 4/29/13 Pharmacy and Therapeutics Meeting o 4/30/13 and 5/1/13 Morning Report - Clinical Services Meeting o 4/30/13 QA/QI Meeting o 4/30/13 IMRT Meeting o 4/30/13 Medical CQI Meeting o 4/30/13 Pre-ISP Meeting for Individual #54 o 5/1/13 Morning Medical Meeting o 5/1/13 Infection Control/Skin Integrity Committee Meeting o 5/1/13 Nursing Operations Meeting o 5/1/13 Medication Variance Committee Meeting o 5/2/13 Mortality Review Meeting

	Facility Self-Assessment: For section M, in conducting its self-assessment, the facility: • Used the statewide facility self-assessment monitoring tools. The monitoring/audit tools the facility used to conduct its self-assessment included: Twelve Nursing Care Monitoring Tools, facility self-assessment Monitoring Tools for Medication Room and Medication Administration audits, and statewide Medication Administration Observation Tool. • These monitoring/audit tools included sufficient indicators to allow the facility to determine compliance with the Settlement Agreement. • The monitoring tools included sufficient methodologies, such as observations, interviews, record reviews to determine status of compliance with the respective monitoring processes. • The self-assessment did not identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number for percent of sample size of individuals/records as compared to the overall population was not included in the self-assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was provided by months, quarters, and overall percentage of compliance. Although this information was not provided, the facility had a formalized procedure for conducting monitoring and/or observing each tool. • The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools: The Chief Nurse Executive, Nursing Operations Officer, RN Nurse Case Manager Supervisor, and Quality Assurance Nurse. • Sufficient inter-rater reliability process had been established between the various facility staff responsible for the completion of the tools. • The facility used other relevant data sources, key indicators, and/or outcome measures. For example, databases/information systems showed the percentage of compliance with assessments, percent of nurses who had completed training classes, and number of pressure ulcers. The facility consistently presented data in a meaningful and useful way. Specifically, the facility's self-assessment: • Presented findings were consistently based on specific, measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress. The indicators clearly identified what was being measured or the criteria used for measurement. • Consistently measured the quality as well as presence of items. The facility's self-assessment stated they were not in compliance with Provisions M1, M2, M3, M4, M5, and M6; the monitoring team concurs with their findings.

	Summary of Monitor's Assessment: The monitoring team was pleased that, despite the complete turnover of the administrative and leadership staff, the recently hired and/or appointed Chief Nurse Executive, Nursing Operation Officer, Program Compliance Nurse, Nurse Educator, Infection Control Nurse, and RN Case Manager Supervisor had assumed their roles and responsibilities, were working diligently, and were highly motivated to re-establish the Nursing Department managerial and leadership team. In the interim period, some of the systems that were found to be making progress had slightly regressed. However, the CNE and leadership staff were well aware of these areas and were beginning to get back on track. The Infection Control Officer also had a Ph.D. in microbiology and was well underway in strengthening the Infection Control Program. At the present time, she was also serving as the Skin Integrity Nurse. She was re-establishing the Infection Control Committee to include skin integrity issues. Considering the short length of time the Infection Control Officer had been on board, she had already begun to make significant progress in revamping the Infection Control Program. The Program Compliance Officer was working collaboratively with all nursing staff to enhance compliance with all of the section M provisions. The Nurse Educator was also revamping the Nursing Education Program. The RN Case Manager Supervisor was working closely with the RN Case Manager to ensure the timeliness and the quality for the annual and quarterly nursing assessments, as well as their day to day responsibilities. The Nursing Department was in the process of interviewing for the Hospital Liaison Nurse Position. When this position is filled, the Nursing Department should have a complete leadership team. The Nursing Department continued to maintain good working relationships with other departments, most notably the pharmacy, medical quality assurance, and psychiatry departments. The results of the facility's self-assessments, audits, and monitoring tools showed the need for continued improvement across all provisions of section M, most particularly in provisions M3 and M5, which relate to nursing assessment and care planning. In M6, much progress was needed to decrease the number of unreconciled medications and the reporting of medication variances.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the	<u>Monitoring Team Findings</u> The monitoring team validated the information presented in the facility's self-assessment through: Independent review of the information presented in Section M, Provision M1 Presentation Book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, Hospital Liaison Nurse, Infection Control Officer, RN Case Manager Supervisor, Nurse Managers, Direct Care Nurses, and Medical Director; Review of individuals' records; Observations of individuals on the units, and Attendance at the Morning Clinical Meetings and Continuous Quality Improvement Meeting. Relevant self-assessment data	Noncompliance

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	individuals' health care status sufficient to readily identify changes in status.	were updated during the onsite compliance visit. Refer to Section L, Provision L2 for a report on mortality reviews. The facility's self-assessment stated they were not in substantial compliance with Provision M1 and the Monitoring team concurred. The facility's self-assessment for this provision reported the following results: • For the past fiscal year, all 12 Nursing Monitoring Tools were completed for a monthly average of 24 per month. Data systems were in place to track and trend compliance by each respective tool, home, and individual nurse responsible for identified deficiencies. • The average results of the Acute Illness and Injury Monitoring Tools from 10/1/12 through 12/30/12 showed improvement as evidenced by 88% compliance. • The Documentation Monitoring Tools for October 2012 through December 2012 showed 57% compliance. As of December 2012, 46 of 72 (64%) direct care nurses had passed the Documentation Class provided by the State Office Nurse Practitioners. • The Infection Control Officer (ICO) Position was vacant for five months, but had since been filled. The ICO conducted Environment of Care Rounds (EOC) on all homes monthly and developed corrective actions with follow-up as needed. The Infection Control Committee tracked all corrective actions to resolution. • The current Skin Integrity Program had been halted due to the Skin Integrity Nurse vacancy. The Nursing Department included Skin Integrity Data within the Infection Control Committee Meetings. Also see M5 below. • The Hospitalization Reports revealed that four of six (67%) records reviewed contained Discharge Plans and Daily Hospitalization Reports. • The Nursing Department had maintained the minimum staffing requirements, except for two isolated occurrences. • Identified issues were brought to the interdisciplinary team through the use of the On Duty RN (ODRN) who provided reports at the Morning Clinical Services meeting to ensure concerns were followed through to resolution. The results of the facility's self-assessment for this provision were relatively consistent with the monitoring team's findings, reported below. This Provision of the Settlement Agreement includes a number of requirements that addresses various areas of compliance. These requirements include staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, skin integrity, and emergency response system. Additional information regarding the nursing assessments, and health care plans are found below in M2, M3, and M5.	

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		Monitoring Team's Findings: Staffing, Structure, and Supervision: At the time of the review, the facility census was 262. There were a total of 109 budgeted nursing positions, of which, 103 positions were filled and six unfilled. There were 51 RN positions budgeted, with four RN vacancies and two LVN vacancies. The Nursing Department was using the Preceptor Program to facilitate retention of nursing staff. Agency nurses were not used. Since the last review, there had been significant turnovers and/or changes to all of the Nursing Department's administrative/leadership staff. The changes included recently appointed/hired Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, Infection Control Officer, RN Case Manager Supervisor, and two Nurse Managers. The Hospital Liaison Nurse was changing positions to become a Nurse Manager and was performing in both positions until another Hospital Liaison Nurse was hired. Interviews were being conducted for this position. They no longer had a Skin Integrity Nurse. This responsibility was being shared with the Infection Control Officer. The Nursing Department's organizational chart showed the following recent changes to the nursing administrative structure. The creation of a RN Case Manager Supervisor who supervises the RN Case Managers. The Nurse Managers directly supervised all direct care RNs, LVNs, and Campus RNS. This was a positive step forward, which should result in closer oversight and supervision of the RN Case Managers and direct care nursing staff. Despite the significant turnover and changes in administrative/leadership staff, the monitoring team's interviews with these staff demonstrated a high degree of dedication and motivation to provide quality nursing services and to meet compliance with the Settlement Agreement, as well as re-establishing the Nursing Departmental managerial and leadership team. No doubt the turnovers and changes in administrative/leadership staff hampered the Nursing Department's ability to move forward toward compliance in all of Section M Provisions, as reported in the last compliance review. This impediment as was evident throughout all the facility's self-assessment of the provisions, as well as throughout the monitoring team's review of Section M Provisions. Administrative/leadership staff, they were able to verbalize and explain their roles and responsibilities for their areas of expertise. None, however, had a formalized functional job description beyond the original state job description completed at the time of hiring. However, before the end of the compliance review, all administrative/leadership staff provided the monitoring team with written drafts of their functional job description relating to actual routine roles and responsibilities. The CNE will continue to work with	

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		staff to refine their job descriptions to ensure all of their roles and responsibilities are clearly delineated. In addition, the CNE expressed the lack of accountability experienced by some staff, particularly the RN Case Managers. It is essential that all nursing staff have functional job descriptions that provide a clear understanding of their roles and responsibilities, that they are sufficiently trained, mentored through the learning process, and receive periodic positive performance evaluations. The monitoring team will follow-up at the next compliance review on finalized functional job descriptions for all levels of nursing staff. The monitoring team's review of the nursing minimum established staffing patterns data found that building 670 fell below the minimum staffing on 3/3/13 (shift not indicated) because they only had one nurse. The other scheduled nurse was pulled to another building. Building 673 fell below minimum staffing on 3/11/13, day shift, and on 3/29/13, day shift. There was no explanation for the shortage on these dates. <u>Record Keeping and Documentation:</u> The monitoring team's comprehensive review of 21 records found: • Current ISPs, Integrated Risk Rating Forms, and Integrated Health Care Plans were frequently not found in the unified records. • Documentation errors were not consistently corrected according to generally accepted documentation standards of practice. • Documentation entries were occasionally written below the last line of the page. • Handwritten documentation was frequently illegible, particularly staffs' signatures and titles. • Documentation of the nursing staff continued to be primarily written in Subjective, Objective (data), Analysis, and Plan) SOAP format. • As was found in previous review, regardless of the individuals' condition that was continued to be monitored the nursing staff continue to use catch phrases, such as "will continue to monitor or will follow-up PRN." <u>Documentation and Assessment of Acute Change in Health Status:</u> Since the last compliance review, it was positive to find that the facility made progress by continuing and/or initiating various activities to enhance the assessment and management of individuals with acute change in status, as well as to identify and track trends through clinical indicators for individuals served. These activities included, but were not limited to the following activities: • Morning Report – Clinical Services Meetings had become more integrated across all clinical disciplines, which included, though was not limited to: Medical	

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		Director, Physicians, Pharmacy Director, Chief Nurse Executive, Nursing Operations Officer, On Duty RN, Hospital Liaison Nurse, Psychiatrists, Physical Nutritionist Management Team Nurse, Dietitian, Dentist, and other relevant supportive living staff when indicated. The On Duty RN compiled the reports. Topics sin the morning reports expanded to include, but were not limited to: o Psychology reports on individuals who experienced maladaptive behavioral incidents. o Medical review of individuals with changes in health status, which included treatment and follow-up, if indicated, as well as hospitalization/emergency room visits and disposition of their status. o Individuals who experienced seizure activity were reported and treatment provided, if required. o Respiratory Therapist reports, if any were reported. o Individuals who had clinical issues requiring follow-up were reviewed and discussed. The issues requiring follow-up were identified, as well as action steps required identified, and responsible staff were assigned to follow-up. o Administrative issues requiring follow-up were identified, actions steps were determined, and responsible staff were assigned to follow-up. o Individuals who required urgent consults were identified. o Weekly Enrollment Reports were reviewed, which included daily census, discharges, pending discharges, and admissions. o Community Placement Follow-up Reports were reviewed and discussed when indicated. • The recently hired Medical Director had established a Continuous Quality Improvement Committee (CQI) in February 2013 for the purpose of identifying clinical indicators unique to the facility. The Committee was chaired by the Medical Director. The Committee's core membership was comprised of integrated clinical disciplines, which included the Physicians, Dentist, Physical Nutritional Management Director, Pharmacy Director, Dentist, Chief Nurse Executive, Program Compliance Nurse, Quality Assurance Nurse, Infection Control Officer, and others when indicated. Established clinical indicators to date included emesis episodes, emergency room visits, hospitalizations, injurious falls, seizures, and weights. Clinical indicators under discussion included osteoporosis and 30-day re-hospitalizations. Clinical indicators to be developed included dental hygiene or other dental indicators, constipation, dehydration, decubitus ulcers, psychiatry indicators, aspiration pneumonia, and others when identified. CQI Indicator Matrix was developed to measure each identified indicator with the responsible discipline assigned. • The Nursing Department maintained an excellent working relationship with the Medical Department, Pharmacy Department Quality Assurance Department, and	

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		Psychiatry Department. o For example, during the 5/30/13 Morning Clinical meeting, one of the physicians stated the nurse told him that Individual #60 was not looking right, but there were no abnormal assessment values to indicate otherwise. He stated Individual #60 did not look any different to him, but based on the nurse's observation, he sent Individual #60 to the hospital, where she was admitted and treated for a UTI. • The Nursing Department had recently developed and implemented a "Hot-Chart" system facility-wide to monitor and document identified change of status of individuals, which provided a holistic approach to follow-up through to resolution for changes in individuals' conditions. • The Nursing Department had continued to try to strengthen the integration of nursing services with other disciplines through interfacing with other clinical service providers, Incident Management Teams, Hospital Liaison Nurse communication with other IDTs regarding hospitalized individuals, providing/training Direct Care Professionals on individuals' health care plans, collaboration and coordination with the Pharmacy Department on reconciliation of medication, and collaboration with the QA Department on Nursing Care Monitoring Tools and Protocol Monitoring Tools. Also, there was integration with Home Management Teams, participation by the RN Case Managers with the IDTs at ISP and ISPA meetings, Infection Control Committee Meetings, On Duty RN Reports, and various other meetings where nursing staff were involved. <u>Infirmary:</u> As reported in previous reports, the facility did not have a dedicated Infirmary. However, they continued to use unit 673 for temporary stays for individuals who required enhanced medical monitoring or required isolation on a time-limited basis. At the last compliance review, the facility had drafted a policy for Transfers for Medically Enhanced Supervision along with a Home to Home Checklist. However, there was no documented evidence provided to the monitoring team that validated that this policy was implemented. Perhaps, this was dropped because of the turnover in the administrative staff. This issue should be reviewed at the next compliance review. <u>Hospitalizations/Emergency Room Visits and Hospital Liaison Activities:</u> At the time of the compliance review, the Hospital Liaison Nurse had taken the position of a Nurse Manager, but was still covering hospital liaison activities. The Nursing Department was in the process of interviewing applicants for her position. There was no back up nurse to assist with performing these activities, either through the work week or on the weekend. The former Hospital Liaison Nurse provided the monitoring team with a detailed functional job description. Hopefully, it will be provided to the next Hospital Liaison Nurse, which should help him or her with quickly picking up on the day to day	

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		duties and responsibilities. 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." The monitoring team reviewed seven individuals who were hospitalized or sent to the emergency room over the past three months. There was general improvement found in the nurses' response to Hospitalizations/Emergency Room Visits and Hospital Liaison Activities. Six of seven (86%) of the individuals' with acute change in health status received a focus nursing assessment of their chief complaints and their primary care providers were promptly notified of the finding. In seven of seven (100%) individuals, the Nursing Hospitalization, Transfer, and Discharge Policy were followed. • According to the IPNs, Individual #277 had coughing episodes with face turning red, particularly after eating on 3/22/13 and 4/2/13. The nurses conducted a focused assessment according to the Aspiration Protocol, but did not follow-up for 48 hours or notify the physician for PNMT. He had an episode of vomiting on 4/10/13 for which the nurse completed a focused assessment according to the Vomiting Protocol, but did not follow-up for 48 hours or notify the physician. On 4/19/13, he had another episode of choking and coughing after meals. The nurse completed a focused assessment according to the Aspiration Protocol. The nurse reported she thought he was aspirating while eating and drinking, however, neither the physician nor PNMT were not notified. On 4/20/13, he had another episode of coughing with face turning red. The plan was to monitor and notify the primary care provided during rounds on 4/22/13. He was not monitored or assessed again until the primary care provider saw him on 4/22/13 at 11:06 a.m. He was diagnosed with bronchitis and ordered a pureed diet, modified barium swallow studies, and nebulizer treatment. On 4/22/13 at 4:51 p.m., he exhibited signs and symptom of respiratory distress with oxygen saturation levels dropping to 84%, requiring three liters of oxygen. He was immediately sent to the hospital and admitted with aspiration pneumonia. Individual #277 was discharged home on 4/30/13. The nursing staff should have been more proactive in following the Aspiration and Vomiting Protocols and in notifying the primary care provider and PNMT when he began having	

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		coughing episodes and was suspected of aspirating after meals. There was documentation that the Hospital Liaison Nurse and/or the RN Case Manager visited or contacted the hospital personnel daily, 4/23/13 through 4/30/13 and kept the IDT apprised of his health status throughout his hospital stay. It was positive to find that the Nursing Hospitalization/Emergency Room, Transfer, and Discharge Policy were followed. • Individual #254 was admitted to the hospital on 4/12/13, and diagnosed with hyponatremia, distended abdomen, and constipation. He remained in the hospital until 4/30/13. A review of the Hospital Liaison Nurse Reports and Integrated Progress Notes found that either the Hospital Liaison or Nurse Case Manager contacted hospital personnel daily throughout his hospital stay. It was positive to find that the Nursing Hospitalization/Emergency Room, Transfer, and Discharge Policy were followed. • Individual #311 was admitted on 2/1/13, and diagnosed with hypoxia, bradycardia, and pneumonia. He remained in the hospital until 2/6/13. A review of the Hospital Liaison Nurse Reports and Integrated Progress Notes found that the Hospital Liaison Nurse contacted hospital personnel three days out of five days during his hospital stay. It was positive to find that the Nursing Hospitalization/Emergency Room, Transfer, and Discharge Policy were followed. • Individual #164 was admitted to the hospital on 3/12/13, and diagnosed with aspiration pneumonia. He was discharged on 3/19/13. A review of the Hospital Liaison Nurse Reports and Integrated Progress Notes found contacted that the Hospital Liaison Nurse hospital personnel five days out of seven days during his hospital stay. It was positive to find that the Nursing Hospitalization, Transfer, and Discharge Policy were followed. • Individual #318, Individual #254, and Individual #235 were seen in the emergency room for minor health condition during the last three months. It was positive to find that the primary care providers were promptly notified of the onset of their complaints. In all cases it was positive to find that the Nursing Hospitalization/Emergency Room, Transfer, and Discharge Policy were followed. The Nursing Department should ensure that individuals with an acute change in health status receive a focus assessment of the affected body system, that relevant nursing protocols are followed through to resolution and incorporated into their acute care plans.	

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		Infection Control and Skin Integrity Activities: The Infection Control Officer position was vacated from 11/1/12 through 1/31/13. The position was filled on 2/1/13. It was positive to find that the new Infection Control Officer (RN) also had a Ph.D. in Microbiology, which should further enhance her ability to organized and manage the Infection Control Program. It was apparent through interview, observation, and review of infection control data that the Infection Control Officer was diligently beginning to make progress in reorganizing and managing the Infection Control Program. Since the Skin Integrity Nurse position was vacant, she had also assumed responsibility for managing skin integrity issues. Regarding Monthly Infection Control Committee Meetings, minutes from the last compliance review until this meeting were not provided for review. Therefore, it could not be determined if committee meetings were conducted. Beginning 5/1/13, skin integrity issues were included in the Infection Control Committee meetings. The last Skin Integrity Committee meeting minutes provided for review was on 11/9/12. The monitoring team's review of the 3/28/13, Infection Control Committee Minutes and attendance at the 5/1/13 Infection Control/Skin Integrity Committee Meeting demonstrated that pertinent and relevant infection control and skin integrity issues were sufficiently reported, discussed with conclusions, recommendations, expected outcomes, and required follow-up assigned to the respective discipline/department. Topics covered and reports of results/findings included: • Review of the Infection Control section of the Settlement Agreement. • Review of February 2013 Infectious and Communicable Reports by homes and facility-wide. The Infection Control Officer should track, analyze, and trend infectious and communicable disease data monthly and longitudinally to identify local and systemic trends. • Review of results of Infection Control Monitoring for Environmental of Care inspections of the homes; Hand washing monitoring; Employee health surveillance; Introduction of new forms for weekly infection control reports, contact precaution signs, and employee health; Disposal of Biohazard bags; and Antibiogram. In addition, the results of the Environmental of Care inspections of the homes; hand washing monitoring data were presented, discussed along with the disposition of corrective actions and follow-up taken on deficiencies identified on both issues to promote and prevent the spread of infections. • Reviewed decubitus/pressure sore data report for the past year. It was positive to find the progress made by the Infection Control Officer and Program Compliance Nurse, who had developed and implemented a robust Pressure Ulcer Tracking Log for tracking monthly and longitudinal data, which included: The Total Pressure Ulcers Facility vs. Community (Facility Totals per Home and	

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		Total Facility and Hospital Acquired); Total Number of Individuals with Pressure Ulcers; Total Pressure Ulcers by Stage (Stage I through IV and Unstageable); Monthly Census Pressure Ulcer Rates per Month for Facility Acquired vs. Hospital Acquired. The data were represented by tabular chart, line graph, bar charts, and pie charts. The longitudinal pressure ulcer data for June 2012 through March 2013 showed: o 33% of pressure ulcers were Stage I o 47% of pressure ulcers were Stage II o 20% were unstageable o The facility goal should be zero tolerance for the occurrence of decubitus/pressure ulcers, unless an individual was diagnosed with a Kennedy ulcer. • Drafted Monthly Infection Control Report Guidelines to provide a summary report of infection cases for the facility, so that the data could be used to identify possible trends and to control and prevent infectious diseases. • Drafted Real-Time Monitoring of Communicable Disease to control and prevent the spread of communicable disease in a timely manner. The guidelines included, but were not limited to procedure for daily reports for all infectious diseases from the ODRN reports, nursing reports, lab cultures results, Hospital Liaison Nurse reports, and transfer back from hospital facility documentation. • An Immunization Database was provided for individuals' status on Hepatitis A vaccinations. However, a database was not provided that included the status of all other required vaccinations (e.g., Tuberculosis Skin Tests, converters screening follow-up, seasonal Influenza vaccinations). The Infection Control Nurse should ensure that an up-to-date database/information system is used to track all vaccinations and is readily accessible to clinicians to use for keeping individuals' vaccinations up to date. • An Employee Health Database was maintained for the monthly status for new employee Tuberculosis Skin Testing and Hepatitis B vaccinations, as well as for current employees. In addition, employee injuries and illnesses related to infectious diseases were tracked. • Employees with infectious/communicable diseases were tracked and interventions taken to prevent their spread. The Infection Control documents provided for review, stated there were no reportable employee communicable diseases since the last compliance review. • The status of new employees and current employees' trained on Infection Control Measures was not included for review. It is essential that the Infection Control Officer ensure all new employees are trained on Infection Control Measures during New Employee Orientation and that current employees receive annual refresher training.	

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		Considering the length of time the Infection Control Officer had been on duty, she appeared to be well underway with evolving into her role and responsibilities. The monitoring team's review and observation of three individuals (Individual #325, Individual #236, and Individuals #311) with pressure ulcers found: • Individual #235 was rated at high risk for constipation and skin integrity. The monitoring team accompanied by the unit Nurse Manager and direct care nurse observed Individual #235's stage II pressure ulcer of coccyx, which appeared healing and free from infection. The direct care nurse performed wound care and dressing change according to accepted standards of care. Individual #235 was provided privacy and treated respectfully during the observations. The direct support staff was asked about his positioning program. When reviewing his positioning plan he was to be repositioned every hour. His positioning sheet for the day was not in the notebook. Individual #235 appeared severely underweight and dehydrated. The Nurse Manager stated that his weight had been of concern and the IDT had suggested the insertion of a G-tube, but the family refused. She said he was a very slow eater. It was of concern that G-tube insertion would be considered if his only problem was that it took him a long time to eat and that he required much assistance. Review of the March 2013 Dining Records (April 2013 was requested, but only March 2013 was provided) indicated that on the average he only consumed 59% of his daily meals and snacks, and 72% of his required fluid intake including meals, snacks, and at other times. His weight in December 2010 was 113 pounds, in March 2012 was 104 pound, and in March 2013 was 84.5 pounds. This represented a 19% weight loss in one year and since December 2012 a total weight loss of 25%. After the monitoring team's observation, Individual #235 was sent to the emergency room and diagnosed with constipation and dehydration. The IDT met after the emergency room visit and developed a plan to provide him six small meals per day, and to provide a one to one staff to assist with meals. • The monitoring team, accompanied by the unit Nurse Manager and direct care nurse, observed Individual #311's stage II pressure ulcer of coccyx, which appeared healing and free from infection. The direct care nurse performed wound care and dressing change according to accepted standards of care. Individual #311 was provided privacy and treated respectfully during the observations. The nursing staff stated that they had been trying to get an airflow mattress for him but there was difficulty in getting CMS to approve coverage. However, the next day an airflow mattress was provided and placed on his bed. • The monitoring team accompanied by the unit Nurse Manager and direct care	

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nurse observed Individual #236 Stage I pressure ulcer of right toe, which appeared healing and free from infection. The direct care nurse performed wound care and dressing change according to accepted standards of care. Individual #236 was provided privacy and treated respectfully.

The monitoring team's review of the three individuals' IPNs found that there was sufficient assessment and treatment of the pressure ulcers. However, the standardized Pressure Ulcer Scale for Healing (PUSH) method was not used. This was discussed with the Infection Control Office who will follow-up to ensure this is implemented. The use of the PUSH method will be assessed at the next compliance review.

Quality Assurance Activities:

The Program Compliance Nurse worked with the Nursing Department and Quality Assurance Department in coordinating quality assurance activities on the Nursing Care Monitoring Tools and other related monitoring/auditing activities. It was fortunate that the Program Compliance Nurse also had an Information Technology back ground and did an outstanding job of presenting the monitoring data in various graphic and color code charts, which were easy to read and understand.

The QA Nurse identified clinical problem areas in consultation with the CNE and NOO and provided assistance in correcting deficiencies. She was a member of the Medication Variance, Pharmacy and Therapeutics, Infection Control, Medical CQI, PIT, and Pneumonia Committees and served on the Peer Review/Mock Survey Team.

Until February 2013, the 12 Nursing Care Monitoring Tools were used. The results of the third and fourth quarters of 2012, for the overall percentages of compliance for each of the 12 Nursing Care Monitoring Tools showed the following:

Nursing Care Monitoring Tools	Third Quarter 2012	Fourth Quarter 2012
Nursing Care Plans	76.72%	61.00%
Management of Chronic Respiratory Distress	92.28%	60.67%
Medication Administration and Documentation	97.33%	96.00%
Nursing Care Documentation	73.89%	57.00%
Annual/Quarterly Nursing Assessments	97.67%	91.00%
Acute Illness and Injury	95.50%	87.67%
Urgent Care/ER Visits, and Hospitalizations	50.33%	None recorded
Prevention	92.17%	81.00%
Skin Integrity	82.17%	97.00%
Infection Control	89.67%	79.33%
Seizure Management	63.00%	70.67%
Pain Management	76.33%	66.67%
Total overall Percentage of Compliance	82.26%	77.09%

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		As the data above show, the consistently low percentage of compliance of some of the Nursing Care Monitoring Tools was of significant concern, particularly since these tools had been in use for at least the past three years. It was reported that the QA Department had not yet implemented Corrective Action Plans. With the exception of documentation found by the RN Case Manager Supervisor to improve the outcome of the Annual Quarterly Nursing Assessments, there were no or little significant efforts to validate improvements in the outcome of the other monitoring tools that fell below 80%. As of February 2013, the Nursing Care Monitoring Tools were revised and reduced to six, which were Annual Nursing Assessments, Urgent Care/ER/Hospitalizations, Skin Integrity, Pain Management, Infection Control, and Nursing Care plans. According to the Quality Assurance and Nursing Meeting minutes, 4/2/13, the decision was made as to which Nursing Care Monitoring Tools and Protocol Monitoring Tools would be used. It was decided the new process implemented for the QA Nurse and Nursing Department would be to monitor four Nursing Care Tools (Nursing Care Plans/Acute Care Plans, Timeliness of the Quarterly Nursing Assessment, Infection Control, and Pain Management) and four Protocol Audit Tools (Documentation, Head Injuries, Temperature Elevation, and Constipation). At the time of this review, limited data were available for review on the new tools monitored. The monitoring team will follow-up at the next compliance review when more data are available to review for compliance with the revised/reduced Nursing Monitoring Tools and Protocol Audit Tools. It is essential that the QA Department and Nursing Department continue to analyze contributing factors that cause monitoring tools to fall below 80% (or desired threshold) and to take local and systemic corrective actions to improve the percentage of compliance. The monitoring team's review of Inter-rater Reliability Checks performed by the QA Nurse found that they were performed monthly on two to four of the individuals monitored on the various monitoring tools, but did not provide the overall percentage of agreement between the QA Nurse and the Nursing Department on a quarterly basis. Therefore, the overall status of agreement between the QA Nurse and the Nursing Department could not be determined. In order to measure the accuracy of the monitoring completed by the Nursing Department it is essential that overall levels of agreement between the two sets of monitors are calculated for an overall monthly/quarterly percentage. The Inter-rater Reliability checks should include the corresponding overall percentage of agreement between the QA Nurse and Nursing Department along with the various nursing quarterly monitoring tool data.	

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		Emergency Response Activities: The monitoring team's review of the facility's Emergency Response System data and observations for the last six months showed: • Emergency Drills were scheduled monthly and all were completed as scheduled. The completed Emergency Drill Checklist sheets indicated whether drills were passed or failed. There was documentation on the failed drills describing why the drills failed and the "on the spot" corrective actions taken. A review of the completed drill checklists showed improvement in the participation by the nursing staff. For example, the February 2013, Emergency Drill Power Point Presentation showed: o Facility-wide, 13 drills were conducted, of which 10 (77%) received passing scores and three drills failed, in homes 665, 670, and 673. The causes of failed drills were listed as Home 665 failed due to equipment not brought to the scene, Home 673, failed due to incorrect Cardiopulmonary Resuscitation (CPR) procedures performed by the nurse, and Home 670 failed due to lack of staff response. The Emergency Drills passing scores showed a low overall compliance score of 77%, which indicated the need for continued improvement in the staffs' performance on the drills. o The monthly results of the Emergency Drill Reports were presented to the Incident Management (IMT) and Quality Assurance Department for further review and disposition, per policy. • The Monthly Emergency Equipment Walkthrough Checklists for all areas where emergency equipment was located were completed. Any corrective action taken was documented. • The Competency, Training, and Development (CTD) Training Report indicated that all staff required to take the CPR for Healthcare Providers and Basic CPR Training were current. • The Monthly Emergency Equipment and Automated External Defibrillator (AED) Checklist sheets completed daily by the nursing staff were not made available for review. • The monitoring team's observations on the homes found: The location of all emergency equipment and AEDs were clearly labeled and readily accessible to staff. All required equipment and AEDs were present and in good working. The nursing staffs observed were able to successfully operate the emergency equipment and AEDs.	

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M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The monitoring team validated the information presented in the facility's self-assessment through: Independent review of the information presented in Section M, Provision M2 Presentation book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, QA Nurse, RN Case Manager Supervisor, Nurse Managers, and Direct Care Nurses; Review of individuals' records; Observations of individuals on the units, and Attendance at the Morning Clinical Meetings and Continuous Quality Improvement Meeting. Relevant self-assessment data were updated during the onsite compliance visit. The facility's self-assessment stated they were not in substantial compliance with Provision M2 and the monitoring team concurred. The facility's self-assessment for this provision reported the following results: • Timeliness of submission of the Annual/Quarterly Comprehensive Nursing Assessments had maintained over 80% compliance for 10/1/12 through 2/1/13. • The Annual/Quarterly Comprehensive Nursing Assessments and Health Maintenance Plans (HMPs) Monitoring Tools for the months October 2012 through December 2012 showed improvement as evidenced by meeting 91% compliance. However, nursing assessments revealed that revisions to the assessment were not added to the document and, thus, were not individualized. • The baseline compliance for the quality of the Annual/Quarterly Comprehensive Nursing Assessments for the months of October 2012 through December 2012 was October 2012, 31%, November 2012, 91%, and December 2012, 75%. • Evaluations for all submitted Annual/Quarterly Comprehensive Nursing Assessments for January 2013 showed 93.75% compliance. • The Nursing Discharge Summaries revealed that appropriate data information was captured to facilitate a smooth transition into the community and/or receiving facility 100% of the time. • Based on the above self-assessment findings, the facility determined this provision was not in compliance due to the continued lack of individualization, revisions, and failure to meet key quality indicators. The results of the facility's self-assessment for this provision were relatively consistent with the monitoring team's findings, reported below. However, it was not clear to the monitoring team what or how "quality indicators" were measured. <u>Monitoring Team's Findings:</u> The monitoring team's interview with the recently appointed/hired RN Case Manager Supervisor and the Quality Assurance Nurse, as well as review of supporting documentation provided, that they were diligently reviewing and working with the RN	Noncompliance

#	Provision	Assessment of Status	Compliance
		Case Managers on the Admission/Annual/Quarterly Comprehensive Nursing Assessment to improve the content and quality of the assessments, as well as meeting the Settlement Agreement and Health Care Guideline requirements for this Provision. The Nursing Department was using "quality indicators" as a means to improve the content and quality of the nursing assessments, however, these indicators were not described. Forty one percent of the RN Case Managers/RNs were reported to have completed the mandated Physical Assessment Class and 41% had completed the RN to RN Check-offs, with 9% having completed the unit Check-Offs. Reportedly, the Nurse Educator will complete the remaining incumbent RNs. The Physical Assessment Class will be taught to RNs in New Nurse Orientation. As reported in the facility's self-assessment: Nursing Care Annual/Quarterly Comprehensive Nursing Monitoring Tools Assessments showed 98% compliance for the Third Quarter 2012, 91% for the Fourth Quarter 2012, and 94% for January 2013. The final monitoring data for February 2013 through April 2013 were not available for review. The overall corresponding inter-rater reliability percentage of agreement between the Nursing Department monitors and the Quality Assurance Nurse was not included. In addition, the RN Case Manager Supervisor had continued to work with the RN Case Manager to achieve 100% compliance with the timeliness of completing Annual/Quarterly Comprehensive Nursing Assessments. Throughout the monitoring team's numerous tours in and out of most of the units, there was a general lack of visibility of the RN Case Managers in the units, with the exception of two of the 15 RN Case Managers. One RN Case Manager who was on home 668 actively engaged with individuals and the nursing staff and there was another RN Case Manager in the nursing office completing paperwork. The lack of visibility on the units was discussed with the RN Case Manager Supervisor, who explained that the state guidelines for RN Case Managers stated that they were not to provide RN coverage for the units/campus on any shift, not to be scheduled to work or provide RN coverage for the units/campus on weekends or holidays, not to works as a campus RN, RN supervisor or Officer on Duty, and not to provide supervision to other nurses. These preclusions were understandable if they were to have sufficient time to devote to the routine case management responsibilities, however, this should not preclude the RN Case Managers from making routine rounds on their respective units to observe individuals on their caseloads, to attend/review the unit nursing shift reports, and make rounds with the attending primary care providers (PCPs) when possible in order to consistently stay abreast of individuals' chronic and acute health conditions.	

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		The monitoring team reviewed 21 individuals' most recently completed Annual and/or Quarterly Comprehensive Nursing Assessments, selected from the facility's At Risk List for high/medium risk rated individuals across campus. A monitoring tool was used that was comparable to the monitoring tool used by the Nursing Department. It was positive to find that the overall content and quality of the nursing assessments showed improvement from previous reviews. Some of the nursing assessments showed more improvement in the content and quality than others, which may be attributable to those RN Case Managers who had completed the mandated Physical Assessment Class, competency-based check offs, and the increased oversight by the RN Case Manager Supervisor. However, there was a need for improvement in essential components contained on the Annual/Quarterly Nursing Assessment Tool, as described below. The monitoring team's review of the nursing assessment found an overall compliance of 93%, which was relatively consistent with the facility self-assessment's overall percentage of compliance for January 2013. However, there were essential items that fell below 90% and require continued improvement. Those essential items were: • Eighteen of 21 (86%) Annual and/or Quarterly Comprehensive Nursing Assessments were completed according to the facility's ISP schedule. • Seventeen of 21 (81%) Annual and/or Quarterly Comprehensive Nursing Assessments included individuals current active medical diagnoses. • Eighteen of 21 (86%) Annual and/or Quarterly Comprehensive Nursing Assessments included all current Nursing Problems/Diagnoses for individuals rated at high and/or medium risk conditions, as well as health conditions that might not be rated as high or medium risk that required continuous nursing assessments, monitoring, and interventions. • Fourteen of 21 (67%) Annual and/or Quarterly Comprehensive Nursing Assessments indicated whether health care plans were implemented for individuals' Nursing Problems/Diagnoses rated at high and/or medium risk conditions as well as health conditions that might not be rated as high or medium risks that required continuous nursing assessments, monitoring, and interventions. • Fifteen of 21 (71%) Annual and/or Quarterly Comprehensive Nursing Assessments' overall nursing summaries sufficiently summarized individuals' health status in relation to the identified Nursing Problems/Diagnoses as to whether their health conditions were improving, maintaining, or regressing, as well as the effectiveness of their health care plans. See M3 regarding Health Management Plans, Integrated Health Care Plans, and for Nursing Summaries and Plans and associated Community Living Discharge Plans.	

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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.	The monitoring team validated the information presented in the facility's self-assessment through: Independent review of the information presented in Section M, Provision M3 Presentation Book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, QA Nurse, RN Case Manager Supervisor, Nurse Managers, and Direct Care Nurses; Review of individuals' records; Observations of individuals on the units, and Attendance at the Morning Clinical Meetings, Continuous Quality Improvement Meeting, and Pre-ISP Meeting. Relevant self-assessment data were updated during the onsite compliance visit. The facility's self-assessment stated they were not in substantial compliance with Provision M3 and the Monitoring team concurred. The facility's self-assessment for this provision reported the following results: • The average for the months of October 2012 through December 2012 Nursing Care Plan Monitoring Tools showed 61% overall compliance. • Monitoring of HMPs was not measured. The Nursing Department will re-establish monitoring of the new IHCP process. • Documentation indicated that nursing staff were receiving training on the respective care plans 100% of the time. The Nursing Department continued to see gaps in the implementation of acute care plans in response to changes in individuals' health status. Based on the above self-assessment findings, the facility determined this provision was not in compliance due to the fact that care plan development, individualization, and revisions were not completed per policy. The results of the facility's self-assessment for this provision were relatively consistent with the monitoring team's findings, reported below. <u>Monitoring Team's Findings:</u> 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. The monitoring team's review of 21 individuals' Health Maintenance Plan (HMP) and/or Integrated Health Care Plan (IHCP) showed that fourteen of 21 (67%) Annual and/or Quarterly Comprehensive Nursing Assessments indicated whether health care plans	Noncompliance

#	Provision	Assessment of Status	Compliance
		were implemented for individuals' Nursing Problems/Diagnoses rated at high and/or medium risk conditions as well as health conditions that might not be rated as high or medium risks that required continuous nursing assessments, monitoring, and interventions and 15 of 21 (71%) Annual and/or Quarterly Comprehensive Nursing Assessments' overall nursing summaries sufficiently summarized individuals' health status in relation to the identified Nursing Problems/Diagnoses as to whether their health conditions were improving, maintaining, or regressing, as well as the effectiveness of their health care plans. This was relatively consistent with the facility's self-assessment, which showed 61% compliance with the Nursing Care Plan Monitoring Tool. Additionally, the self-assessment stated monitoring of HMPs was not measured. The RN Case Managers did not consistently include all high and medium risk ratings that should require nursing interventions into the nursing problem/diagnosis list. Not all identified nursing problems/diagnosis had a corresponding HMP or IHCP. Since the implementation of the IHCP, many of the individuals who did not have an IHCP developed had little attention paid to their existing HMPs. Of the individuals who had IHCPs, few of the nursing interventions were sufficient to meet individuals' health care need. Most were very general and nonspecific. Of the 21 records reviewed, most of the HMPs that were in use had been developed and implemented previous to the most recent ISP, of which it was rare to find they reviewed/revised at the time of the ISP. As the facility transitions and improves the quality of the revised IRRF and IHCP processes, it is expected that future compliance reviews with find improvement in the content and quality of individuals' health care plans. <u>Monitoring Team's Review of Acute Care Plans:</u> The review of 16 recently developed and implemented Acute Care Plans (ACPs) for a variety of acute conditions showed little improvement in their individualization and quality of the intervention. Most of the content of the care plans continued to be mostly generic adapted from stock care plans. The monitoring team's findings were relatively consistent with the facility's self-assessment findings of 61% percent compliance with nursing care plans. Finding included • Fourteen of 16 (88%) baseline data were sufficient to describe the acute change in health status that led up to the need for an acute care plan. • Twelve of 16 (75%) goals sufficiently described the desired outcome as a result of the acute care plan interventions. • Eleven of 16 (68) care plans interventions were sufficiently individualized to meet individuals' needs to resolve the acute change in health status. Primarily, only the individuals' names and the physician's orders were individualized. • Ten of 16 (62%) include specific frequency for assessing/monitoring the acute	

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		condition. • Zero of 16 (0%) incorporated relevant nursing protocols. • 12 of 16 (75%) included the signatures of the Home Managers and Direct Support Professionals validating that they were trained on their care responsibilities. The Nursing Department should ensure that all RN case Managers are re-trained on developing Acute Care Plans, as well as on the nursing protocol to ensure relevant protocols are incorporated into the care plans. <u>Nursing Discharge Summaries and Community Living Discharge Packages:</u> • Four of five (80%) Nursing Discharge Summaries were included in the Community Living Discharge Packets. • Three of four (75%) were completed on the Nursing Discharge Summary form. One was completed on the Comprehensive Nursing Assessment form. • Four of four (100%) Nursing Discharge Summaries were completed within 45 days of community discharge. • Four of four (100%) Nursing Discharge Summaries provided a sufficient overview of individuals' health problems and a summary of their preferences and status in relation to their identified problems. • There were no additional plans of care provided for the receiving community provider to follow. • Five of five (100%) of the Community Living Discharge Packets validated that nurses participated in training the community.	
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.	The monitoring team validated the information presented in the facility's self-assessment through: Independent review of the information presented in Section M, Provision M4 Presentation Book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Program Compliance Nurse, Nurse Educator; and Review of training material, training records, and samples of revised health care plans. Relevant self-assessment data were updated during the onsite compliance visit. The facility's self-assessment stated they were not in substantial compliance with Provision M4 and the monitoring team concurred. The facility's self-assessment for this provision reported the following results: • All (100%) of new employees were provided the Observing and Reporting Clinical Indicators course in New Employee Orientation. • No Annual Nursing Competencies had been conducted. The Annual Nursing Competencies Program will be reinitiated in May 2013. • Bedside Nursing Competencies Training was currently in the process of being	Noncompliance

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		updating for all nurses with the new Nursing Bedside Competencies. • Protocol cards were distributed to all nurses and further evaluation will be completed in the area of nursing compliance for specific protocols. New protocol cards were being distributed to all nurses. Based on the above self-assessment findings, the facility determined this provision was not in compliance due to additional monitoring needed in the areas of nursing compliance with the specific protocol cards. <u>Monitoring Team's Findings</u>: The Nurse Educator assumed this position in December 2012. During the monitoring team's interview with him, it was evident that he was well qualified for the position and was beginning to re-organize and make progress toward providing quality education to the nursing staff. He expressed some barriers to providing mass training. He stated that most of the training took place in his office, which could only accommodate four nurses. The Nursing Department did not have a dedicated classroom room/skills lab. Neither did they have adequate, if any, necessary training equipment to conduct actual hands-on return demonstrations for many of the required competency-based procedures. The Nurse Educator urgently needs a functional manikin that allows for G-Tube and Foley catheter insertion and oral suctioning. Such return demonstrations should not be practiced on the fellow nurses, much less the individuals. The nursing staff should be checked off on such procedures before performing them on the units. Additionally, the classroom/skills lab needs a projector, screen, and a sink for hand washing demonstrations and general hygiene. <u>Policies, Procedures, Protocols, and Guidelines</u>: The Nursing Department reported there had been no new state or facility policies since the last compliance review. However, the Nursing Department had developed and implemented the following new guidelines: • Five new protocol cards were added to the original 18 protocols • Hot Charting Guidelines • Medication Reconciliation Guides "real time baggy system" • Psychiatric Medication Guidelines • "Pass" Medication Guidelines • Oxygen Administration Guidelines • Nursing Coverage Guidelines, Updated • Direct Support Staff – Skin Integrity Guidelines	

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		Training Records Reviewed: • Of the new guidelines above, there was no documentation provided to indicate the number/percentage of nurses trained on the guidelines. • Thirteen nurses had received the state's Preceptor Training, using experienced nurses to mentor new nurses through the orientation period. However, recruiting nurses to serve as preceptors was reported to be challenging because of requirements necessary to perform as a preceptor. • All 25 protocol cards had been distributed to the nursing staff, but there was no documentation available for review that indicated they were competency-based trained on the use of the cards. In order to ensure that the nurses clearly understand the protocol cards and how to use them, some formalized system should be put in place to assess their knowledge and ability to apply them to actual practice situations. • Forty one percent of the RN Case Managers/RNs had completed the mandated state Physical Assessment Class, 41% had completed the RN to RN Check off, with 9% having completed the unit check-offs. The Physical Assessment Class will be taught to RNs in New Nurse Orientation. • Twenty three nurses (10 RNs and 13 LVNs) had received the state Documentation Class. • Thirty seven percent of the direct care nurses, Nurse Managers, and ODRN had received the state Medication Administration for Individuals with Developmental Disabilities Training. The projected date for completion is September 2013. • Numerous training curricula with attached signed training sheets were provided, however, they were not listed on a centralized training spreadsheet. Therefore, it was not possible to determine the percentage of nurses trained on any one topic. As stated in the self-assessment, no Annual Nursing Competencies had been conducted. The Annual Nursing Competencies Program will be reinitiated in May 2013. The Annual Nursing Competencies will be implemented with specific competencies conducted on monthly basis throughout the year. The Nurse Educator had developed a Nursing Education Training Year Calendar projecting the topic to be covered each month. The Nurse Educator had worked closely with the RN Case Managers and nursing Staff to improve the quality of the Acute Care Plans. Numerous copies, on a variety of conditions, of the corrected care plans were provided for review, which demonstrated critical thinking and improvement on the overall quality of the care plans. Once corrected they were sent back to the respective nurses who developed the original care plans, with copies entered in the shared drive to use for future reference.	

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		The Nurse Educator was making significant progress in reorganizing and improving the quality of nursing education. However, continued improvement is needed. The next step the Nurse Educator should take is to develop a centralized tracking system to record all training provided, including each topic trained, names and titles of nurses receiving training, ongoing percentage of nurses trained on each topic, and for trainings not completed, identify projected dates for the completion of training on each topic. This would provide an ongoing status of required training. The Nursing Department should consider developing and implementing a process for assessing nursing staff's competency related to the protocols, as well as auditing the protocols to ensure that compliance was achieved through actual clinical practice sufficient to address the health status of individuals served. Only when this can be demonstrated through actual clinical practice will compliance with this Provision achieved.	
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.	The monitoring team validated the information presented in the facility's self-assessment through: Independent review of the information presented in Section M, Provision M5 Presentation Book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, QA Nurse, RN Case Manager Supervisor, Nurse Managers, and Direct Care Nurses; Review of individuals' records; Observations of individuals on the units; and attendance of a Pre-ISP Meeting. Relevant self-assessment data were updated during the onsite compliance visit. The facility's self-assessment stated they were not in substantial compliance with Provision M5 and the Monitoring team concurred. The facility's self-assessment for this provision reported the following results: • Five of 10 (50%) records reviewed had appropriate identification of individuals' risk criteria. • Fifteen of 15 (100%) RN Case Managers had received training on the At Risk process, which further opened the Interdisciplinary Teams (IDTs) line of communication. • The Infection Control Committee did not meet every other month due to the temporarily vacant Infection Control Officer position. • EOCs were not conducted for the months of August 2012 through January 2013 because of the vacant Infection Control Officer position. An Infection Control Officer was recently hired who conducted EOC rounds, and developed corrective action for deficiencies identified, which were referred to the responsible disciplines for correction. • Tuberculosis (TB) Surveillance Reports revealed that 100% of New Employees	Noncompliance

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		Orientation employees were screened for TB. • Antibiograms were not utilized in the Infection Control Committee Meetings. • The Skin Integrity Nurse was vacant for the months of November 2012 through February 2013. • Based on the above self-assessment findings, the facility determined this provision was not in compliance due to the need for further training and evaluation in the At Risk processes. In addition, the Infection Control Officer and Skin Integrity Nurse positions were temporarily vacant. The results of the facility's self-assessment for this provision were relatively consistent with the monitoring team's findings, reported below. <u>Monitoring Team's Findings:</u> Since the last review, the facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) processes. The facility's self-assessment stated that the state office continued to provide training on the revised IRRF and IHCP processes. From a review of the records, the IRRF and IHCP processes were continuing to evolve, but were not yet fully implemented and proficient in assessing risk ratings. The IRRF form had been revised to include six clinical risk groups. The effort to group interrelated conditions into six groups was a positive start. However, the interrelationship of conditions does not yet seem to be fully realized. Of the 21 records reviewed, only four had recently completed IRRFs and IHCPs. The review found • Four of four (100%) had comprehensive interdisciplinary assessments completed. However, some of the baseline data rationales that supported the risk ratings were more clinically comprehensive than others. The format for reporting baseline data continued to vary from unit to unit and from IDT to IDT. • Three of four (75%) IRRFs provided data that helped identify risk ratings. • One of four (25%) IHCPs were clinically sufficient to meet the needs for the individual's identified risks. • Two of four (50%) IHCPs included preventative interventions to minimize individuals' identified risk rating conditions. • Two of four (50%) IHCPs were sufficiently integrated among all appropriate disciplines. • Zero of four (0%) changes were made in individuals' services and supports for all identified risk ratings. • Two of four (50%) IHCPs contained functional and measurable objectives in the ISPs to measure efficacy of the plans. • Two of four (50%) IHCPs identified appropriate clinical indicators to be	

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		monitored and the frequency of monitoring. • Example: Individual #277: Review of the 1/16/13 ISP, Integrated Risk Rating Form (IRRF), and Integrated Health Care Plan (IHCPs) found that the individual was assessed at low risk for aspiration because he had a history of pneumonia, but not aspiration pneumonia. Based on the clinical data reviewed, he had a history of non-pneumonia, history of coughing until he turned red in the face within the last year, and incidences of coughing after meals related to compulsive jumping. He received a finely chopped diet, used a youth spoon for smaller bites, and required direct supervision by staff at meals. There were no clinical data indicating that the nurse performed an assessment according to the Aspiration Protocol after the coughing episodes to rule out aspiration. All episodes of coughing, especially after meals, should have such an assessment. It should not be assumed, even if the coughing episodes were thought to be behaviorally related, that he was not aspirating while jumping. Because of these issues, combined with medium risk rating for choking and respiratory compromise, the IDT should have considered him at medium risk for aspiration. In general, as was found in past reviews, there was wide variation from unit to unit, and within the IDTs in the formats used for ISPs, IRRFs, and IHCPs, as well as the quality of the clinical data used to support the risk ratings. The facility needs to ensure consistency across all IDTs, as well as among disciplines, if compliance is to be achieved regarding the IRRFs and IHCPs processes. The monitoring team will follow-up on the status and implementation of the IHCP process at the next compliance review.	
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	The monitoring team validated the information presented in the facility's self-assessment through: Independent review of the information presented in Section M, Provision M6 Presentation Book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, Nurse Educator, Pharmacy Director, Physical Nutritional Management Team (PNMT) Nurse, Nurse Managers, and Direct Care Nurses; Reviewed Medication and Treatment Administration Records, Narcotic/Control Drug Logs, and Glucometer Control Logs; and Conducted Inspections of Medication Rooms and Medication Administration Observations on the units, and Attendance at the Morning Clinical Meeting and Continuous Quality Improvement Meeting. Relevant self-assessment data were updated during the onsite compliance visit. The facility's self-assessment stated they were not in substantial compliance with Provision M6 and the Monitoring team concurred. The facility's self-assessment for this provision reported the following results: • The Medication Variance Committee meetings were held for the months of October 2012, November 2012, February 2013, and March 2013. This process	Noncompliance

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	care with regard to this provision in a separate monitoring plan.	had been reinstituted to address reconciliation of medications. • This Audit had been suspended and will be reinstituted in April 2013. • Compliance for the months of October 2012 through December 2012 Monitoring Tools in the area of Medication Administration showed 96% compliance. • Fill sheets were inconstantly being completed. The Nursing Department had instituted a new bagging process to regularly identify discrepancies of extra/omitted medication. Discrepancies will be tracked by the medication Variance Committee for recommendations. • Fourteen of 20 (70%) Medication Administration Records (MARs) had an updated Physical Nutritional Management Plans (PNMPs). • Based on the above self-assessment findings, the facility determined this provision was not in compliance due to the need for additional compliance monitoring and corrective actions in the areas of medication administration. The results of the facility's self-assessment for this provision were relatively consistent with the monitoring team's findings, reported below. <u>Monitoring Team's Findings:</u> <u>Facility's Medication Administration Policies, Procedures, and Guidelines:</u> Since the last compliance review, there were no new policies provided for review. However, there was a 1/11/13, email from the state office Pharmacy Director regarding Procedural Guidelines for Medication Reconciliation. The facility had a copy of DADS Medication Variances Policy, Policy Number: 053, Effective: 9/23/11. However, a facility operationalized policy for this state policy was not provided for review. Therefore, the monitoring team was not able to determine whether the facility had operationalized this policy. The facility should ensure that the DADS Medication Variances Policy, Policy Number: 053 is operationalized. The Medication Reconciliation and Medication Error Processes were discussed with the CNE and Pharmacy Director. The procedure for medication errors/variances included: When medication errors/variances were identified, the nurses were to call the medication hotline to notify the Pharmacy Director, who investigated the medication errors/variances and completed the Medication Variance Forms. Then, the Pharmacy Director returned the form to the respective Nurse Manager who completed a plan of correction. Upon further discussion, it was agreed by the CNE and Pharmacy Director that completion of the Medication Variances Forms and investigations was the Nursing Department responsibility. Then, a draft procedure for reporting/investigating medication errors/variances was developed, returning this to the Nursing Department.	

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		The revised draft Medication Reconciliation and Medication Error/Variance Procedure instructed the nursing staff to daily notify the Nurse Managers or ODRN, who will investigate medications left in the medication carts daily and take corrective actions. The excess medications will be reported to the Medication Hotline for the NOO or ODRN, who will further investigate with the respective Nurse Manager. The draft procedure was presented at the Medication Variance Committee on 5/1/13 and was approved in draft form. The CNE will finalize and implement the draft procedure for reporting, investigating, and taking corrective actions for medication errors/variances. The monitoring team will follow-up on the finalized procedure for reporting, investigating, and taking corrective action at the next compliance review. <u>Facility's Processes for Supervising, Training and Monitoring Nurses on Medication Administration:</u> Thirty seven percent of the direct care nurses, Nurse Managers, and ODRN had received the states' Medication Administration for Individuals with Developmental Disabilities and/or swallowing difficulties. The projected completion date was for September 2013. Since the last compliance review, there were no quarterly Medication Administration Observation reports or percentage of compliance provided for review. The data provided were from the last compliance review, which was for Nursing Bedside Competencies. As reported in Provision M4, Nursing Bedside Competencies (which included some training on medication administration) had been suspended and were projected to resume in June 2013. The failure to compete the quarterly Medication Administration Observations may be attributable to the significant turnovers and changes in administrative/leadership staff, as reported above in Provision M1. A copy of the Power Point Training material was provided on areas of medication administration practices found deficient at the last compliance review. The topics included instruction on hand washing during medication administration. There were no training rosters that indication whether nurses were trained on these topics. According to the facility's Provision M6 Action Plans, several actions were in process of being completed for the NOO/Nurse Managers and were projected to be completed between 9/1/13 and 10/31/13. Action Plans included: • Processes will be put in place that provide the necessary supervision and training to minimize medication errors. • Nursing Medication Administration Observations are conducted quarterly. • Nurses responsible for medication administration and the transcription of physician orders will be competent and suitable according to accepted	

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professional standards of care for medication administration. Nurses who have been identified as not following accepted professional standards of care will be provided additional training by the Nurse Manager or Nurse Educator.

The monitoring team will follow-up on these action plans for completion at the next compliance review.

Facility's Medication Variance and Medication Reconciliation Data Reports:
The facility had a database/information system for monthly reporting and representing data for each medication variance by Severity Index Category, node, home, type, number, and responsible discipline/department. Data were represented in tabular charts and line graphs. The overall reported medication variances for September 2012 through March 2013 showed erratic patterns of increased and decreased number of medication variances across months reported:

Medication Variances by Month and Discipline

Discipline	September 2012	October 2012	November 2012	December 2012	January 2013	February 2013	March 2013
Medical	0	1	10	3	0	0	2
Multiple	0	0	1	1	1	0	1
Nursing	215	146	146	40	107	158	274
Pharmacy	46	20	32	20	25	51	108
Total	261	167	189	64	133	209	385

In addition to the Medication Variance database/information system, the facility was tracking monthly the number of reconciled and unreconciled medications found in the medication carts and returned to the pharmacy. Data were analyzed by month, home, discipline/department, number, and percentage of medications reconciled and unreconciled. Data were represented in line graphs. An acceptable threshold was set for 90% of the medication to be reconciled. This threshold was questionable because all medications should be reconciled and unreconciled medications should be reported as medication variances. The overall report for September 2012 through March 2013 showed:

Medication Reconciliation

	September 2012	October 2012	November 2012	December 2012	January 2013	February 2013	March 2013
Number Medications Returned to Pharmacy	2904	4133	4849	3794	6816	4612	5411
Number Medications Unreconciled	462	1042	814	1026	6795	1643	1590
Number	2442	3091	4035	2768	21	2969	3821

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Medications Reconciled								
Percentage Medications reconciled	84.1%	74.8%	83.2%	73.0%	0.3%	64.4%	70.6%	

Additional medication reconciliation data were provided for April 2012, which showed a total excess of 2969 medications, of which 2218 medications were reconciled for a percentage of 75%. These data showed no appreciable improvement in the reduction of unreconciled medications.

The monitoring team's comparison of the Medication Variance data and the Medication Reconciliation data showed a wide disparity between the number of monthly medication variances and the number/percentage of medications reconciled. For each unreconciled medication, a Medication Variance Report should have been completed, which would have significantly increased the number of monthly medication variances. Lumping found medications in the medication carts at any given time into one Medication Variance Reports skews the data and renders it invalid.

The CNE stated that the medication reconciliation process had stopped in January 2012, which accounted for the drop in the medications reconciled. The Medication Reconciliation Procedure was reinstated in February 2013. In an effort to further improve the medication reconciliation procedure a "Baggy" system was implemented in March 2013, where any extra medications found were placed in a small plastic bags with labels that indicated the location the medications were found, reason for the excess medications, the name of the medication, and the name of the nurse who found the medications. The bags were returned to the Pharmacy. With the revised draft procedure for reporting medication variances, the Nursing Department will be responsible for reconciling and reporting excess medication. As the facility continues to reconcile the number of medications found in the medication carts and returned to the Pharmacy, each unreconciled medication should be considered a medication variance and a Medication Variance Report completed. The monitoring team will review the number of medications variances report to the number of unreconciled medications reported at the next compliance review.

<u>Medication Variance Committee Meetings:</u>
For the six months prior to the compliance review, the Medication Variance Committee met four of six (67%) monthly scheduled meetings. The Medication Committee was chaired by the CNE with the core membership comprised of the Medical Director, Pharmacy Director, Quality Assurance Nurse, Program Compliance Nurse, Nurse Educator, RN Case Manager Supervisor, and Nurse Managers.

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		• The core membership participated in one of four (25%) scheduled Medication Variance Committee Meetings. • Four of four (100%) monthly meetings showed the committee reviewed each month the total number of medication variances by type, and discipline. Medication Variance data were tracked, analyzed, and trended for local, systemic, and longitudinally issues contributing to the medication variances, and took for corrective actions on areas of deficiencies to prevent and/or minimize the incidences of medication variances. For example, they developed and implemented Medication Reconciliation Procedures and Redlining Chart that consisted of 24 hour check of Physician Order's to ensure all orders, particularly medication orders were transcribed and sent to the Pharmacy for filling. • The Medication Variance Committee minutes and medication variance data were distributed at the Pharmacy and Therapeutic Committee Meeting for further review, discussion, and corrective action if needed. • Audits for Medication Room Inspections, Medication Administration Records, and Medication Administration Observations were not included in the Committee minutes. <u>Pharmacy and Therapeutics Committee Meetings:</u> The Pharmacy and Therapeutics Committee was chaired by the Pharmacy Director. The core membership included: the Clinical Pharmacist, Medical Director Lead Psychiatrist, Director of Psychology, Primary Care Physicians, Nurse Practitioner, and CNE. • The core membership participated in six of six (100%) scheduled Pharmacy and Therapeutics Committee Meetings. • For the six months prior to the compliance review, the Pharmacy and Therapeutics Committee met for six of six (100%) monthly scheduled meetings. • Six of six (100%) monthly meetings showed the Medication Variance Committee minutes and Medication Variance data were distributed at the Committee meeting for further for further review, discussion, and corrective action if needed. Refer to Section N8 for additional information <u>Inspections/Observations of Unit Medication Rooms, Medication Administration Records, and Medication Administration Observations:</u> The Nursing Department did not provide the monitoring team with audit data for Medication Room Inspections, Medication Administration Records, and Medication Administration Observations. However, they reported the Nurse Managers were conducting weekly audits of the medication room and medication administration records. This may be due to the significant turnover and changes in the administrative and leadership staff. The Nursing Department should ensure that periotic audits are conducted for Medication Rooms Inspections, Medication Administration Records, and	

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		quarterly Medication Administration Observations. <u>Monitoring Team's Inspection/Observation of Medication Rooms, Medication Administration Records, Narcotic/Control Logs, Glucometer Logs, and Medication Administration Observations:</u> Inspection of Medication Rooms in buildings 668, 670, 671, 672, 673, 674, and 766: • Seven of seven (100%) medication rooms were clean and free from unnecessary clutter. • Seven of seven (100%) medication rooms had medication properly stored with topic and oral medications stored separately. Six of seven (86%) open medications were dated and initialed by nurses. • Seven of seven (100%) medication room refrigerator temperature logs were checked daily and within acceptable temperature ranges. Six of seven (86%) refrigerators contained no personal foodstuff. • Seven of seven (100%) medications carts were locked when not in use by the nurses. • Seven of seven (100%) medication carts showed that Narcotic/Control Drugs were double locked in a separate container on the carts. Narcotic/Control Logs were kept in the locked container. Five of seven (71%) of the Narcotic/Control Logs contained double nursing signatures at the beginning and end of shifts, with the exception of buildings that did not have a 10 pm-6 am shift nurse but were covered by the ODRN. • Seven of seven (100%) Glucometer Logs showed they were checked daily and the testing solutions were changed every 30 days. • Zero of seven (100%) Universal Signature Sheets in the front of the Medication Administration Record Notebooks were updated with the signatures and initials of the nurses administering medications. The Nurse Managers reported that they had probably not been updated in over a year. Most of the signatures and initials on the sheets were illegible. • Seven of Seven (100%) Medication Administration Record Notebooks showed PNMPs for individuals who required a PNMP. <u>Monitoring Team's Medication Administration Observations:</u> The monitoring team conducted oral Medication Administration Observations in home 668 on 4/29/13 at the 7:00 p.m. med pass. Findings include: • The medications were passed through a Dutch door. The Direct Support Professionals assisted the nurse by bringing one individual at a time to the door for mediations. Other individuals were attempting to come to the door and this did not provide the individual with much privacy or the nurse with much freedom from distraction. Individuals were treated with dignity and respect.	

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		• The nurse followed generally accepted standards of practice for safe medication administration with the following exceptions: o The individuals' PNMPs were located behind their Medication Administration Records and were not readily accessible for use. The nurse required minor prompting to refer to the PNMPs prior to administering medications. o Although the nurse consistently told individuals the name and purpose of their medication, there was little Self-Administration of Medication Training provided. o The medication packages were not consistently reserved for the required third check, rather once opened and the medication placed in the cup, they were put in the waste container. • Individual #71's PNMP indicated that all medication was to be crushed. Valproic Acid capsules were prescribed that could not be crushed or pierced. The PNMT Nurse was notified and contacted the physician who changed the order to sprinkles. The PNMT provided documentation of the change in order from capsules to sprinkle for Valproic Acid. • Individual #55 coughed after receiving medication and drinking liquids too fast. The direct care nurse promptly performed a focus assessment according to the Aspiration Protocol and continued implementing the protocol for 48 hours. Documentation was provided validating the Aspiration Protocol was followed for 48 hours without any complications arising from the coughing episode. This was a positive finding. The monitoring team conducted oral Medication Administration Observations in home 674 on 5/1/13 at the 7:00 p.m. med pass. Most of the individuals' received medication enterally with only a few who received medications orally. Findings include: • The nurse who administered medication did an outstanding job. The nurse was exemplary to his peers. He followed all generally accepted standards of practice for safe oral and enteral medication administration, provided privacy, treated individuals with respect. Individuals were told the name and purpose of their medications. Self-Administration of Medication was implemented for individuals who had a program. In general, it appeared that improvements were made in medication administration practices since the last compliance review. However, there remains a need for continued improvements in regard to training on medication administration practices, conducting medication administration related audits, reconciling excess medications, and reducing medication variances.	

Recommendations:

1. The Nursing Department should ensure that individuals with an acute change in health status receive a focus assessment of the affected body system, that relevant nursing protocols are followed through to resolution and incorporated into their acute care plans (M1).

2. The Infection Control Officer should track, analyze, and trend infectious and communicable disease data monthly and longitudinally to identify local and systemic trends (M1).

   The Infection Control Nurse should ensure that an up-to-date database/information system is used to track all vaccinations and is readily accessible to clinicians to use for keeping individuals' vaccinations up to date (M1).

3. It is essential that the Infection Control Officer ensure all new employees are trained on Infection Control Measures during New Employee Orientation and that current employees receive annual refresher training (M1).

4. It is essential that the QA Department and Nursing Department continue to analyze contributing factors that cause monitoring tools to fall below 80% of compliance or desired threshold and to take local and systemic corrective actions to improve the percentage of compliance (M1).

5. The Inter-rater Reliability checks should include the corresponding overall percentage of agreement between the Quality Assurance Nurse and Nursing Department along with the various nursing quarterly monitoring tool data (M1).

6. The Nursing Department should ensure that RN Case Managers make routine rounds related to their respective units to observe individuals on their caseloads to attend/review the unit nursing shift reports, and make round with the attending primary care providers (PCPs) when possible in order to consistently stay abreast of individuals' chronic and acute health conditions (M2).

7. The Nursing Department s should ensure that all RN case Managers are re-trained on developing Acute Care Plans, as well as on the nursing protocol to ensure relevant protocols are incorporated into the care plans (M3).

8. The Nurse Educator should take would be to develop a centralized tracking system to record all training provided including, each topic trained, names and titles of nurses receiving training, ongoing percentage of nurses trained on each topic, and for trainings not completed identify projected dates for the completion of training on each topic. This would provide an ongoing status of required training (M4).

9. The Nursing Department should consider developing and implementing a process for assessing nursing staff's competency related to the protocols, as well as auditing the protocols to ensure that compliance was achieved through actual clinical practice sufficient to address the health status of individuals served. Only when demonstrated through actual clinical practice will compliance be achieved (M4).

10. The facility should ensure that the DADS Medication Variances Policy, Policy Number: 053 is operationalized (M6).

11. The Nursing Department should ensure that periotic audits are conducted for Medication Rooms Inspections, Medication Administration Records, and quarterly Medication Administration Observations (M6).

12. As the facility continues to reconcile the number of medications found in the medication carts and returned to the Pharmacy, each unreconciled medication should be considered a medication variance and a Medication Variance Report completed (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:** <u>Documents Reviewed</u>: 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, 3/15/13 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 Notes, 8/21/12, 10/16/12, 11/13/12 1/8/13, 2/12/133/12/13, o Medication Variance Review Committee Meeting Notes, 5/30/12, 8/22/12, 10/19/12, 2/28/13 3/25/13 o Polypharmacy Committee Meeting Minutes, 8/21/12, 10/16/12, 11/13/12, 2/12/13, 3/12/13 o Pharmacy Clinical Intervention Reports, October 2012 – March 2013 o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Clozapine • Phenobarbital • Probiotic Use o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #325, Individual #198, Individual #126, Individual #23, Individual #342, Individual #259, Individual #245, Individual #213, Individual #114, Individual #292, Individual #206, Individual #32, Individual #333, Individual #113, Individual #282, Individual #148, Individual #235, Individual #256 Individual #164 Individual #87, Individual #42, Individual #198, Individual #83, Individual #335, Individual #31, Individual #274, Individual #140, Individual #47, Individual #222, Individual #241, Individual #35, Individual #267, Individual #32 o MOSES and/or DISCUS Evaluations for the following individuals • Individual #284, Individual #126, Individual #259, Individual #198, Individual #325

	Individual #342, Individual #341,Individual #249, Individual #229, Individual #255, Individual #314, Individual #199, Individual #256, Individual #301, Individual #278, Individual #113, Individual #148, Individual #138, Individual #315, Individual #122, Individual #173, Individual #327, Individual #222, Individual #279, Individual #267 Individual #32, Individual #35, Individual #23, Individual #80, Individual #90, Individual #77, Individual #92, Individual #79, Individual #55, Individual #94, Individual #87 Interviews and Meetings Held: o Sharon Tramonte, PharmD, Lead Pharmacist o Nicole Cupples, PharmD, Clinical Pharmacist o David Espino, MD, Medical Director o Yenni Michel, DO, Primary Care Physician o David Bessman, MD, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Family Nurse Practitioner o Mandy Pena, RN, QA Nurse o Ann Richards, PharmD, Pharmacy Director, San Antonio State Hospital o Assistant Pharmacy Director, San Antonio State Hospital Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o QA/QI Council Meeting o Medical Staff Meeting o Medical Continuous Quality Improvement Meeting o San Antonio State Hospital Pharmacy Department
	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 pharmacist listed the activities engaged in to conduct the self-assessment, the results of the self-assessment and a self-rating. The self-assessments presented a plethora of data, however, the selection of data did not always appear to be the most relevant data. For example, N1 should include data on the types of interventions. It might also be helpful when self-assessing to look at the corrective actions required and the percentage that remain outstanding. Provision item N5 should include data for completion of all required evaluations and the percentage that were completed adequately and in a timely manner. For N7, additional data points could include the number of corrective actions implemented and the number completed. These data elements should not increase the size of the databank but will allow the facility to assess itself in a manner more consistent with the monitoring team's assessment.

	Overall, the self –assessment was greatly improved. 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 N1, N2, N3, N4, N5, N6, and N7. For provision item N8, the facility rated itself in noncompliance. The monitoring team found the facility to be in substantial compliance with N2, N3, N4, N5, and N7. The monitoring team rated provision items N1, N6, and N8 in noncompliance.
	Summary of Monitor's Assessment: Progress in the provision of pharmacy services and safe medication practices was evident in some areas. The new clinical pharmacist began working at the facility in August 2012 and the impact of having a second full time clinical pharmacist was very evident during this compliance review. The pharmacy technician continued full time employment also. The lead clinical pharmacist was under the supervision of the medical director and this appeared to be a beneficial arrangement given the fact that many of the activities of the pharmacy department were tightly interwoven with the medical department. This provided greater clinical oversight to the pharmacy department and made the newly appointed medical director more aware of the activities of the department. SASSLC faced unique challenges because medications were dispensed at the San Antonio State Hospital (SASH) and not the facility. Even so, the number of documented interventions increased, as did the documentation of the resolution of the problems. The Intelligent Alerts module was implemented in December 2012. The monitoring team had the opportunity to meet with the director, associate director, and a staff pharmacist at SASH. They were all aware of the requirements related to the dispensing of medications and appeared more than willing to assist SASSLC in achieving substantial compliance. They provided a demonstration of how they used the IA module in addition to providing updates on the recently replaced dispensing robot. The monitoring team also noted significant improvements in the QDRR process. There were no timeline deficiencies identified in the documents reviewed. The clinical pharmacists demonstrated even more improvements in content and format. The reviews were robust in content and provided an excellent source of clinically relevant information for the prescribers and the IDTs. The monitoring for metabolic risks associated with the new generation psychotropic agents was clearly identified in all QDRRs reviewed. The Polypharmacy Oversight Committee continued to meet regularly, however, this area will continue to need additional work. There were some QDRRs that required repeat recommendations from the clinical pharmacists. Overall, given the volume of recommendations made prospectively and retrospectively, there was ample

	documentation in the records and other documents that the prescribers did follow-through on many recommendations. The clinical pharmacists will need to continue to assess this through QDRRs and other audit sampling processes. There were several problems related to completion of the MOSES and DISCUS evaluations. The evaluations were completed for those individuals who were enrolled in psychiatry clinic, but individuals who received other medications, such as metoclopramide and AEDs, did not always appear to have timely completion based on record and document reviews. Completion of the evaluations by the primary providers was also challenging, as some primary providers did not appropriately complete the evaluations. The clinical pharmacist reported that these issues were being addressed, however, the facility could not provide any data to indicate the magnitude of the problem. The very prominent and significant delays in reporting ADRs that were observed in August 2012 were not seen in this review. In fact, ADRs were simply not being reported. A total of 12 ADRs were documented over a nine-month period and three of those occurred just prior to the compliance review. The medical director acknowledged in meetings and interviews that the facility was not adequately reporting ADRs. He understood the importance of ADR reporting and was aware that this information was potentially beneficial and was not necessarily a negative finding. Three Drug Utilizations Evaluations were completed. All were done in a timely manner and presented to the Pharmacy and Therapeutics Committee. Corrective action plans were implemented for identified deficiencies, but minutes did not always indicate closure of identified problems. Progress was noted in the medication variance system based on the re-institution of some reconciliation practices. Unfortunately, after more than two years of encouraging the facility to fully reconcile medications, it was discovered that a significant number of medications could not be reconciled. New processes targeted at resolving this problem were implemented shortly before the compliance review. Overall, progress was noted in several areas of pharmacy services while other areas appeared to have no substantial forward movement. The actual clinical work done by the pharmacists was adequate and, in some cases, very good, but the monitoring team observed that there continued to be a lack of an overarching plan at the time of the compliance review for how the department would make greater progress. The medical director acknowledged that much work needed to be accomplished. By the close of the review week, the medical director was beginning to formulate a plan on how to prioritize the work that needed to be done. The involvement of the medical director will be critical in organizing a cogent plan for moving forward. The clinical ability of the staff was evident. The new supervisory structure of the pharmacy staff and relationship with the medical director should provide the necessary oversight for planning and implementation. Thus, greater organization should be noted in how policies and procedures are developed, implemented, and monitored. These issues have impeded progress over the past years. It will be important for the medical director to ensure that policy revisions occur as needed and that proper

	follow-up occurs for problematic areas. Finally, the last concern is related to the need to improve timelines. Some issues at SASSLC were hampered by the arrangement with the State Hospital, but many issues were simply caused by a failure to adequately explore issues and develop solutions. The medication reconciliation problem is one such example of a question and ultimately a problem that had now existed without resolution for several years.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>N1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.</td><td>Medication orders for the facility continued to be filled by the pharmacy department of the San Antonio State Hospital. 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 from October 2012 through March 2013. Data related to the clinical interventions are summarized in the table below:

<table>
<tr><th></th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>Total Interventions</td><td>105</td><td>61</td><td>54</td><td>54</td><td>44</td><td>107</td><td>139</td><td>196</td></tr>
<tr><td>Prescriber Interventions #(%)</td><td>22(21)</td><td>11(18)</td><td>9(17)</td><td>7(13)</td><td>12(27)</td><td>49(46)</td><td>75(54)</td><td>72(37)</td></tr>
<tr><td>Intelligent Alerts</td><td>--</td><td>--</td><td>--</td><td>--</td><td>2</td><td>5</td><td>15</td><td>--</td></tr>
</table>

The number of interventions cited in the table represented the interventions that occurred with medical providers prospectively and retrospectively, excluding QDRR recommendations. Prospective interactions were those that occurred at the time medication orders were received and processed and included the Intelligent Alerts that were implemented on 12/18/12. Intelligent Alerts were communicated to the prescribers via fax. The clinical pharmacists also began documenting interventions in January 2013. It was reported that many of these were the result of the pharmacists' participation in psychiatry clinics. Together, the IAs and clinical pharmacists' interventions resulted in increased communication and contact with the prescriber. Prescriber contact represented, on average, 46% of all interventions for the months of January 2013 through March 2013. This was increased from 19% for the previous three months. It was clear that the facility was making progress in the documentation of the interactions.</td><td>Noncompliance</td></tr>
</table>

		The monitoring team reviewed the documentation of interventions submitted by the facility. The interventions captured several types of issues related to medication orders, such as incomplete orders, allergies, side effects, missing indications, drug doses, and drug interactions. Incomplete orders and missing indications were frequently noted. There were also several interventions related to medication allergies and drug interactions. Many interventions reviewed by the monitoring team were evidence of some very good work being done by the clinical pharmacists in terms of providing recommendations to the medical staff. Other interventions indicated problems with medication orders and medication monitoring. The format of the WORx report was difficult to read and the monitoring team was not able to identify individuals when the name was not provided in the text of the comments. The following are a few examples of interventions documented in the reports submitted to the monitoring team: • 2/1/13: 1/9/13 - Olanzapine decrease was discussed in psychiatry clinic. Pharmacist followed up and discovered the order was never written. Notified MD and order was written. • 2/1/13: 1/11/13- Needed indication and EKG for quetiapine. Nursing was notified. • 2/1/15: 1/15/13 - Advised in Neurology clinic that divalproex may affect hyponatremia. • 2/1/13: 1/15/13 – Provided drug interaction information for valproic acid and lamotrigine noting that current dose is too high. • 2/1/13: 1/16/13 - Addressed EKG being overdue. Father to be called. • 2/1/13: 1/16/13 - Orders for monthly clozapine monitoring written in November but not followed. Orders were written again. • 02/01/13: Spoke to unit regarding Levaquin new order. Individual has a quinolone allergy listed on profile. Unit to clarify. Individual received Levaquin while hospitalized and the primary care physician has approved. • 2/4/13: Spoke to unit regarding pseudoephedrine 12.5 mg new order. Medication is not available in 12 .5 mg and pharmacy does not stock liquid. • 2/06/13: Spoke to nurse regarding po chlorpromazine pre-sedation order. Individual has a G-tube. Nurse will clarify order to reflect this. • 2/7/13: 2/5/13 - Spoke to unit regarding Level II drug interaction between valproic acid and the lamotrigine new order. Need acknowledgment from MD. Also left numerical page on MD's cell phone. o 2/6/13 -Spoke with unit again for follow-up. Nurse stated that the order is on hold and MD will talk to clinical pharmacist. o 02/7/13- Spoke with primary care physician regarding the concurrent use of the lamotrigine and divalproex. PCP and neurologist are aware that this individual is treated with divalproex in the addition of the lamotrigine could result in increased risk of blood dyscrasias and skin reactions, specifically Stevens Johnson Syndrome.	

		• 02/11/13: 1/3/12 - New order for Depakote ER 250 mg with no monitoring ordered. Faxed order. • 02/12/13: Left message for unit regarding new orders for Xopenex and Pulmicort - missing strengths. • 02/15/13: Spoke to unit regarding medication order with missing dosage formulation and duration. Also, it is missing a physician signature. • 02/15/13: 1/28/13 - Advised weight loss may be due to then the venlafaxine which usually occurs within a few weeks of initiation of treatment. Will continue to monitor. Also advised that blood pressure could not be located in chart and falls have been occurring. Recommend vital sign checks for one week. Recommendation not followed. • 02/15/13: 1/31/13 - Reminded nursing that FVC is overdue and sedation was suggested for next exam Doctor wrote order. • 02/15/13: 1/31/13 - Reminded EKG overdue - getting done. • 02/15/13: 02/4/13 - Consult for increased liver function tests. • 02/15/13: 02/7/13 - Reminded to write for vital sign checks for one week with increased quetiapine dose. • 02/15/13: 2/14/13 - Discovered that the order for divalproex was never written. Should have been initiated at last month's clinic. Started today and reminded that a serum level needed to be drawn. • 02/19/13: Left message for doctor regarding vitamin D new order. It is ordered both daily and four times a week. Also, days of week to be administered are missing from order. • 02/19/13: Spoke to doctor regarding new Depakote taper order. Individual is on Depakote ER and not plain Depakote. Order clarified. • 02/25/13: Spoke to nurse regarding phenobarbital order on 180 day re-admit orders from 2/23/13. Order was changed on 2/18/13 but this is not reflected on the recent orders. Unit will clarify. • 03/28/13: Spoke to doctor regarding carbamazepine new order as profile indicates an allergy to carbamazepine. Per doctor, individual is not allergic to carbamazepine. It is not a true allergy. • 03/27/13 - Spoke to unit regarding order to cancel guaifenesin DM. Individual is not on guaifenesin DM. • 03/27/13: Spoke to unit regarding Depakote new order. Individual has been on valproic acid syrup and not Depakote. Valproic acid order is still active. Unit to clarify drug order. • 03/16/13: 03/15/13 – Doctor wrote to increase quetiapine to 1000 mg which is over max dose. Called and discussed with him that hypotension may be in issue especially since individual has been having a lot of falls. Agreed and canceled order. Will discuss other options in clinic next week. • 03/16/13: 03/15/13 - Individual has an appointment for TIVA. Advised	

		obtaining EKG as well since it is overdue. Nurse case manager agreed to coordinate. • 03/12/13: 03/11/13 - Spoke to staff regarding the Lipitor order from 3/4/13. Order was not written on re-admit. Orders from 3/8/13. Unit will clarify. • 03/11/13: 9/27/12 - Need CBC/diff for current week. Spoke with staff on unit. They will draw on Friday a.m. o 9/28/12 –Spoke with staff. Blood was drawn but could not be spun today. Will have to redraw on Monday. • 3/11/13: 2/21/13 - Check that platelets had been drawn as individual has a history of thrombocytopenia. They did not show up on the last lab report. • 3/11/13: 2/20/13- Reminded nursing that individual is overdue for an EKG. Nursing stated they will schedule. • 3/11/13: 2/19/13- In neurology clinic, clinical pharmacist made the recommendation to taper the lamotrigine since individual was taking 1000 mg daily. Max dose is 400 mg. Medication is being tapered slowly to 400 mg. • 01/7/13: 1/4/13- Intelligent Alert monitoring needed for new Coumadin orders. CBC was not ordered. • 12/27/12: Spoke to staff on unit regarding allergy as acetaminophen is ordered and Vicodin has acetaminophen in it. Individual has gotten acetaminophen previously with no documented reactions. • 11/19/12: Spoke to staff on unit regarding new order for Pen-VK. Individual is penicillin allergic. Unit to notify prescriber. Notwithstanding the improvements in the documentation of the interactions, the monitoring team had several concerns about the prescribing and dispensing of medications at SASSLC: • Many of the interventions summarized above indicated continued problems with the medication use system, particularly the prescribing component of the system. Incomplete orders resulted in numerous interactions between the pharmacists and SASSLC staff. • Documentation demonstrated that there continued to be orders written for medications when allergies were documented on the profile. Discrepancies in allergy documentation posed a real risk to the individuals and this pattern did not appear to receive appropriate attention. The monitoring team has commented on this finding in previous reports. • The clinical interventions report documented several incidents in which medications were not accurately reconciled upon return of the individual to the facility. This did not appear to receive adequate attention. • The examples of clinical interventions listed in this section included several comments related to the use of drugs over the recommended doses. These appeared to be usually addressed by the SASSLC clinical pharmacists. Given this	

		provision's requirement to make recommendations "if the prescribed dosage is not consistent with facility policy or current drug literature," it would appear that these recommendations would occur prospectively at the time the medications were processed for dispensing. The format of the report made it difficult to determine when issues were resolved. While documentation of closure was lacking for several interventions, and delays were noted for some resolutions, it was clear that there was improvement in the documentation of closure of the interventions. During previous reviews, the monitoring team recommended that the medical director review and analyze intervention data to determine the presence of trends or patterns related to prescribing practices. The self-assessment documented that reporting and trending were done. This reporting and trending did not result in any information related to the categories of interventions. The lead pharmacist indicated this was not a priority item. As a result of this, there was no information on which issues presented the greatest challenges for the facility. However, it was reported that the most notable problem occurred with writing complete medication orders. The lack of true data analysis was a significant concern for the monitoring team because a review of several months of information indicated that many problems were recurrent and there was no evidence that the issues had been adequately explored and addressed. For example, the continued prescribing of medications in the face of documented allergies should have prompted a review to determine if this was limited to a particular practitioner or if the facility's current system of documentation of allergies contributed to this problem's recurrence. Over the past two years, the monitoring team has encouraged the facility to develop a process for management of drug interactions. The Pharmacy Services policy indicated that drug interactions would be handled by the policy of the State Hospital. No other information was provided and the policy was not submitted. The monitoring team did notice that the clinical interventions included entries related to the requirement to have the prescriber acknowledge certain drug interactions. 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." In order to fulfill this requirement, SASSLC implemented the Intelligent Alerts module of WORx in mid-December 2012. This was several months later than other facilities and was likely due to the fact that the facility contracted dispensing services to the nearby San Antonio State Hospital. During the conduct of the compliance review, the monitoring team visited the State Hospital Pharmacy and discussed the process with the pharmacy director, assistant director, and staff pharmacist. All were very familiar with	

		the requirements and the process. The staff pharmacist demonstrated the functionality of the Intelligent Alerts via the use of a test individual. State office issued guidelines to the SSLCs for use of the IA module. Per guidelines issued by state office, "At order entry, the pharmacist will verify that there is a corresponding order for the appropriate drug level or proper lab written, to be drawn within an appropriate amount of time, with orders for the following medications: carbamazepine, digoxin, levothyroxine/thyroid, lithium, phenytoin, valproic Acid / DVPX, warfarin, potassium. The list for SASSLC did not include the required monitoring for potassium." Additionally, SASSLC had added one additional drug for monitoring: quetiapine. According to state guidelines, "this list will constitute a minimum requirement, with the facility adding to the list as deemed appropriate for their particular drug utilization." During interviews, the lead clinical pharmacist stated that the previous medical director did not want to expand the list and the topic had not been re-visited with the current medical director. State office guidelines also required that "A report indicating all lab orders/monitoring will be ran weekly or monthly to ensure that monitoring is occurring and the Pharmacy Director or designee will discuss with the Medical Director on a monthly basis, any patterns or prescribing concerns." The medical director and clinical pharmacist reported that the follow-up on the actual implementation of required monitoring was included in the daily clinical services meetings. The items were not necessarily discussed, but were documented in daily reports. Quite a few retrospective clinical interventions were related to deficient lab monitoring and some were associated with drugs monitored by the IA module. It was not clear if these were detected prospectively, but nonetheless remained outstanding at the time of retrospective reviews, indicating that increased attention was needed to ensure that implementation occurs. Overall, the implementation of the IAs and improved documentation of interactions represented a significant improvement in this provision item. Even so, this area will require remediation of several issues that have been discussed in this and previous reports: • The documentation of communication and interactions must serve as a mechanism for improving the medication use system. In order to accomplish this, the medical director and lead pharmacist must ensure that the problems identified are corrected at the individual level and at a systems level. This will require a regular review of the clinical interventions aggregate data inclusive of the intelligent alerts. The facility must also codify this process in policy and procedure, thereby, outlining all of the actions necessary to fulfill the requirements of the Settlement Agreement and guidelines issued by state office.	

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.	Thirty QDRRs were assessed to determine the compliance rating for this provision item. The documents were evaluated for compliance with the timelines for completion and content. The QDRRs were thorough and commented on many clinically relevant issues. Recently completed reviews included a section that listed active medical problems, medication therapy, and the effectiveness of the medications. Comments relative to medication dosing guidelines/high doses, renal adjustments, metabolic risk, and osteoporosis were also found in the reviews. The monitoring of medication use, anticholinergic burden, and benzodiazepine use were discussed as well. Each review included a table listing pertinent lab values and the dates of the studies. With some exceptions, all values were usually documented. Normal ranges were included in the table. This was a very effective format that resulted in good information for the medical staff. The medication regimens for the individuals were very complex and the clinical pharmacists did a very good job of assessing these regimens and making many recommendations. The monitoring team did note a few, but not many, opportunities to improve upon evaluations that overall were excellently done. The following are a few examples: • Individual #333, 2/6/13: The individual was considered at risk for metabolic syndrome due to Zyprexa use. The last blood glucose, documented in October 2012, was 115. The previous glucose was dated June 2011. There was no hemoglobin A1c and no recommendation to obtain one. The weight was listed as elevated, but not specified. The clinical pharmacist also noted risk factors for osteoporosis, but there was no DEXA documented or recommendation to obtain one. • Individual #32, 1/28/13: This individual received multiple medications that required monitoring of the metabolic panel. The last was done in February 2012 and the clinical pharmacist noted that the next scheduled lab was March 2013. A recommendation to obtain one immediately should have been made given this severe deficiency. • Individual #113, 1/11/13: This individual received 600 mg of topiramate. The last metabolic panel was dated 8/12 and the weight was listed as below range, but not specified. The individual was also listed as at risk for osteoporosis, but no DEXA was documented. • Individual #282, 2/8/13: Comments noted that the individual had chronic renal failure. Chronic kidney disease was not included in the APL for the individual and there was no recommendation to update the APL. • Individual #64, 1/19/13: A recommendation was made to provide iron supplementation. This was not the most prudent recommendation because the results of the iron studies were not entirely consistent with iron deficiency. A more appropriate recommendation, if iron deficiency was believed to be present, would have been to investigate the etiology.	Substantial Compliance

		In addition to very good content, there was also marked improvement in the timeliness of completion of the QDRRs. During the August 2012 review, it was noted that 21% of individuals did not have QDRRs completed in a timely manner. The sample submitted by the facility, as well as the QDRRs included in the record reviews, indicated that the evaluations were being completed in a timely manner. Overall, there were no significant delays in physician review. The monitoring team does recommend that the facility have a process for date stamping the QDRRs when they are received by medical services for routing to the physicians. Overall, the clinical pharmacists completed through reviews in a timely manner. The monitoring team finds the facility to be in substantial compliance with 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 use of new generation antipsychotic medications.	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. 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. The monitoring team attended the meeting during the week of the review. This topic is also discussed in detail in section J11. <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. Some QDRRs included specific recommendations to decrease the anticholinergic burden and unnecessary medications. Additional recommendations were observed in the clinical interventions that resulted from psychiatry clinic. <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	Substantial Compliance

		section/statement related to metabolic risk that provided comments on the relevant parameters.	
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 providers' responses to both prospective and retrospective reviews. Based on the documentation provided, the providers accepted the majority of recommendations made by the pharmacists during prospective and retrospective reviews and they took appropriate actions. There were some instances in which the recommendations were not implemented, but overall the vast majority of recommendations were considered and subsequently implemented. Explanations were provided on the QDRR report when the recommendation was not accepted. Therefore, this provision remains in substantial compliance. The facility provided data on the total number of QDRR recommendations made by the pharmacists, stratified by providers. There were no data on the actual compliance with the implementation of actions following acceptance of recommendations. Documentation related to acceptance and rejection of recommendations also noted that many QDRRs were "not returned." This issue needs further exploration by the medical director and lead pharmacist. 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.	Substantial Compliance
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.	This provision item addresses the requirement to have, at a minimum, a quarterly evaluation of side effects completed by facility staff. Achieving compliance requires timely and adequate completion of the evaluation tools. Moreover, the intent of the evaluations is to provide clinically useful information. This provision item does not specifically address the pharmacy department's assessment of compliance with the requirement. The facility utilized the Dyskinesia Identification System: Condensed User Scale to monitor for the emergence of motor side effects related to the use of psychotropic medications. The Monitoring of Side Effects Scale was completed to capture general side effects related to psychotropic medications. While nursing conducts the reviews, the evaluation requires review and completion by a physician. 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, were reviewed. The findings are summarized below:	Substantial Compliance

		Thirty-four MOSES evaluations were reviewed for timeliness and completion: • 32 of 34 (94%) evaluations were signed and dated by the prescriber • 28 of 34 (82%) evaluations documented no action necessary • 1 of 34 (3%) evaluations documented actions taken, such as drug changes and monitoring • 5 of 34 (15%) evaluations did not include a physician conclusion Thirty-three DISCUS evaluations were reviewed for timelines and completion: • 31 of 33 (94%) evaluations were signed and dated by the prescriber • 26 of 33 (79%) evaluations indicated the absence of TD • 3 of 33 (9%) evaluations indicated the presence of TD • 3 of 33 (9%) evaluations did not include a physician conclusion Ten of the 34 MOSES evaluations were from the record sample. Fifty percent of the evaluations found in the record sample (random and not submitted by the facility) were not completed and had no MD assessment. Seven of the 33 DISCUS evaluations were from the record sample. Two of seven were not completed and had no MD assessment. For the 30 QDRRS reviewed, 27 of 30 required a MOSES, DISCUS or both evaluations. The clinical pharmacists commented on the completion of the evaluations: • 4 of 27 (15%) QDRRs indicated that the one or both evaluations were overdue • 8 of 27 (30%) QDRRs indicated that the one or both evaluations had no physician assessment and were therefore incomplete While the sample submitted by the facility indicated that the evaluations were appropriately and timely completed, the documents included in record sample and comments in the QDRRs indicated problems with timely and through completion. This problem was recognized by facility staff. In fact, the lead pharmacist surfaced this problem in the quarterly QA report stating "quite a few of the recommendations involved timely completion rates of the required MOSES and DISCUS exams." It appeared that the evaluations involved were for those individuals not seen in psychiatry clinic. The monitoring team requested the schedule for completion of the MOSES and DISCUS evaluations including the schedule for those not enrolled in psychiatry clinic. This information was requested onsite and following the compliance review. Two weeks following the review, the monitoring team was informed that this information was not available. The monitoring team did not have data on the total number of reviews or what percentage of reviews was for individuals not enrolled in psychiatry clinic. Record reviews indicated and the lead pharmacist acknowledged that there was a problem.	

		As noted in the August 2012 monitoring report, the clinical pharmacist indicated 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 completes the MOSES and DISCUS every quarter for all individuals who were seen in psychiatry clinic and for all individuals who received Reglan. The monitoring team was informed that this revision was not completed. Current nursing policy required completion of the MOSES evaluations every 6 months and the DISCUS evaluations every 3 months for psychotropic and other medications. 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. The neurology clinic template included the results of the most recent MOSES and DISCUS evaluations, but the neurologist made no comments on this information. The monitoring team has and continues to recommend that the primary care providers and neurologists review this information and appropriately utilize it in clinical decision-making. As already noted, the intent of the provision is to ensure that evaluations monitoring for side effects of medications are completed and the information utilized. This provision remains in substantial compliance. Maintenance of the rating <u>will require</u> the following: • All MOSES and DISCUS evaluations must be completed in accordance with facility policy and the Health Care Guidelines. Physician completion of the evaluation is a mandatory component of the process. • SASSLC must maintain data on all individuals that require the evaluations including those individuals not receiving psychotropic medications. • The primary care providers and neurologists must utilize this information in clinical decision. There should be documentation of data review such as an IPN entry, or notation in the required routine assessments.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow-up remedial action regarding all significant or unexpected adverse drug reactions.	The facility reported adverse drug reactions and developed a procedure for the 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 nine ADRs in the log since the last compliance review. There was one ADR reported to the FDA. The monitoring team attended the Pharmacy and Therapeutics Committee meeting during the onsite review. The meeting covered a variety of topics, including the presentation of three ADRs. Throughout the conduct of the meeting, several issues arose related to the occurrence of ADRs. For example, Individual #90 experienced probable akathisia related to a medication, but no ADR was reported. The medical director acknowledged that the facility was significantly under-reporting ADRs. The clinical pharmacist noted that the	Noncompliance

		recent reporting of the three ADRs was very unusual. Reviews of active records, clinical intervention data, and other documents indicated that the facility was under-reporting ADRs. An ADR procedure was implemented on 9/1/12. The procedure included most of the necessary components, however, it failed to define a threshold for further review or analysis by the facility. This is an important component of the ADR system because it provides a threshold for completing a more in depth assessment of ADRs that are serious, but may not be defined as sentinel events at the facility. This recommendation has been made in previous reports. The monitoring team noted the absence of discussion related to provision items N6 and N8 during the QAQI Council meeting. This seemed odd given that there were significant concerns regarding both provision items during the August 2012 compliance review and little progress was made since that time. The lead pharmacist commented to the monitoring team and state office staff that she was not sure of what to do about these two areas. She was encouraged to utilize the QAQI Council as a resource by presenting these problems for discussion rather than omitting them. This provision remains in noncompliance based on the under-reporting and deficiencies related to the ADR procedure.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The facility's DUE policy required completion of one DUE each quarter. SASSLC maintained a DUE calendar that was approved by the Pharmacy and Therapeutics Committee. Since the last review, DUEs on clozapine monitoring, phenobarbital and probiotic utilization were completed. Several ad hoc DUEs were also completed. Generally, the DUEs were thorough and provided clinically relevant information for the medical staff. Highlights are discussed below. The Clozapine DUE, presented at the November 2012 Pharmacy and Therapeutics Committee meeting, was conducted to determine if clozapine monitoring at the facility was appropriate. The DUE made several recommendations, including a recommendation to designate a staff member to manage the monitoring of the drug. The Pharmacy and Therapeutics Committee meeting minutes provided no follow-up on this recommendation. The Phenobarbital DUE was presented in February 2013. The exact objective was not clear with the report stating, "A DUE was completed for evaluation of individuals treated with phenobarbital. Specifically, the number of individuals treated with phenobarbital, the indication, the dose, and monitoring for vitamin D." The report summary noted that the majority of individuals receiving phenobarbitol were on monotherapy and had been seizure free for more than five years. Two of the three recommendations listed were crossed out. A recommendation was made to conduct a follow-up DUE to determine if	Substantial Compliance

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<tr><td></td><td></td><td>those on phenobarbital monotherapy had been evaluated by a neurologist to determine if continued therapy was warranted. The Pharmacy and Therapeutics Committee meeting notes documented that the medical staff did not think this was warranted

The monitoring team would like to emphasize that the Health Care Guidelines and facility policy require that individuals who are seizure free for five or more years undergo evaluation by a neurologist to determine the need for continued receipt of AEDs. An explanation regarding the decision to continue AEDs should be documented in the records of the individual. While this is required by medical policy, a DUE is not necessary to achieve this goal.

The probiotic DUE was presented at the P&T meeting conducted during the compliance review. The objective stated, " This review will focus on the incidence of Clostridium difficile and if probiotics have been beneficial to prevent this occurrence." Interestingly, the data revealed that one case of C. difficile occurred during the baseline interval of January 2012 – March 2012 and no cases were reported during the same period of 2013. The reported low baseline incidence could have been determined without a DUE and this may have impacted the decision to utilize critical resources for completion of a probiotic DUE. This finding does not diminish the facility's decision to utilize probiotics, but may have impacted the decision to utilize resources to conduct a DUE.

The monitoring team encourages the facility to adopt a utilitarian approach in conducting DUEs. That is, DUEs should focus on evaluations that will likely result in the greatest good for the greatest number of individuals. To that end, the continued use of criteria outlined in the Health Care Guidelines, emphasizing completion of DUEs on high use and high-risk medications, should be useful.

This provision remains in substantial compliance.</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, but insufficient progress was noted with the medication variance system. The Medication Variance Committee was implemented in October 2011 and was required to meet monthly, but only four meetings were conducted since the last compliance review.

The monitoring team reviewed data submitted by the facility. Minutes from the Pharmacy and Therapeutics and Medication Variance Committees were also requested and reviewed. The total number of variances and reconciled meds is presented in the table below:

<table>
<tr><td></td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sep</td><td>Oct</td><td>Nov</td><td>Dec</td><td>Jan</td><td>Feb</td><td>Mar</td></tr>
<tr><td>Total</td><td>175</td><td>166</td><td>213</td><td>--</td><td>--</td><td>167</td><td>189</td><td>64</td><td>133</td><td>209</td><td>385</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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</td><td>Noncompliance</td></tr>
</table>

Returned	--	--	--	3857	2904	4133	4849	3794	6816	4512	5411
Reconciled	--	--	--	3185	2442	3091	4035	2768	21	2969	3821
% Reconciled				83	84	75	83	73	.3	64	71

The number of variances had increased largely because of omissions. Over the past three years, the monitoring team has discussed the issue of medication reconciliation. Initial comments from SASSLC staff were that no medications were routinely returned to the pharmacy. During subsequent compliance reviews, the State Hospital pharmacy staff indicated that a small number of medications were returned, but the exact numbers were not known. It was revealed during the August 2012 visit, that significant, but unknown numbers of medications were being returned to the pharmacy. During the P&T Committee and Medication Variance Committee meetings conducted for this review, the data for returned medications were presented, beginning with the month of August 2012. It was documented that several thousand medications were returned to the pharmacy each month and there was no explanation for many of the returned medications. In fact, 1590 medications were returned in March 2013 for which no explanation existed. Some two years after this topic emerged, the facility still struggled to understand the etiology of unreconciled medications. The monitoring team made a specific request for the spreadsheet (database information) that listed each variance. A series of graphs was provided without the detailed information included in the spreadsheet.

Throughout the various meetings, it was clear that there were problems related to the critical analysis of the data. The following were noteworthy concerns based on the observations of meetings, discussions, and interviews:

- The format and types of data reviewed did not lend itself to appropriate analysis. Critical data analysis requires multiple presentations of data including tabular and graphic formats. Moreover, in order to conduct an adequate analysis, the data should be presented longitudinally in addition to monthly and quarterly reporting periods. Longitudinal assessments were noted for the medication reconciliation data. Beyond this, in order to note potential trends, all of the major metrics should be at least quickly reviewed longitudinally by the committees.
- Most errors were attributed to nursing and the pharmacy department. There were no graphs related to prescribing errors nor was there any discussion of prescribing errors until the monitoring team surfaced the topic. The monitoring team inquired about prescribing errors based on clinical intervention data that reported several issues that should have been investigated as prescribing errors.
- The lack of a robust assessment of data was also evident in the lack of information on the actual number of medications dispensed. Thus, the relative magnitude of the number of variances reported was not known.

Notwithstanding the series of problems discussed, the facility had taken some actions to address the medication variance issues. Medication reconciliation issues have dominated

		discussions for some two years. During this period, partial reconciliation was implemented, discontinued, revised, and re-implemented. The SASH robot was replaced at the end of 2012. Even so, the lead clinical pharmacist reported that many errors were in fact robot errors. In March 2013, a new reconciliation process was implemented and the CNE believed this would make a significant impact on the number of un-reconciled returns. The facility will need to take several actions to move towards substantial compliance: • The medication reconciliation issue must be resolved. Beyond this, due to the significant use of liquid medications associated with enteral tube use, the facility must be able to account for liquid medications in addition to pill medications. • The medical director should ensure that prescribing errors are appropriately reported. This will require the use of currently reported data such as the clinical interventions and QDRR data. • Every discipline head should discuss error rates and actions taken to correct problems during the variance meetings. This requires no new data but a critical analysis of the data already collected. • All disciplines should receive adequate training on the medication use system but particularly the facility's medication variance system. This provision item 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 continued. The outcomes of the interventions should be documented.
    b. There should be documentation of the resolution of the interventions. The medical director should be notified of resolution problems.
    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. This data should be analyzed for patterns and trends. Appropriate corrective actions should be taken for deficiencies and problems identified.
    e. The Intelligent Alerts module drug list should be reviewed and expanded to meet the needs of the facility. The state issued list was a minimum requirement.

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. The ADR policy must include a threshold for intense case review. The procedure should be outlined in policy. (N6).

7. The chairperson of the P&T Committee must ensure that recommendations resulting from the DUE are reviewed. When accepted, appropriate corrective actions should be implemented and followed through to completion. The P&T minutes must document closure of every corrective action that was implemented as a result of the DUE recommendations.

8. The facility should develop a DUE policy that specifies the process. The facility's DUE policy should clarify the requirements for development of the DUE calendar by the Pharmacy and Therapeutics Committee (N7).

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: <u>Documents Reviewed</u>: o SASSLC client list o Admissions list o Physical Nutritional Management Policy 012.3 (3/4/13) o PNMT Staff list and Curriculum Vitae o Staff PNMT Continuing Education documentation o List of Medical Consultants to PNMT o Section O Presentation Book and Self-Assessment o Section O QA Reports o PNMT Evaluation template o PNMT Referral form o Criteria for Referral to PNMT o PNMT Meeting documentation submitted o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o Individuals with PNM Needs o Dining Plan Template o Compliance/Effectiveness Monitoring template o Completed Compliance/Effectiveness Monitoring sheets submitted o Schedule of required monitoring o Monitoring Flow Chart documents o Competency training for trainers o Trend analysis documentation submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Lists of individuals who completed PNM core competency training o Hospitalizations for the Past Year o ER Visits o List of individuals who cannot feed themselves o List of individuals requiring positioning assistance associated with swallowing activities o Summary Lists 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 Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain

	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 With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs and sample picture pages submitted o APEN Evaluations: Individual #281, Individual #18, Individual #167, Individual #149, Individual #228, Individual #301, Individual #302, Individual #239, and Individual #126 o PNMT Assessments and ISPs: Individual #204, Individual #317, Individual #189, Individual #325, Individual #164, Individual #171, and Individual #267 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 #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. o PNMP section in Individual Notebooks for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104, Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #162, Individual #90, Individual #89, Individual #39, Individual #104,

	Individual #114, Individual #99, Individual #54, Individual #50, Individual #79, Individual #123, Individual #58, Individual #23, Individual #59, Individual #111, Individual #15, Individual #52, and Individual #31. Interviews and Meetings Held: o Margaret Delgado-Gaitan, MS, CCC-SLP, Director of Habilitation Therapies o Edward Harris, PT, DPT o JoAnna VanHoove, OTR o Allison Block Trammell, MA, CCC/SLP o Patricia Delgado, RN o Tracy Brazier, RD/LD o Retha Morgan Skinner, MOT, OTR o Wilfredo Diaz, PT, DPT o Various supervisors and direct support staff o ISP Meeting for Individual #54 Observations Conducted: o Living areas o Dining rooms o Day programs o Work areas o Bathing areas
	Facility Self-Assessment: As in previous reviews, the Director of Habilitation Therapies, Margaret Delgado-Gaitan, MA, CCC-SLP, outlined specific activities, many 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 taken. The Presentation Book provided the audit tools used to evaluate each Settlement Agreement element with data presented to illustrate those assessed, an analysis of the findings, and sample work products. The activities for self-assessment were generally appropriate and significantly improved from previous reviews. There was an effort to better analyze the findings for each provision and this should continue. Further refinement of the self-assessment process, analysis, and presentation of data is encouraged. Though continued work is needed, the monitoring team acknowledges the strides that Ms. Delgado-Gaitan and the habilitation therapies department made during the last six months. The facility rated itself as not in compliance with 0.1 – 0.3 and 0.5 – 0.8, and in substantial compliance reported with 0.4. While the actions taken continued to be definite steps in the direction of substantial compliance for 0.1 – 0.3 and 0.5 – 0.8, the monitoring team concurred with the facility's findings of noncompliance. Though there was clear progress in 0.4, there continued to be a number of errors with key elements of the plans, particularly related to positioning. Error rates as reported by the facility were low, but did not take into consideration

	which elements were not in compliance; when tracked in this manner, equal weight was applied to all elements. Also, the samples were skewed in that monitoring occurred across similar times of day and activities rather than being sampled across all times and environments. Excellent progress, however, was made in each of these.
	Summary of Monitor's Assessment: Progress was made towards substantial compliance with provision O. The PNMT was fully staffed, though there had not been a dietitian member for approximately two months. Each of the members, other than the new assigned dietitian, had participated on the team since the previous review. Back-ups had been identified and attendance at the meetings held was generally very consistent. A number of comprehensive assessments had been completed and these were much improved. The meeting observed by the monitoring team was organized and the documentation greatly improved. Team members were encouraged to more concisely and efficiently present data for analysis and review relative to individual status. There appeared, however, to be a significant delay/absence of referrals of individuals who would benefit from PNMT evaluation by the IDT. Also, the team was encouraged to pursue completion of action items in a more timely manner as the status of individuals requiring PNMT supports were urgent to resolution of identified health care needs. The team needs to recognize the urgency of the need for swift action and follow through. Outside consults and missing/delayed (e.g., height and weight) impacted the team's ability to make decisions and take further action. The PNMT appeared to be routinely and proactively reviewing individuals with a high risk of key PNM indicators. The status with regard to outcomes and exit criteria should be clearly established, reviewed, and modified as needed to ensure that transition to the IDT occurred consistently. Documentation of transition to the IDT was inconsistent. Mealtimes and position and alignment were improved, though some issues positioning continued to be an issue. Staff continued to lack confidence in their knowledge of key risk areas and the rationale for related supports they were responsible for providing. Significant issues related to availability of PNMPs was noted, though immediate corrections were made once pointed out by the monitoring team. There continued to be some inconsistencies on Dining Plans and PNMPs, some critical to staff accuracy of implementation. Review of these plans is needed in order to make corrections in a more timely manner. There were monitoring systems in place and these errors should not be missed. Monitoring of staff compliance must be consistent and effective. Monitoring should answer the following questions: • Are staff trained to do what is needed? • Are they routinely expected to do what is in the plan by supervisors? • Are staff doing the right thing even when they think no one is watching? PNM monitoring did not address all areas required, such as medication administration, oral care, and bathing. A system of effectiveness monitoring was not well established and will be necessary for further

	progress with this provision. Areas such as toothbrushing and oral sensitivity should be addressed through assessment, supports, and monitoring. Monitoring did not occur across the day. It instead focused on the first shift staff and on a limited number of activities and environments. The therapists were encouraged to more objectively evaluate individuals for protective equipment. There are a large number of helmets, gait belts, staff assistance, protective boots, for example. The least restrictive options should be selected. Decisions related to equipment should be data driven. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 17 individuals who were chosen from a list provided by the facility of individuals identified as being at a medium or high risk for or experienced an incidence of PNM related issues (i.e., aspiration, choking, falls, fractures, respiratory compromise, weight [over 30 or under 20 BMI], enteral nutrition, GI, osteoporosis), required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, presented with health concerns and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of the individuals who were assessed or reviewed by the PNMT over the last six months. Sample O.3 consisted of 10 individuals at SSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of	<u>Core PNMT Membership</u>: The PNMT at SASSLC included the appropriate disciplines as defined in the Settlement Agreement. Each were part-time team members who had other clinical duties, with the exception of the nurse which was a full time position. These were essentially the same staff as during the previous review, (Edward Harris, PT, Joanna Ramert VanHoove, OTR, Allison Block Trammell, MA, CCC/SLP, and Patricia Delgado, RN) with the exception of the dietitian member. The newly appointed dietitian was Tracy Brazier, RD/LD, who joined the team in February 2013. Back-up team members were identified for all positions, except the nursing position, however, the facility reported that a process was in place to do so. <u>Consultation with Medical Providers and IDT Members</u> The following were listed as consultants to the PNMT: Dr. David Espino (Medical director), Dr. Linda Fortmeier (physician), Dr. Yenni Michel (physician), and Dr. David Bessman (physician). A number of these individuals attended the meeting observed by the monitoring team and their contributions were very valuable to the process.	Noncompliance

#	Provision	Assessment of Status	Compliance
	care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	<u>Qualifications of PNMT Members</u> The qualifications of the current PNMT members were as follows: 5 of 5 core team members (100%) were currently licensed to practice in the state of Texas, as verified online. All designated back-up team members held current licenses to practice in their disciplines per online verification. 4 of 5 core PNMT members (80%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. The dietitian appointed to the team in February 2013 had no documented experience specifically with individuals with developmental disabilities, however, she had worked as a clinical dietitian since 2002 providing nutrition services at a number of hospitals and the Department of State Health Service. Her CV documented working on interdisciplinary teams, providing enteral and parenteral nutrition support wound care, comprehensive nutrition assessments and training of staff, patients, and their families. <u>Continuing Education</u> 5 of 5 PNMT core team members (100%) had completed continuing education directly related to physical and nutritional supports and transferrable to the population served during the past 12 months. Courses attended by the team members included the following, most of which were attended by multiple team members: • Back to Basics and Up to Speed Nutrition (7 hours) • Understanding the Vestibular System to Improve Balance and Reduce Falls in Older Adults, Parts I and II (2 hours) • Aspiration Pneumonia and the Role of the SLP: Using Evidence to Determine Risks Associated with Oral Feeding (6 hours) • Drugs and Dysphagia: How Medications Effect Eating and Swallowing (4 hours) • How Do We Treat This Patient with Dysphagia? (1 hour) • Medication Administration for Nurses for Individuals with Developmental Disabilities (7 hours) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities (11 hours) • Medication Administration for Nurses (7 hours) • Wheelchair, Seating, Mobility, and Positioning (3 hours) • PESI Healthcare: Managing Dysphagia (1 hour) • Wheelchair Seating and Mobility Evaluation (2 hours) • Equipment Webinar- Positioning (1 hour)	

#	Provision	Assessment of Status	Compliance
		• Selecting a Dysphagia Patient's diet (1 hour) • Seating: bottom to Top and Standing Justified (20 hours) • 2012 Neurorehabilitation Conference (6 hours) The extent of continuing education obtained by this group of clinicians was extensive and commendable. <u>PNMT Meetings</u> From 8/2/12 to 3/28/13, the PNMT met 40 times, based on the documentation submitted. The team generally met at least one time weekly with additional attendance at IDT meetings as needed. Based on review of the minutes, attendance by core PNMT members for 40 meetings conducted during this time frame was: • RN: 98% attendance by core member, no back-up member, and 98% overall. • PT: 90% attendance by core member, 10% for back-up member, 100% overall. • OT: 93% attendance by core member, 0% for back-up member, and 93% overall. • SLP: 93% attendance by core member, 5% for back-up member, 98% overall. • RD: 53%% attendance by core member, 0% for back-up member, 53% overall. Attendance was very good with the exception of the dietitian. This position was vacant from 12/13/12 until 2/14/13. The provision for back-up team members generally ensured representation by most of the key disciplines at each meeting and a back-up for the dietitian was assigned as of April 2013. In addition, a PCP, the Medical Director, and the Pharm.D attended eight meetings during that time. This section of provision O requires that the PNMP 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. Also, the PNMP is to be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. This aspect of O.1 is reviewed in O.3 below. A fully constituted PNMT was not in place throughout this review period, due to the lack of a dietitian member as of 12/13/12 and a replacement was not in attendance until 2/14/13. Consistency should be improved if this position is maintained. Further there was limited evidence of physician consultation throughout this period (20% attendance at meetings). This appeared to be improving. The participation of the physicians was excellent during the meeting observed by the monitoring team. While attendance is an excellent method to gain the input of the medical staff, alternate methods to demonstrate their availability to the PNMT is advised as well for compliance with this aspect of O1.	

#	Provision	Assessment of Status	Compliance
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	<u>Identification of PNM risk</u> All individuals at SASSLC identified with PNM needs were provided a PNMP, thereby ensuring that each individual who could not feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who was at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a current PNMP. There were only 23 individuals identified with no PNMPs. Based on lists of individuals with identified PNM concerns, including requiring positioning assistance associated with swallowing, who are dependent on others to eat, and/or have difficulty swallowing, there were four individuals with one of these concerns who were listed as not having PNM needs: Individual #43, Individual #86, Individual #296, and Individual #205. There was no evidence that these individuals had a PNMP, though they were each identified with difficulty swallowing. The identification of other PNM concerns was via the at-risk system implemented at the facility. Improvements were noted in the completion of the risk rating tools. The action plans were also improving as there was more evidence that the IDTs attempted to identify unique strategies to address issues for the individual rather than rotely stating that they would follow existing plans. <u>PNMT Referral Process</u> The PNMT received some referrals from the IDTs, though most individuals followed by the team were self-referrals. From 7/26/12 to 3/21/13, there were 13 individuals referred to the PNMT with 92% of those self-generated. One for Individual #171 was a referral by his IDT. Several individuals were followed by the team for extended periods of time (Individual #302, Individual #47, and Individual #106). There were 8 individuals on the current active caseload for the PNMT as of 3/29/13. Six of these individuals were referred seven to nine months ago (Individual #266, Individual #302, Individual #47, Individual #267, Individual #106, Individual #23). Two were discharged since the previous review (Individual #266, Individual #149). The specific criteria for IDT referral were included in the state policy, Physical Nutritional Management (012.3), effective 3/4/13 as follows: • Two choking incidents in one year • Two aspiration pneumonia diagnoses in one year • Results of PNMT nurse Post-Hospitalization Assessment for individuals diagnosed with any of the following: a. Aspiration Pneumonia b. GI Issues c. Fractures d. Skin Integrity	Noncompliance

#	Provision	Assessment of Status	Compliance
		e. Seizures • New or proposed enteral feeding • Unresolved vomiting (>3 episodes in 30 days not related to viral infection) • Significant/unplanned/verified weight loss or gain of: a. 5 pounds in one month b. 3 or more pounds per month for 3 consecutive months, or 7.5% of body weight for 3 consecutive months c. 10% if body weight in 6 months • Any stage III or IV decubitus, or any stage II with delayed healing • Fracture of a long bone, spine, or hip A flowchart was developed to outline PNMT criteria for discussion, investigation, and/or actions. These were used as guides for PNMT review to determine the follow-up necessary by the team. This was a very good approach and also provided additional guidelines for steps the team should take related to specific occurrences and health issues. This essentially served as a screening to determine the need for a comprehensive assessment by the team. It also served as an assessment plan to direct the team and integrated collaboration with the IDT as indicated, as well. Further, the team established thresholds for intervention related to nine PNM-related risk areas: aspiration, decubitus, fractures, choking, weight, respiratory, bowel obstruction, dehydration, and GI. These were tracked by the team based on data derived from the clinical rounds, pneumonia team minutes, ODRN reports, CC logs, and hospital reports from the liaison. This was intended to identify needs for supports and interventions early, rather than waiting for significant health issues to occur before action was taken. The reasons for referral since the last review were respiratory compromise (3), falls (3), weight loss (1), weight loss and GI concerns (1), falls and weight loss (1), aspiration pneumonia (3), aspiration, falls and fracture (1), falls and fractures (1). Evaluations were completed for 13 of these, all since the previous review. • When an individual experienced a change in status that would warrant a referral to the PNMT, for 1 of the 10 individuals (10%), there was evidence of an IDT referral to the PNMT. It could not be determined if this was completed within five days of the ISPA, however. Per the assessment completed by the PNMT (2/14/13), Individual #171 had not actually met criteria for weight loss to warrant referral, but upon review, they noted a number of irregularities in documented weights, observation of general deconditioning and appearance, and a significant number of falls in the past 12 months (13). The other individuals were self-referred by the PNMT itself. o Individual #164 had been hospitalized for chemical pneumonitis	

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		secondary to emesis (ruled as aspiration syndrome rather than aspiration pneumonia by the Pneumonia Committee in July 2012 and aspiration pneumonia in December 2012). He was self-referred to the PNMT due to two hospitalizations related to respiratory concerns. o An assessment was completed on 2/1/13. Individual #325 was self-referred to the PNMT due to undesired weight loss (continued for three months and was greater than 10%). An assessment was completed on 2/14/13. o Individual #317 was self-referred to the PNMT due to two hospitalizations for respiratory concerns and a diagnosis of aspiration pneumonia. He was assessed on 1/31/13. o Individual #189 was self-referred to the PNMT after two hospitalizations for respiratory concerns in six months with a diagnosis of aspiration pneumonia in August 2012. He was evaluated by the team on 12/28/12. o Individual #204 was also self-referred after at least three documented falls in one month and at least six over the past year. Though she did not experience a long bone fracture, she had three small bone fractures in the past year. She received a PNMT assessment 2/28/13. • There were several references to aspiration pneumonia for individuals reviewed by the PNMT, yet only two individuals were identified with aspiration pneumonia on the list submitted by the facility (Individual #54 and Individual 149). Dates of diagnosis or hospitalizations were not listed for either. Neither had been referred to the PNMT in the last 12 months. • There were approximately 55 individuals listed with an unplanned weight loss of 10% or greater in six months, which per the criteria, would require referral and at least review by the PNMT. If this was accurate, there was a significant issue related to weight loss that was not effectively being addressed. It is of concern that there was not sufficient attention to prevent most of these individuals from significant weight loss over a six months period. • There were approximately 51 individuals listed with falls based only on injury reports. At least 13 of these were listed with a serious injury (Individual #41, Individual #255, Individual #106, Individual #266, Individual #71, Individual #204, Individual #194, Individual #214, Individual #270, Individual #171, Individual #120, Individual #198, and Individual #254). The actual number of falls, that included non-injury falls, was not provided. Based on the list submitted there were at least 21 individuals who experienced more than one fall with injury. Twelve individuals had at least two falls with injury, two with serious injuries (Individual #255, Individual #204, Individual #194, and Individual #198). Five individuals experienced at least three falls with injury, one with a serious injury (Individual #266). There were at least three individuals with four	

#	Provision	Assessment of Status	Compliance
		falls with injury, two serious (Individual #191 and Individual #254). Three individuals with falls were also identified with fractures in the last six months (Individual #266, Individual #204, and Individual #254). Some individuals were self-referred for PNMT intervention related to falls: Individual #266, Individual #254, Individual #47, Individual #106, and Individual #204. There was one IDT referral related to falls: Individual #171 (in addition to weight loss). • 0 of 2 individual who received a feeding tube (not on an emergency basis) since the last review (0%) had been referred by the IDT to the PNMT prior to the placement of the tube. Individual #106 and Individual #23 had tube placements during hospitalizations, though these did not appear to be emergency situations. Individual #106 was self-referred within 10 days of tube placement and Individual #23 was self-referred to the PNMT on 7/26/12 prior to tube placement on 8/15/12. There was no evidence of an assessment, however, for either individual. A PNMT meeting was observed by the monitoring team. PCPs and the medical director attended for the portion of the meeting for the individuals on their caseloads. No other IDT members were present. The PNMT had significantly improved its method of documentation. There was a projector available for use, allowing the documentation to be readily available to all team members throughout the meeting. Further refinement of the discussion process to make best use of physician time was encouraged. The PNMT developed a very clear flow sheet to direct the type of review and actions required by the PNMT. This carefully defined who should be referred, yet provided appropriate brevity of the PNMT to determine the type of review that was indicated based on the data present. Specific PNM-related elements were tracked or reviewed for individuals in weekly PNMT documentation, so that the PNMT could track established thresholds for specific incidents or health events in order to permit individuals to be identified sooner. This information was gleaned from morning reports attended by the PNMT RN as well as from other sources. This process should also address facility trending of occurrence for specific individuals, facility wide, and over time. Collaboration across departments was indicated, including incident management, risk management, QA, and others. This is another area where specific benchmarks may be tracked in an effort to reduce the occurrence of some of these key indicators. <u>PNMT Assessment and Review</u> • 0 of 7 PNMT assessments submitted (0%) were initiated at a minimum within five working days of the referral. • 4 of 7 PNMT assessments (100%) were completed in less than 30 days of the referral.	

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		The assessments completed by the PNMT should be comprehensive, including specific clinical data reflecting an assessment of the individual's current health and physical status, with an analysis of findings, recommendations, measurable outcomes, monitoring schedule, and criteria for discharge. Based on review of the assessments submitted, the comprehensiveness of the PNMT assessment components was as follows: • 7 of 7 (100%) contained date of referral by the IDT (or self-referral). Most of these were self-referrals; • 7 of 7 (100%) contained date assessment was initiated; • 7 of 7 (100%) contained evidence of review and analysis of the individual's medical history; • 7 of 7 (100%) identified the individual's current risk rating(s), including the current rationale • 7 of 7 (100%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data. • 7 of 7 (100%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition; • 7 of 7 (100%) contained assessment of current physical status; • 7 of 7 (100%) contained assessment of musculoskeletal status; • 7 of 7 (100%) contained evaluation of motor skills; • 7 of 7 (100%) contained evaluation of skin integrity; • 7 of 7 (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene; • 7 of 7 (100%) contained evaluation of current adaptive equipment; • 2 of 7 (29%) contained nutritional assessment, including but not limited to, history of weight and height; intake, nutritional needs, and mealtime/feeding schedule; • 7 of 7 (100%) contained evaluation of potential or actual drug/drug and drug nutrient interactions; • 0 of 3 (0%) identified residual thresholds, if enterally nourished; • 7 of 7 (100%) contained a tableside oral motor/swallowing assessment, including but not limited to, mealtime observation; • 7 of 7 (100%) contained respiratory status; • 7 of 7 (100%) contained evidence of review/analysis of lab work, though this was related to pharmacy only, with no evidence of review relative to nutrition or other health concerns; • 7 of 7 (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects;	

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		• 7 of 7 (100%) contained discussion as to whether existing supports were effective or appropriate; • 7 of 7 (100%) contained oral hygiene status, though not all were current. Observation of oral hygiene/tooth brushing was reported for only 4 of 7 individuals (57%); • 7 of 7 (0%) contained evidence of observation of the individual's supports at their home and/or day/work programs; • 7 of 7 (100%) contained evidence that the PNMT conducted hands-on assessment; • 7 of 7 (100%) identified the potential causes of the individual's physical and nutritional management problems; • 7 of 7 (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rational for the recommendations; • 1 of 7 (14%) contained recommendations for measurable skill acquisition programs, as appropriate; • 0 of 7 (0%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status; • 0 of 7 (0%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. The outcomes were identified, but only criteria for re-assessment were outlined rather than clinical indicators for when nursing staff should contact the PNMT. The criteria for re-assessment or review were often occurrences of negative outcomes (such as additional fracture, for example), rather than specific indicators that may require attention prior to actual occurrences; • 7 of 7 (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP); and • 4 of 7 (57%) contained recommendations for monitoring, tracking or follow-up by the PNMT; and • 0 of 7 (0%) contained signatures with dates, though other core team members signed, only two contained signatures by a dietitian. Compliance with each of the 32 elements outlined above was 100% for 69% of the elements. All others were below 60%. This was a significant improvement from the previous review. Individuals followed by the PNMT, should have clinical indicators included as part of the risk action plans. The IHCPs for individuals with physical or nutritional management difficulties require effectiveness monitoring to assess the individuals' status and the	

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		impact of interventions and supports. The individuals' IHCPs should also identify objective clinical data to define health and wellness. Furthermore, the IHCP should identify objective clinical data to indicate when an individual might be experiencing a change in health status. Effectiveness monitoring requires monitoring of these individual-specific objective clinical data to determine the efficacy of the IHCPs interventions (of which PNMT interventions are a part). Team review would be necessary to determine if the plan is being implemented as written, staff are adequately trained, etc. However, if the team determines interventions are not effective, the IDT/PNMT should revise these interventions. Plans should be revised within 24 hours, or sooner if the concern is critical, when a change is indicated. This should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u> Plans resulting from PNMT recommendations included the following components: • For 0 of 7 individuals (0%), all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs, and IHCPs. Though requested, notations were submitted that they were not obtained. • Integrated Health Care Plans (IHCPs) were submitted for 5 of 7 individuals, identified as Change of Status Health Care Plans. These addressed all of the recommendations made by the PNMT in their assessments, but did not reflect integration into the full IHCP and ISP. There were no ISPAs submitted to reflect discussion with the IDT that evidenced integration of the recommendations. Of these, four were included in the Sample O.1 (Individual #204, Individual #325, Individual #189, and Individual #317). These documents were also not noted in the active record documents submitted for Individual #325 (no ISPA, the IHCP was not dated), Individual #189 (no ISPA, no IHCP), Individual #204 (no ISPA, no IHCP), and Individual #317 (no ISPA, no IHCP). • In 1 of the 7 plans reviewed (14%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. Measurable outcomes were related to discharge criteria rather than measures of efficacy. The action steps were assigned an implementation date and a completion date, but there were no target dates. • In 1 of the 7 plans reviewed (14%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In 1 of the 7 individual's plans reviewed (14%), the plans included the specific clinical indicators of health status to be monitored. • In 0 of the 7 individual's plans reviewed (0%), the plans defined individualized triggers. • In 7 of the 7 individual's plans reviewed (100%), the frequency of monitoring was included in the plans.	

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		PNMT Follow-up and Problem Resolution There were a total of 73 action steps identified across seven assessments. Of these, only 10 were identified as completed (14%). Some of these items were likely implemented as of the implementation date specified in the plan, but others required a completion date, such as staff training, revision of a PNMP, order diagnostic testing, and consult with family. Many of the plans were developed months ago, but did not appear to be in place. Individuals Discharged from the PNMT There were two individuals discharged from the PNMT during the last six months: • Individual #266 (referred: 10/4/12, discharged: 11/14/12) • Individual 149 (referred: 2/29/12, discharged: 11/8/12) For individuals discharged by the PNMT, there should be an ISPA meeting to discuss PNMT discharge to the IDT. A discharge summary should be completed that provides objective clinical data to justify the discharge. All recommendations should be integrated into the IHCP with specific criteria for referral back to the PNMT. Individual #149 was included in Sample O.1. Based on review of her documentation, there was an ISPA to document review of her PNMT Comprehensive Assessment (undated), but nothing to indicate that she had been discharged from the team. There was no plan to document steps and strategies to ensure this process integrated all of the elements of the PNMT plan with monitoring and follow-up as required. In any effective PNM program, the referral to the PNMT is required to occur in a timely manner, so as to capitalize on the collective expertise of the team members in order to see the problem in a new way and to identify new strategies to address ongoing issues that had not yet been resolved. There is an urgency to complete PNMT assessments that are thorough, current, and accurate, and to implement appropriate and effective interventions. This should be completed within 30 days, though some interventions may need to be implemented immediately before the written report is finalized. It is critical that the assessments be completed in a timely manner because these individuals present with significant identified needs for supports and services to address PNM health concerns. The SASSLC PNMT appeared to understand this responsibility and the assessments were conducted in a very timely manner. Follow-up, however, did not always reflect a sense of urgency (e.g., Individual #302, Individual #325). This was discussed during the PNMT meeting observed by the monitoring team. That being said, the PNMT was moving along the continuum toward compliance with this aspect of O.2. Further work was needed, however, with regard to identification of need, timely referral by the IDT, follow-up, integration into the ISP, and documentation of each of these.	

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O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>Identification of Individuals Requiring a PNMP</u> In Section O.1, the Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team, as appropriate. Per current state office policy, each individual's team should decide which team members should attend the annual meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individuals' care and treatment do not need to attend. Attendance by key IDT members for review and approval of the PNMP included the following current ISPs with signature sheets (13/17 ISPs included signature sheets): • Medical: 23% (2/13), improved from 13% • Psychiatry: 0% (0/13) • Nursing: 88% (14/13) • RD: 8% (1/13) • Physical Therapy: 46% (6/13) • Communication: 85% (11/13) • Occupational Therapy: 54% (7/13) • Psychology: 92% (12/13) • Dental: 0% (0/13) • Pharmacy: 8% (1/13) 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 unless each of the team members is present to participate in that process. The new pre-ISP process will identify which team members are required to attend the ISP meeting and they should consider which key members are required to ensure appropriate review of the PNMP. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1: • PNMPs for 17 of 17 individuals (100%) were current within the last 12 months. • PNMPs for 17 of 17 individuals (100%) included a list of PNM risk levels. Only PNM risks and triggers were listed. Outcomes were no longer included in the plans. It was understood that the state guidelines related to the PNMP format had changed and that this was consistent with those changes. There was also no indication on the plan whether the individual had an aspiration trigger data sheet. • In 14 of 17 most current PNMPs (82%), there were large and clear color	Noncompliance

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		photographs with instructions. The picture of wheelchair alignment for Individual #213, showed her in a slumped position and not well supported. Though a wheelchair was identified during meals for Individual #277, there were no pictures provided with his PNMP. • 17 of 17 PNMPs (100%) listed the assistive equipment required by the individual with rationale or purpose. In some cases a wheelchair was used by the individual, but not listed as assistive equipment (Individual 149, Individual #213, and Individual #277) • In 17 of 17 PNMPs (100%), positioning was adequately described per the individuals' assessments or the individual was described as independent. • In 17 of 17 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 13 of 17 PNMPs (100%), bathing instructions were provided. These were often general descriptions of level of assistance required only. • In 12 of 17 (71%) PNMPs, toileting-related instructions were provided, including check and change. These were typically general descriptions of level of assistance required, however, often in therapy terms of max-mod-min assist. • In 17 of 17 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. • In 17 of 17 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • 17 of 17 individuals (100%) Dining Plans were current within the last 12 months. • 6 of 17 individuals had feeding tubes with no oral intake. 6 of 6 PNMPs/dining plans indicated the individual was to receive nothing by mouth (100%). • In 17 of 17 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. Though as described above, some individuals were not in optimal positions in the photographs. • In 12 of 12 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 12 of 12 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 12 of the 12 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and the rationale was provided. • In 17 of 17 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency.	

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		• In 17 of 17 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • 17 of 17 PNMPs (100%) included information related to communication (how individual communicated, how staff should communicate with individual). The PNMPs reviewed were generally very good with very comprehensive content. Though there were definite improvements in the content of the PNMPs, there was an issue related to the availability of these to staff. Audits showed improvements, but consistency with the essential elements was not well established. Instructions and pictures related to position and alignment continued to be problematic.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	<u>Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs</u> Dining Plans were readily available in the dining areas. There was a significant issue with the availability of the PNMPs during the week of this onsite review. Staff across homes reported that these had either been locked up or put away due to concerns for privacy. In one home, one staff was assigned to 10 individuals. When asked to see one individual's PNMP, she indicated that to do so, she would need to get a replacement staff for the group, seek a supervisor with a key to the room where they were locked up, and only then could she access the plan to look up something contained in it. This was not acceptable. Subsequently, there was a noted improvement in the availability of the individual notebooks and PNMPs. General practice guidelines (foundational training) 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 by the therapists and PNMCs. There appeared to be some issues as to what was actually considered to be NEO training per CDT and, as such, documentation of completed competency testing in all areas of PNM was not clear. This needs resolution. • 39 of 50 individuals' (78%) dining plans were implemented as written. • 12 of 22 individuals' positioning plans were implemented as written (55%). Based on additional observations: • 0 of 1 (0%) individual's oral hygiene plans were implemented appropriately. Staff did not brush for an appropriate length of time and head alignment was not adequate. • 3 of 3 individuals' transfer plans were implemented as written (100%). No bathing was observed, so the following metric did not apply: • ___ of ___ individuals' bathing plans were implemented as written. However, a number of concerns were identified related to the wedges used for bathing. At least one of these was not appropriately and safely secured to the bathing table.	Noncompliance

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		Observations and suggestions were shared with the director. <u>Choking/Aspiration Events</u> There were 5 individuals identified at high risk for choking and 156 others were considered to be at medium risk. There were no choking incidents since the previous review. This is commendable and reflective of improved implementation of dining plans. Many staff continued to require prompts to answer questions related to risks, though others did an excellent job of describing the individual's risks and could explain why they had a modified texture or liquid consistency, or required a special spoon or mealtime strategy. Most immediately indicated that they needed to look at the plan in order to answer questions, but when prompted, they were able to provide the answers accurately. They continued to need to refer to a written plan to know what they were to look for. Review of the plans and risks should be done when the staff were initially assigned for the day, but even so, staff should have an active knowledge of the individuals to whom they were assigned on any given day, however: • The staff were assigned as responsible for the individual. • The staff should have already reviewed the plan prior to taking on that responsibility. • The staff should be trained to competency to work with that individual. • Staff should know many, if not most, of the risks and rationale for the supports they provide. It is critical that they know what to look related to potential triggers or clinical indicators so that any necessary action may be taken promptly. While there was clear progress in this area, there continued to be a number of errors with key elements of the plans, particularly related to positioning. Error rates as reported by the facility were low, but did not take into consideration which elements were not in compliance. Some elements were essential, however, when tracked in this manner, equal weight was given to all. Also, the samples were very skewed in that they monitoring occurred across similar times of day and activities rather than sampling across all times and environments.	
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	<u>NEO Orientation</u> Habilitation Therapies and CTD staff provided new employees with classroom training on foundational PNM-related skills. Class time to address PNM was two hours for orientation and mobility, four hours for communication/deaf awareness and AAC, and eight hours for lifting and transfers (CTD provided this training with check-offs). It was reported that there was a presentation of foundational skills, with modeling by the trainers to new	Noncompliance

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	nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	employees. Practice time was provided with coaching by the trainers and then new employees were checked off on each skill, using the checklist, outside of the classroom, by the PNMCs with the exception of lifting and transfers. If the new employee failed to demonstrate competency, the check-off was discontinued and re-training and coaching were provided. There appeared to be some discrepancy in the understanding of this aspect of new employee staff training. In a conversation with CTD staff, this training was not characterized as part of the required NEO training, but rather was provided as a part of home-based training. All aspects of PNM training, including the competency check-offs provided to new employees, should be a key part of NEO. This training should ensure competency of all newly-hired staff for implementation of basic foundational skills related to PNM, prior to assignment to the homes. Home-based (non-foundational) training should focus on individual-specific programs. Non-foundational training requires individualized techniques or strategies that vary from the basic foundation skills taught in NEO and, as such, requires further training and check-offs. A system to track which staff have been determined in each level of training should be a coordinated effort by the facility and include CTD, Habilitation Therapy, and residential leadership. This is critical to effective staff management to ensure assignment of properly trained staff to individuals for safety and optimal support of specific needs related to care and programming. New trainers participated in a process of observation, practice, co-teaching, independent teaching, and audits to establish and maintain competency. By report, every trainer was audited by the Habilitation Therapies Director annually. NEO training was provided by licensed therapists with assistance from PNMCs. The PNM-related core competencies (i.e., foundational skills), in addition to communication and AAC addressed in section R, included in the NEO training was comprehensive. It was an extensive curriculum containing the following minimum elements: • Lifting and Transfers; • Positioning and re-positioning(Alternate, bed, wheelchair, and bathing/showering); • Adaptive Equipment; • PNMP orientation and implementation; • Safe Mealtime strategies and dysphagia; and • Preventing aspiration pneumonia, skin breakdown, injuries, falls. There were extensive associated skills-based competency check-offs for most of this content. The check-off process observed in the previous review by the monitoring team	

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		was excellent. Revisions had occurred over the last six months resulting in improvements in content and check-offs. <u>Individual-Specific Training</u> Since the previous review, the facility had initiated specialty competency-based training for non-foundational skills that were specific to individual PNMPs. At the time of this review, it was reported that 53% of staff who required this training had completed it. <u>PNM Core Competencies for Current Staff</u> Refresher courses for all existing staff were required annually for lifting and transfers only. Skills-based competencies were also required for this. Consideration for additional refresher courses across more of the core PNM competencies should be considered. Individual-specific training had recently been implemented so further progress is expected in future reviews.	
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.	<u>Facility's System for Monitoring of Staff Competency with PNMPs</u> The monitoring tools generally included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. Instructions for use of these forms were not submitted. SASSLC continued to use separate PNMP monitoring and mealtime monitoring forms rather than the Universal Monitoring Form used in other facilities. The forms used at SASSLC included discrete measures, thus, issues could be readily identified for systemic change. For example, there were separate elements related to implementation positioning, techniques, adaptive equipment, bite size, and pace, whereas on the universal form, these were clustered together. The staff conducting monitoring were also generally competent in the areas they were monitoring based on the existing system of competency training, though the system of validation on a routine basis was not clearly established. Monitoring was to be conducted on intervals determined by the therapists based on the newly established flow chart (see below) and depending on the individual's risk levels. While the department had the ability to track staff names, these were not used to ensure that all staff were routinely monitored for the implementation of all aspects of the PNM for individuals to whom they were assigned. The current frequency of monitoring (PNM and Mealtime) appeared to be occurring at least at the prescribed frequency or, in most cases more frequently. This will be examined more carefully during the next review as the new system to determine frequency was newly implemented at this time. While the system to establish frequency was adequate to establish staff competency, there was a wide range of options for therapists to select and many were not sufficient for	Noncompliance

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		individuals at highest risk for PNM concerns. It was also of concern that it was likely that some staff were not monitored routinely for continued compliance with implementation of plans for which they were deemed to be competent. The monitoring team requested monitoring forms completed in the last month. There were 49 Physical Management Observation Forms and 43 Meal/Oral Intake Observation Forms submitted. One of these was marked as a competency check. PNMP monitoring was completed as follows: • There was no monitoring conducted on third shift. • 9 forms (18%) were marked as completed after 2:00 pm (second shift) and none of these were completed after 3:30 pm. • 3 forms (6%) were completed between 12 noon and 2:00 pm. • 34 forms (69%) were completed between 8:00 am and 12 noon. • 0 forms (0%) were initiated prior to 8:00 am. • 4 forms had no time designated. Compliance scores were not calculated. Only six forms identified any "no" responses, indicating that a concern was noted. This did not appear to be consistent with general observations by the monitoring team. Transfers were rarely noted as observed. There was an action documented in each of these cases, however. The PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase PNM risk, including bed position, bathing, medication administration, and oral care. Also, because monitoring occurred only one time, all aspects of alternate positioning were not typically observed. In most cases, the monitor identified the position the individual was in at the time of the observation. Mealtime monitoring was completed as follows: • There was no monitoring conducted on third shift because breakfast times appeared to be scheduled on first shift only. • 4 forms (9%) were marked as completed for the dinner meal. • 31 forms (72%) were completed for lunch. • 8 forms (19%) were completed for breakfast. • None of these appeared to be related to individuals who received non-oral intake. It was of concern that only 1 individual had been reviewed because a number of the individuals who received enteral nutrition were at high risk in some area of PNM and should have been monitored at least monthly. Compliance scores were not calculated.	

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		There was consistent trend analysis of the findings from monitoring in both areas. The facility tracked error rates and the target was 20% or less each month. As there was no weight value assigned to any of the elements, 20% could be very high depending on the specific elements that were in error. This should continue to be reviewed to ensure that key elements were not consistently missed across homes or within a particular home (the facility reported that it looked at specific homes). Also, since it appeared from the forms reviewed that transfers were not consistently observed, the calculations may not be comparable to others due to the limited number of observations in this area. Likewise, as monitoring did not consistently occur across all activities related to positioning (such as bathing and oral hygiene), issues may exist that were not identified. The bathing areas were observed during this review by the monitoring team and issues related to bathing wedges were identified and discussed with the Director of Habilitation Therapies. Further follow-up was indicated. <u>Individual-Specific Monitoring</u> The current monitoring system for implementation compliance and staff competency was based on the newly established flow chart for mealtime and physical management. Factors to determine the frequency of monitoring included: • Physical Management: o The individual has a 24 hour positioning schedule with specific times o The individual is rated high for fall risk o The individual has a feeding tube and any occurrence of aspiration pneumonia o The individual has a PNMP with special instructions or equipment to assist with mobility, transfer, or positioning • Mealtimes: o Choking history o Oral intake with pneumonia history o Modified food texture or liquid consistency While this type of monitoring focused on staff performance, it was tracked per individual rather than per staff, though staff names were a data point. It was not possible, however, to ensure that all staff were monitored for continued and consistent compliance. This is different than monitoring that focuses on the individual's health status and the impact of supports and services on health, function, and risk levels, as well as effectiveness. This should be a key element in an effective PNM system and is reviewed in O.7 below.	

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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.	Effectiveness Monitoring A system of routine effectiveness monitoring of the PNMPs and dining plans by the professional staff was to be conducted at least quarterly, or more often as indicated. There was a specific process for this established at SASSLC based on risk, individual factors, and the need for special instructions in the PNMP. A flow chart was developed and implemented on 4/22/13. The flow chart asked questions related to individual status and then offered options to the clinician to select for monitoring by PNMCs and therapists, which included effectiveness monitoring. Options were outlined for Mealtime and Physical Management monitoring. Effectiveness monitoring was limited to the following as listed on the monitoring form: • Observed interventions worked effectively for the individual. • Observed interventions continue to be needed in their current capacity. • No additional interventions are needed. These were addressed in addition to compliance monitoring conducted with staff. It was a concern that not all strategies would necessarily be reviewed using this approach. For example, at the time of the observation, the therapist might observe positioning, but not necessarily transfers. While this was an effective manner in which to accomplish this, additional factors should be considered related to effectiveness. In the current manner, effectiveness of the strategy as implemented is addressed, but effectiveness related to health and/or safety concerns are not. Review of specific health concerns for which the specific strategy was intended to address should also be addressed. These should include any health occurrences since the last review and whether the strategy continued to be the right one. This was done consistently in the annual assessments, but routine review should also occur in the interim. The monitoring forms were not included in the individual's active record and, as such, there was no evidence of this reviews. There was IPN documentation by therapists related to direct interventions or contacts for equipment or other troubleshooting, but none routinely done to review all interventions for effectiveness related to the occurrence of health concerns. These reviews should also report on compliance with implementation of plans by staff. Effectiveness monitoring should include programs across all environments and not only in the home.	Noncompliance
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	Individuals Who Received Enteral Nutrition There was a list of individuals who received non-oral intake that identified 53 individuals who received enteral nutrition (20% of the current census). Individual #106 and Individual #23 were listed as having received new tube placements since the previous review. Ten individuals were listed as with some level of oral intake.	Noncompliance

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	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>Evaluation of Individuals who Received Enteral Nutrition</u> Ten APENs were requested and submitted. Six of these were completed since the previous review, three were not dated, and one was completed during the period of the previous review. • 7 of 10 individuals who received enteral nutrition were evaluated at a minimum annually. Three assessments were undated (Individual #239, Individual #126, Individual #228). • 6 of 10 individuals evaluated had an at least a partial evaluation to determine the medical necessity of the tube, though assessment of oral motor status by the SLP and/or OT did not provide comparative analysis and safety of intake or development of an oral motor treatment plan, as appropriate for any assessment. In several cases, the individual's primary intake was oral and there was insufficient evidence of why there was continued tube placement and/or use (Individual #121, Individual 149, and Individual #228). No one admitted to SASSLC since the previous review received non-oral intake so the following metric did not apply: • ___ of the ___ individuals who received enteral nourishment and were admitted since the last review had a review of the medical necessity of the feeding tube within 30 days. <u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u> • 5 of 10 individuals who received enteral nutrition had been evaluated by the IDT to determine if a plan to return to oral intake was appropriate, though these were generally incomplete. Most did not clearly reflect assessment by the SLP and/or OT regarding oral motor status with a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake, but for improved saliva control. Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. A number of these individuals already received ongoing oral intake. • None of the APENs reflected an adequate assessment by the dietitian regarding current formula and schedule of feedings with a determination if the feeding schedule was the least restrictive or there were potential modifications needed in preparation of transition to oral intake. Plans for individuals identified as potentially benefitting from oral motor intervention or cleared to return to some form of oral intake require a comprehensive plan outlining the treatment or return to PO process. These plans should be:	

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		• Integrated into the IHCP, ISP, and/or an ISPA. • Implemented in a timely manner. • Staff responsible for implementation of these oral intake plans trained to competence by a licensed clinician with specialized training in PNM. • Monitored as outlined in the plan. <u>PNMPs</u> All individuals who received enteral nutrition in the selected sample had been provided a PNMP and Dining Plan that included the same elements as described above.	

Recommendations:

1. Continue to provide training and support to the IDTs for consistency and timeliness of appropriate referrals to the PNMT (O1, O2).

2. Ensure that evidence of participation by medical providers is clearly documented (O1).

3. Team members were encouraged to more concisely and efficiently present data for analysis and review relative to individual status (O2).

4. The team needs to recognize the urgency of the need for swift action and follow through as individuals reviewed by the team were the most at risk so prompt response is warranted. Issues such as outside consults needed and data such as height and weight had been delayed unnecessarily, impacting the team's ability to make decisions and take further action (O2).

5. Consistently document completion of actions and recommendations to close the loop on identified needs. Streamline system of documentation to ensure ease of use of this valuable information (O2).

6. Review specific measurable exit criteria established in the assessment and include these routinely in PNMT documentation. These should pertain to the reason for referral, but also other issues identified as a function of the comprehensive assessment (O2).

7. The IDTs should utilize referral criteria and other measurable outcomes developed by the PNMT for improved consistency of referral of individuals in a timely manner (O2, O3).

8. Centralize database of key health clinical indicators to ensure it is current and accurate. This should be a facility-side project that includes key staff. This information should be updated routinely. These may be used by the PNMT to track individuals who meet certain thresholds for health issues that would indicate a need for referral (O2).

9. PNMPs require better integration into the ISP via descriptions of PNM strategies and clear evidence of review of these and their effectiveness relative to risk levels (O3).

10. There continued to be some inconsistencies on Dining Plans and PNMPs, some critical to staff accuracy of implementation. Review of these plans is needed in order to make corrections in a more timely manner. There were monitoring systems in place and these errors should not be missed (O3).

11. PNM monitoring should address all areas including medication administration, oral care and bathing. A system of effectiveness monitoring was not well established and will be necessary for further progress with this provision. Areas such as toothbrushing and oral sensitivity should be addressed through assessment, supports and monitoring. Monitoring should occur across the day and instead focused on the first shift staff only and a limited number of activities and environments (O6).

12. Conduct objective reviews of individuals for protective equipment. There are a large number of helmets, gait belts, staff assistance, protective boots, for example. The least restrictive options should be selected. Decisions related to equipment should be data driven (O3).

13. Improve consistency of documentation of transition of individuals from PNMT to the IDT (O2).

14. Address toothbrushing via actual observations in the PNMT evaluations and OT/PT evaluations (O2, O3, and O4).

15. A system to track which staff have been determined to be competent in each level of training should be a coordinated effort by the facility and include CTD, Habilitation Therapy and residential leadership. This is critical to effective staff management to ensure assignment of properly trained staff to individuals for safety and optimal support of specific needs related to care and programming (O5).

16. Establish a system of effectiveness monitoring documentation that can be included in the personal record (O7).

17. Clarify the purpose and process for completion of the APENs. Perhaps this should be a function of the ISP process. Integration into that document may be more meaningful and useful (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:** Documents Reviewed: o SASSLC client list o Admissions list o Staff list and Curriculum Vitae o Continuing Education documentation o Section P Presentation Book and Self-Assessment o Section O and P QA Reports o OT/PT Tracking o Individuals with PNM Needs o Dining Plan Template o Compliance/Effectiveness Monitoring template o Completed Compliance Monitoring sheets submitted o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o List of Competency-Based Training in the Past Six Months o Hospitalizations for the Past Year o ER Visits o Summary Lists 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 Individuals with Aspiration or Pneumonia in the Last Six Months o Individuals with Pain 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 With Falls Past 6 Months o List of Individuals with Chronic Respiratory Infections o List of Individuals with Enteral Nutrition o Individuals with Chronic Dehydration o List of Individuals with Fecal Impaction o Individuals Who Require Mealtime Assistance o List of Choking Events in the Last 12 Months o Individuals with Pressure Ulcers and Skin Breakdown o Individuals with Fractures Past 12 Months o Individuals who were non-ambulatory or require assisted ambulation o Individuals with Primary Mobility Wheelchairs

	o Individuals Who Use Transport Wheelchairs o Individuals Who Use Ambulation Assistive Devices o Individuals with Orthotics or Braces o Documentation of competency-based staff training submitted o PNMPs and sample picture pages submitted o PNM Maintenance Log o Wheelchair evaluations submitted o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to SASSLC**:** Individual #305, Individual #53, Individual #222, Individual #120, and Individual #322 o OT/PT Assessments and ISPs for the following individuals: • Individual #229, Individual #63, Individual #302, Individual #239, Individual #115, Individual #254, Individual #167, Individual #349, Individual #72, Individual #51, Individual #18, and Individual #58 o OT/PT Assessments, ISPs, ISPAs, and other documentation related to PT intervention for the following individuals: • Individual #151, Individual #287, and Individual #227 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 #213, Individual #144, Individual #204, Individual #198, Individual #325, Individual #333, Individual #189, Individual #317, Individual #106, Individual #259, Individual #226, Individual #228, Individual #54, Individual #149, Individual #135, Individual #193, and Individual #277. o PNMP section in Individual Notebooks for the following: • Individual #213, Individual #144, Individual #204, Individual #198, Individual #325, Individual #333, Individual #189, Individual #317, Individual #106, Individual #259, Individual #226, Individual #228, Individual #54, Individual #149, Individual #135, Individual #193, Individual #277. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #213, Individual #144, Individual #204, Individual #198, Individual #325, Individual #333, Individual #189, Individual #317, Individual #106, Individual #259, Individual #226, Individual #228, Individual #54, Individual #149, Individual #135, Individual #193, Individual #277.

	Interviews and Meetings Held: o Margaret Delgado-Gaitan, MS, CCC-SLP, Director of Habilitation Therapies o Edward Harris, PT, DPT o JoAnna VanHoove, OTR o Retha Morgan Skinner, MOT, OTR o Wilfredo Diaz, PT, DPT o Various supervisors and direct support staff o ISP Meeting for Individual #54 Observations Conducted: o Living areas o Dining rooms o Day programs o Work areas
	Facility Self-Assessment: As in previous reviews, the Director of Habilitation Therapies, Margaret Delgado-Gaitan, MS, CCC-SLP, outlined specific activities, many 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 taken. The Presentation Book provided the audit tools used to evaluate each Settlement Agreement element with data presented to illustrate elements assessed, an analysis of the findings, and sample work products. The activities for self-assessment were generally appropriate and significantly improved from previous reviews. There was an effort to better analyze the findings for each provision. Further refinement of the self-assessment process, analysis, and presentation of data are encouraged. Though continued work is needed, the monitoring team acknowledges the strides that Ms. Delgado-Gaitan and the habilitation therapies department made. The facility rated itself as not in compliance with P1 through P4 and, while the actions taken continued to be in the direction of substantial compliance, the monitoring team concurred with the facility's findings of noncompliance. P3 and P4 require extensive cooperation and collaboration across departments. Excellent progress, however, was made in each of these and the establishment of specific measures of success will ensure continued movement toward substantial compliance.
	Summary of Monitor's Assessment: The monitoring team found continued progress. Improvements in the area of positioning were observed, though some individuals were not properly positioned and staff required prompts to correct this. Staff need more training and prompting to check for optimal pelvic alignment, particularly after transfers. In home

	674, staff repositioned everyone right before they entered the dining room, which was excellent practice. There were also some wheelchairs that appeared to need revision. It is suggested that the therapists seek further continuing education in the area of seating. Some specific suggestions were provided to the Director. Improvements in the assessment and design of seating systems will impact the ability of direct support staff to achieve alignment for each individual in a system that fits properly and provides the appropriate supports. OT/PT assessment content had improved, but timeliness continued to be a concern. Many, but not all, assessments were completed prior to the ISP. All of the assessments for individuals newly admitted were completed prior to the ISP. Establishment of clinical competence of the therapists and review of their continued compliance was accomplished via an audit system that appeared to be very effective, but the findings were not generally consistent with the reviews conducted by the monitoring team. In subsequent reviews, it may be useful to compare these to determine the source of the differences. The system of documentation of therapy interventions appeared to be consistent, though integration into the ISP was not. Many of the assessments identified that effectiveness would be reviewed on an annual basis, but it was not clear how often this occurred in the interim. Clarification of the frequency of effectiveness monitoring by the licensed clinicians versus staff compliance monitoring is needed.

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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.	Assessments were submitted for a total of 35 individuals. Of those, 34 individuals had assessments current within the last 12 months. The samples of assessments used for review included the following: • Sample P.1 = 7/17 individuals. No current assessment was submitted for Individual #54. The assessment for Individual #149 was incomplete in the records, but was duplicated in Sample P.2. Both copies of the assessment dated 1/18/13 for Individual #311 were incomplete and the copy for Individual #259 (4/11/13) was illegible. Current assessments for Individual #204, Individual #135, Individual #193, Individual #226, Individual #106, and Individual #277 were Annual Updates of Services and Supports. As updates, they did not stand alone in the absence of the comprehensive. Four of the six updates were submitted with the associated Comprehensive OT/PT Assessment. Though they referenced previous comprehensives, these were not contained in the personal record documents submitted for Individual #277 and Individual #135, so were incomplete. Assessments submitted for Individual #317 and Individual #106 were new comprehensives following an extended hospitalization and/or change in status rather than in relation to an annual ISP. The assessment for Individual #106 was dated 9/19/12, but there was also an update on 11/29/12, the date of his annual ISP. • Sample P.2 = 12/18 individuals (four were duplicated in Sample R.1: Individual #325, Individual #311, Individual #149, and Individual #106). The most current	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment submitted for Individual #63 was a CPDP assessment and the assessment for Individual #222 was a new admission assessment. • Sample P.3 = 5/6 individuals newly admitted to SASSLC in the last six months for whom a current assessment was submitted. • P.4 = 3/9 individuals who were provided direct OT and/or PT services per the list submitted. <u>Timeliness of Assessments</u> Six individuals were admitted to SASSLC in the last six months and included in Sample P.3. • 6 of 6 individuals admitted since the last review for whom assessments were submitted (100%) received an OT/PT assessment within 30 days of admission or readmission. Only assessments and updates were completed rather than OT/PT screenings, so the following metric did not apply: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. OT/PT assessments were submitted as requested : • 3 of 18 individuals' OT/PT assessments included in Samples P.1 and P.2 (17%) were dated as completed at least 10 days prior to the annual ISP. Additionally, there were 117 assessments listed in the tracking log for ISPs dated 8/23/12 through 3/7/13. Based on this log, only 26% of the assessments were performed prior to the designated due date. <u>OT/PT Assessment</u> Based on review of the sample of the most current assessments submitted in Samples P.1 and P.2 described above, the analysis for comprehensiveness of the OT/PT assessments was as follows: • 18 of 18 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. Same as previous review. • 2 of 18 assessments (11%) included diagnoses and relevance to functional status. A slight improvement from 0% in the previous review. • 18 of 18 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. • 9 of 18 assessments (50%) included medical history and relevance to functional status. While the medical history portion of the evaluation was very extensive, it did not refer to the manner in which these impacted functional status. There were numerous medical issues reported that were not related to the provision of	

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		OT and PT supports and services. Omitting these may be considered. An improvement from 8% in the previous review. • 18 of 18 assessments (100%) addressed health status over the last year. Same as the previous review. An improvement from 92% in the previous review. • 13 of 18 assessments (72%) listed medications and potential side effects relevant to functional status. An improvement from 8% in the previous review. • 18 of 18 individuals' OT/PT assessments (100%) included individual preferences, strengths, and needs. An improvement from 68% in the previous review. • 11 of 18 assessments (61%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). Improved from the previous review. An improvement from 60% the previous review. • 17 of 18 assessments (94%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. Essentially the same as the previous review. • 11 of 17 assessments provided a description of the current seating system for those requiring a wheelchair with a rationale for each component and need for changes to the system outlined as indicated also with sufficient rationale (65%). A decrease from 86% in the previous review. • 14 of 18 assessments (78%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. Improved from the previous review. An improvement from 44% in the previous review. • 8 of 18 assessments (44%) included discussion of the expansion of the individual's current abilities. Improved from the previous review. An improvement from 24% the previous review. • 4 of 18 assessments (22%) included discussion of the individual's potential to develop new functional skills. A slight decrease from 32% in the previous review. • 16 of 18 assessments (89%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. An improvement from 36% the previous review. • 16 of 18 assessments (89%) included documentation of how the individual's risk levels impact their performance of functional skills. An improvement from 0% the previous review. • 18 of 18 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. An improvement from 88% the previous review. • 12 of 18 assessments (67%) included a monitoring schedule. Same as the previous review. A slight decrease from 76% in the previous review. • 17 of 18 assessments (94%) included a re-assessment schedule. Same as the	

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		previous review. A slight improvement from 92% in the previous review. • 18 of 18 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. • 1 of 18 assessments (6%) provided a statement detailed the supports and services needed for successful community living. An improvement from 4% the previous review. • 17 of 18 assessments (94%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. Same as the previous review. An improvement from 40% the previous review. Further findings were as follows: • There were improvements related to the majority of elements (approximately 86%). • Approximately 61% of the assessments reviewed contained over 70% of the required elements. • These findings were not consistent with the peer to peer audits conducted which reported that 91% of assessments contained more than 90% of the elements. Some specific concerns included the following: o 4 of 7 required updates (57%) were completed consistent with the established schedule, or the individuals' need. o For 3 of 5 individuals for whom updates were actually completed (60%), the updates provided the individuals' current status, a description of the interventions that were provided, effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, monitoring data, and monitoring/assessment schedules. o Individual #229 was not recommended for any further assessment per the comprehensive assessment dated 12/29/11 even though she was provided a variety of OT/PT supports and services. The subsequent year (12/28/12) this was again the recommendation in the Comprehensive Assessment at that time. The assessment/update schedule was not clear for this individual. The current comprehensive assessments, generally identified the need for an annual assessment with the following exceptions: • Individual #144: Comprehensive Assessment in three years, but no update specified. • Individual #115: Comprehensive Assessment in three years with an annual update in the interim. • Individual #254: Comprehensive Assessment in three years with an annual update in the interim.	

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		• Individual #302: Comprehensive Assessment in three years with an annual update in the interim. • Individual #58: Comprehensive Assessment in three years with an annual update in the interim. • Individual #229: No further assessments recommended despite the provision of a dining plan, PNMP, walking program, and other related supports. She was to be monitored quarterly for mealtimes only. The assessments should clearly state the plan for re-assessment, and whether they are comprehensive or updates only. This should be distinguished from the recommended intervals for monitoring for compliance and effectiveness of any supports and services. A number of assessments referred to annual review of supports, such as equipment (e.g., Individual #144, Individual #51, Individual #228, and Individual #349) without mention of additional monitoring, so it was not clear what the annual review addressed. The monitoring team concurred with the facility in finding this provision to be in noncompliance. Assessments for individuals newly admitted (5/6) were generally completed prior to the ISP. Establishment of clinical competence of the therapists and review of their continued compliance with the elements of the OT/PT assessments was accomplished via an audit system that appeared to be effective as improvements were noted since the previous review, though the findings were not otherwise consistent with that of the monitoring team. However, the assessments were not consistently completed 10 working days prior to the ISP. Based on the tracking log submitted, only 26% of the assessments were performed prior to the designated due date. Assessments were generally completed prior to the ISP itself.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing	<u>Direct OT/PT Interventions:</u> The records of individuals in Sample P.4 were reviewed with the following findings: • 2 of 3 individuals' direct intervention plans (67%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. Though the evaluation to initiate PT for Individual #227 (1/10/13), there was no evidence that therapy was implemented within 30 days. PT was not initiated until 3/15/13, over two months later. • For 2 of 3 individuals (67%), the current OT/PT assessment identified the need for direct intervention with rationale. While there was an assessment for Individual #227 (1/10/13), there was no clear rationale why the PT was initiating direct therapy at that time. The annual OT/PT assessment recommended a home program for trunk control, lower extremity stretching, and a hand roll to reduce hand contractions and prevent hyperextension of his finger. This appeared to be a continuation of a program initiated in April 2012. It was	Noncompliance

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	regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	apparently discontinued after 3/14/13, when the SAP was to begin. There was no rationale offered. • For 0 of 3 individuals' records (0%), there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. • None of the direct therapy had been terminated for any individual included in Sample P.4. Therefore, this metric was not relevant to this review: For ____ of ____ individuals' records whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. The system for documentation was generally consistent for each of the three individuals reviewed. There was an assessment to establish the rationale for intervention and to design a plan with measurable and functional objectives. There was an associated SAP associated with the service, daily data collection, and at least weekly progress notes completed by the PTA implementing the intervention plans. In each case, monthly summaries were completed by the PT. The weekly notes appeared to be IPNs, but the monthly progress notes may have been filed in the Habilitation Therapy tab of the active record. The IPNs identified the need for continued PT based on progress with the established objectives. The monthly summary reviewed the progress made for the month and authorized the continuation of the plan. There was no evidence that an ISPA was conducted when the intervention was to be added to the plan in the interim of the annual ISP (Individual #171 or Individual #227). The direct intervention for Individual #287 or home program for Individual #227 was not integrated into their annual ISPs, though the annual OT/PT assessments established this as a need for each. Documentation was routine and generally effectively closed the loop on the direct services provided, with the exceptions highlighted above. Review of progress notes should be considered with the following elements: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. • A comprehensive progress note was completed on at least a monthly basis that offered a comparative analysis to progress made the previous month or across a quarter. • Termination of the intervention was well justified and clearly documented in a timely manner. None of the three individuals were terminated from therapy at the time of this review.	

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		With the exception of documentation of termination, each of these elements were noted for 3 of the 3 (100%) individuals in Sample P.3. <u>Indirect OT/PT Interventions:</u> The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O3 above regarding PNMP format and content. Implementation of PNMPs is addressed in section O5. • For individuals included in the Sample P.1, for 14 of 16 individuals for whom a current ISP was submitted, PNMPs (88%) were developed/revised within 30 days of the date of the ISP, and/or assessment/update, or sooner as indicated by need. The ISP for Individual #311 was not current within the last 12 months. • For 6 of 17 individuals (35%), the ISPs addressed each of the recommendations for indirect supports outlined in the current OT/PT assessment, including the PNMP. Though recommendations were listed in the ISP for Individual #193 and Individual #204, it was not clear whether these were accepted by the IDT. There was no current OT/PT assessment within the last 12 months submitted for Individual #54. The assessment for Individual #106 was dated 9/19/12, but was not signed until 11/29/12, the date of his ISP. There was no evidence of an ISPA held during September 2012 after the fracture in August 2012 or in relation to the completed OT/PT assessment in September. <u>Integration of OT/PT Supports and Services in the ISP</u> Review of the ISPs submitted was as follows: • 94% (16 of 17) of the ISPs submitted were current within the last 12 months. 14 of 16 current ISPs had attached signature sheets (none for Individual #213 and Individual #149). • 19% (3 of 16) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 19% (3 of 16) were attended by PT only. • 19% (3 of 16) was attended by OT only. • 44% (7 of 16) of the current ISPs had no representation by an OT or PT. The new system of pre-ISPs will designate which disciplines will be required to attend the ISP. The monitoring team looks forward to review of this system during the next review. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	

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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 were addressed in detail in section O.5 above. Substantial compliance with O.5 is the standard for compliance with this element. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	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 for staff compliance with the implementation of physical supports and the condition and availability of adaptive equipment was implemented at SASSLC. This was addressed in section O.6 and O.7 above. There was a system of routine effectiveness monitoring conducted by the clinicians. Recommended frequency of PNMP monitoring was typically included in the OT/PT assessments. Beyond the monitoring for staff compliance and effectiveness, it was reported that quarterly maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per the self-assessment, the number of adjustments due to an unreported issue reduced from 24% to 0%, though it was not clear how this was determined. The maintenance log appeared to only track requests for repairs. These (21 modifications or repairs) were completed for 10 of the individuals included in Sample P.1 who required them. The log listed projected completion dates, though it was assumed that these were actual completion dates. If that was accurate, the time frames were generally very good for those individuals as follows: • Same day = 65% • Three days or less = 4% • One week or less = 17% • Less than 30 days = 4% Upon review of the Physical Management Observation Forms, only one identified a maintenance issue (Individual #248 on 2/26/13) within the timeframe of the maintenance log submitted. It was stated that the right wheelchair brake was not working, which should be considered an immediate safety concern. The PNM Maintenance Log listed that the request was received on the day of the monitoring, yet the broken wheel lock was not repaired until nearly one week later. Though most of the other urgent concerns appeared to be completed on the same day. This should be tracked by the facility. Actual completion dates should be listed in the tracking log and the timeframes for urgent safety needs should be revised.	Noncompliance

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		Since these activities were based on referral or requests only, the timeliness of reporting specific issues that required attention could not be determined. PNMP monitoring conducted by PNMCs checked all equipment for working order and cleanliness based on the monitoring forms submitted. This element was self-rated to be in noncompliance at this time and the monitoring team concurred with the self-assessment.	

Recommendations:

1. 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 (P1 and P2).

2. Consider strategies to further standardize peer audits of OT/PT assessments (P1).

3. Rationale for therapist attendance in the pre-ISP process needs to be sound and clearly supported (P2).

4. The assessments should clearly state the plan for re-assessment, whether they are comprehensive or updates only. This should be distinguished from the recommended intervals for monitoring for compliance and effectiveness of any supports and services. A number of assessments referred to annual review of supports, such as equipment (Individual #144, Individual #51, Individual #228, and Individual #349, for example) without mention of additional monitoring, so it was not clear what the annual review addressed.

5. Timeliness of assessments continued to be an issue. Strategies to address needs to continue (P2).

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: 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 SASSLC Consent and Authorization for Treatment and Services, 10/11/12 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 SSLC Dental Conference Call Notes o SSLC State Dental Conference Notes o Dental Records for the Individuals listed in Section L o Listing, Individuals Receiving Pretreatment Sedation, October 2012– March 2013 o Listing, Individuals Receiving Treatment with TIVA o Desensitization plan for Individual #227 and Individual #114 o Annual Dental Summaries for the following individuals • Individual #156, Individual #73, Individual #249 Individual #287, Individual #82, Individual #342, Individual #226 o Comprehensive/Annual Dental Assessments for the following individuals: • Individual #300, Individual #220, Individual #280, Individual #136, Individual #227, Individual #190, Individual #132, Individual #324, Individual #263, Individual #325, <u>Interviews and Meetings Held</u>: o Alvydas Kukleris, DDS, Dental Director o David Espino, MD, Medical Director o Amy Jo Hush, RDH, Dental Hygienist o Sharon Costello, Dental Assistant <u>Observations Conducted</u>: o Dental Clinic o Informal observation of oral hygiene regimens in residences o Observation in dental clinic of treatment for Individual #135 and Individual #10

	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 dental 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. To take this process forward, the monitoring team recommends that the dental 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: There was minimal progress noted in the provision of dental services since the last compliance review. The lack of progress was largely due to several changes in the dental director's position over the past year. A new dental director was hired in November 2012 and over the six months that he was in the position, he was learning about the operations of the facility and clinic in addition to assessing the needs of every individual. This, however, was an important step for the facility because stability in the clinic is essential to moving forward. During interviews, the dental director expressed a desire to collaborate with other departments in order to improve the services provided and move towards achieving substantial compliance with the Settlement Agreement. The number of clinic appointments increased 43% since the last compliance review. The number of off campus appointments and the reasons for these appointments was not clear. Compliance with completion of annual assessments increased, but remained less than desirable. The lack of timeliness was partly due to the need for the dental director to re-assess all individuals living at the facility. The facility's appointment failure rate remained without change. The majority of missed appointments were due to a lack of staff and no shows, but the facility did not have documentation of any corrective action plans to address this problem. Individuals who required oral sedation for treatment were referred to psychology for further assessment via a request on the daily clinic report. The clinic staff reported that the effectiveness of this approach was unknown. Oral hygiene ratings improved slightly. There was no documentation in the assessments that oral hygiene instructions were provided and in home training was discontinued in favor of a weekly toothbrushing clinic. Criteria for participation in the clinic were not defined. Suction toothbrushing was provided to more

	individuals, but several problems related to that process were noted as well. Informed consent continued to present challenges. The facility's consent policy was revised in October 2012. Individuals with no guardian could have treatment approved by the facility director with the advice and consent of three doctors. The facility was not appropriately executing this process because the policy required one of the three doctors to be a physician primarily involved in private practice. There continued to be a disconnect between the dental clinic staff and other clinical departments. The daily dental report included a request for evaluation for desensitization for any individuals who required oral sedation for treatment, but the clinic staff reported they did not receive feedback from psychology. There were two desensitization plans implemented since the last review. More importantly, the outstanding needs for strategies and interventions were actually unknown by the dental clinic staff. The only evidence that the clinic submitted to support a proactive approach was a series of emails sent in March 2013 requesting documentation of strategies and interventions form the QDDPs. This was an unacceptable approach given the continued problems in this area.

#	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, and medical director. The monitoring team also observed treatment provided to individuals in the dental clinic. <u>Staffing</u> Staffing changes continued in the dental clinic, however, some stability was noted with the hiring of a new dental director in November 2012. His work at the facility began in September 2012 as a contract dentist. The dental director reported to the medical director. The hygienist and dental assistant were supervised by the dental director. <u>Provision of Services</u> The current dental clinic opened 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. Dental services that were provided included 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.	Noncompliance

Clinic Appointments 2012 - 2013

	Oct	Nov	Dec	Jan	Feb	Mar	Total
Preventive	44	40	26	45	41	28	224
Restorative	11	9	8	10	9	13	60
Emergency	5	4	5	4	2	0	20
Extractions	4	3	3	1	3	5	19
Total Appointments	158	143	76	106	81	65	629

#	Provision	Assessment of Status	Compliance
		A total of 629 appointments occurred during the reporting period. This represented 43% more appointments than completed during the previous six months. According to the dental director, some individuals were referred to the local oral surgery center and others were referred to a community dentist who completed work under anesthesia at a local hospital. The facility presented somewhat vague and inconsistent information related to off campus appointments. The original document request required a listing of all individuals who received treatment off campus as well as information on the type of sedation or anesthesia used. The document submitted listed individuals, including those with multiple extractions done at the surgical center, but there was no information related to sedation used. An onsite request was made for a list of individuals who received treatment off campus for August 2012 through March 2013. A list for January 2013 and February 2013 was provided. The list was not consistent with information for January 2013 and February 2013 previously provided. In addition to the list of individuals receiving off campus treatment, the monitoring team also requested copies of all consultation notes related to off campus appointments. For the second consecutive review, the facility failed to provide this information. In lieu of submitting the consultation reports, SASSLC elected to submit the request for consultation and not the actual findings of the consultant. The monitoring team was, therefore, unable to determine the reason for the consultation, the findings of the dental consultants, explanations related to multiple extractions, and the extent of the treatment provided. <u>Emergency Care</u> The clinic staff reported that 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. The dental director was available by phone to discuss care with the primary providers. The self-assessment documented one case in which the dentist was not notified and the individual ended up going to the emergency room. Clinic staff reported this was not a normal occurrence (i.e., for the dentist to not be notified). 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 records of five individuals receiving emergency are were reviewed and summaries are presented below: • Individual #148 was seen in clinic on 10/31/12 complaining of pain after eating an apple. A deep cavity was noted. Consents were in progress. On 1/7/13, the individual was seen in clinic again, but consents were still in progress. • Individual #36 was seen on 10/15/12 after spitting out blood. A loose tooth was	

#	Provision	Assessment of Status	Compliance
		noted and was believed to be due to trauma. Follow-up care was documented until the problem was resolved. • Individual #42 was seen on 10/5/12 with an ulcer. Follow-up on 10/15/12 documented resolution of the ulcer. • Individual #41 was seen on 10/3/12 due to left lower pain. Symptomatic pulpitis was diagnosed and consents were initiated. The dental documentation did not note pain management but the IPN notes indicated that Tylenol was given. Definitive treatment was provided under TIVA on 11/20/12 The emergency care appeared to be appropriate and timely. The monitoring team recommends that pain management be clearly documented in the records. <u>Oral Hygiene</u> The facility tracked oral hygiene rating for all individuals. The quarterly data submitted are presented in the table below.	

Oral Hygiene Ratings 2012 - 2013			
Quarter	Poor %	Fair %	Good %
Mar – Jun 2012	34	49	17
July – Sep 2012	27	37	36
Oct – Dec 2012	20	42	38
Jan –Mar 2013	32	46	22

While the data indicated an improvement in oral hygiene ratings, clinic staff indicated that problems with home hygiene remained problematic. The home instructions related to toothbrushing were discontinued because the hygienist reported that this resulted in greater dependency on the clinic for routine toothbrushing in the homes.

For the 10 Annual Evaluations and seven Annual Dental Summaries reviewed:

- 3 of 17 (18%) individuals were edentulous
- 2 of 14 (14%) individuals had good oral hygiene ratings
- 2 of 14 (14%) individuals had fair oral hygiene ratings
- 8 of 14 (57%) individuals had poor oral hygiene ratings
- 2 of 14 (14%) individuals had unknown oral hygiene ratings

In response to the request for corrective action plans to improve oral hygiene, the documents submitted stated there were none other than implementation of the toothbrushing clinic.

#	Provision	Assessment of Status	Compliance
		Seventeen individuals received suction toothbrushing. The direct care professionals were trained by the dental hygienist to provide this treatment. During the August 2012 review, it was reported that a Performance Improvement Team was developed to address this issue of developing a formal program and suction toothbrushing policy. This PIT had not been finalized and the need for a suction toothbrushing policy remained outstanding at the time of the compliance review. The facility submitted a draft policy from state office. The monitoring team reviewed this procedure and noted that it was a copy of the suction toothbrushing policy from Lubbock SSLC dated 9/8/11. Only one page of the procedure was submitted. Clinic staff indicated this procedure provided guidance for the suction toothbrushing program at SASSLC. Even with one page, it was clear that SASSLC was not performing the procedure in accordance with the guidelines. The "draft" required that all individuals at risk for aspiration pneumonia, those who were enterally fed, those diagnosed with dysphagia, or those who had the prognosis of poor hygiene be prescribed suction toothbrushing or a Crest Spinbrush with simultaneous suctioning. The Lubbock SSLC procedure also stated "treatment with a suction toothbrush must be completed by a licensed nurse." Chlorhexidine was used on a daily basis at SASSLC and the treatment was completed by direct care professionals. This was inconsistent with the draft policy and comments from the state dental services coordinator who, during previous interviews with the monitoring team, stated that chlorhexidine was to be used for the first 14 days of each month. The dental director indicated that he did not believe the continuous use of chlorhexidine posed any risk. Training was no longer conducted in the homes. Beginning 4/1/13, the facility implemented a toothbrushing clinic that was conducted once a week. Six individuals were seen in the clinic and were provided oral hygiene training. The facility had not clearly defined the criteria that would be used to select these individuals. The role of habilitation services in the dental clinic was also discussed. 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. This provision remains in noncompliance.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></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>Policies and Procedures
The facility maintained a dental services policy. During interviews, it was acknowledged that policies and procedures related to the provision of services and management of the clinic were needed.

Annual Assessments
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 facility did not track timelines for several months after the August 2012 review. 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>Oct</td><td>Nov</td><td>Dec</td><td>Jun</td><td>Feb</td><td>Mar</td></tr>
<tr><td>No. Exams</td><td>47</td><td>36</td><td>19</td><td>23</td><td>15</td><td>12</td></tr>
<tr><td>Compliant Exams</td><td>28</td><td>20</td><td>14</td><td>17</td><td>15</td><td>11</td></tr>
<tr><td>% Compliance</td><td>60</td><td>56</td><td>74</td><td>74</td><td>100</td><td>92</td></tr>
</table>

SASSLC continued to have problems completing annual assessments in a timely manner. The overall compliance rate was 76%. While this was a relatively low compliance score, it represented an improvement from the 61% compliance score for January 2012 – June 2012. The hygienist explained that the untimely examinations were due to the dental director re-assessing all individuals to determine their needs. The facility reported that since February 2013, almost all individuals were up to date with annual assessments.

The comprehensive annual exams for 10 individuals were requested. For each, the facility submitted the (1) Dental Record/Initial Exam Report, (2) Dental Progress/Treatment Record and (3) the IPN entry. The following is a summary of information found in the 10 assessments:
• 2 of 10 (20%) individuals were edentulous
• 3 of 10 (30%) records included an IPN entry (pointer note) by the dentist
• 2 of 10 (20%) assessments commented on the completion of x-rays or the need for x-rays
• 10 of 10 (100%) assessments included an entry on cooperation, behavioral issues, and the need for sedation/restraint use
• 10 of 10 (100%) records commented on the OH ratings
• 0 of 10 (0%) assessments documented the Oral Hygiene Index
• 0 of 10 (0%) assessments commented on risk ratings
• 2 of 10 (20%) records provided recommendations for oral hygiene</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		The Initial Exam Report listed a section for the oral exams including the Oral Hygiene Index and suggested radiographs. The OHI was blank on all documents reviewed and most of the Initial Exams Reports did not have entries for the suggested radiographs section. Risk ratings were also not included as part of the comprehensive exams, but were found in the Annual Dental Summaries. The monitoring team recommends that the form be fully completed, entering NA or other comments as indicated. <u>Initial Exams</u> The facility submitted data for five individuals admitted since the last onsite review. All of the individuals completed initial dental evaluations 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 majority of the records reviewed, however, did not have an IPN entry by the dentist. The pointer note written in the IPN should be written by the staff that is actually completing the documentation in the dental records. Thus, if the dentist makes an entry in the dental progress notes, a pointer note should be made in the IPN by the dentist. The facility required completion of the Annual Dental Summaries. This document was provided for the IDT's review in preparation for the annual for ISP. The summaries included information, such as the dental risk assessment, treatment performed, oral hygiene ratings, self-care assessments, present conditions, needs, behavioral assessment, desensitization, strengths, preferences, recommendations, and transition statement. As noted above, the annual exams did not include risk ratings, but the information was provided in the annual summary. The recommendations related to supports for oral hygiene were also noted in the annual summary. However, the documents reviewed did not indicate that oral hygiene instructions were provided to the individuals or staff. <u>Failed Appointments</u> The facility reported data on refusals and missed appointments. The numbers as identified and reported by SASSLC are summarized in the table below: | | Oct | Nov | Dec | Jan | Feb | Mar | | | --- | --- | --- | --- | --- | --- | --- | --- | | Refused | 7 | 9 | 4 | 8 | 7 | 5 | 40 | | Failed | 22 (14%) | 19 (13%) | 22 (29%) | 17 (16%) | 23 (28%) | 10 (15%) | 113 | | Missed | 15 | 10 | 18 | 9 | 16 | 5 | 73 | | Total Appts. | 158 | 143 | 76 | 106 | 81 | 65 | |	

#	Provision	Assessment of Status	Compliance
		Missed appointments were appointments not attended by the individuals because of reasons beyond his/her control. Refusals were appointments not attended because the individual stated he or she did not want to go. Failed appointments were defined as the total number of missed appointments and refusals. The overall failure rate for the reported period was 19%. This was essentially unchanged from the previously reported period failure rate of 20%. The facility submitted a list of explanations for missed appointments. For each missed appointment, an explanation, such as no show, off campus, or no staff was listed. The number of appointments listed did not match the data provided for the number of missed appointments. Nonetheless, the majority of missed appointments were attributed to no staff or no shows. The monitoring team requested documentation of the interventions and strategies that were implemented to address missed appointments and refusals. Similar to previous reviews, SASSLC did not provide appropriate documentation of interventions. A list of all failed appointments was submitted. For seven of the refused appointments, explanations, such as TIVA or email, sent were listed. In a separate request, the hygienist sent emails, all dated in mid to late March 2013, to the QDDPs and SAC stating, "It is once again that time when we are asking for documentation request." This email was a request to provide evidence that the IDTs had strategies and interventions in place to overcome barriers to treatment. It was very unfortunate to again note that these efforts were not ongoing. The only documentation provided by the dental clinic to support that teams were being encouraged to assist in supporting the dental clinic was in the response to the need to fulfill the monitoring team's document request. With continuous and ongoing efforts, the concept of "that time" would be eliminated. Additionally, the facility did not appear to have any plan to ensure that individuals who missed appointments due to no fault of their own would receive timely assessment and treatment. Although there was no strategy to reduce the occurrences, the facility reported that each individual was re-scheduled within the subsequent two weeks. During previous reviews, the issue of assessments for desensitization strategies indicated a lack of integration between the dental clinic and psychology. A Performance Improvement Team was developed to address this issue. The result of the PIT was the recommendation to include on the daily dental report a column that indicated the need for assessment for strategies and/or desensitization based on the need to use oral sedation. Both the dentist and the hygienist stated that they never received feedback from psychology on the status of the recommendations to conduct an assessment. The self-assessment documented that follow-up was done. However, the dental clinic had no	

#	Provision	Assessment of Status	Compliance
		compelling evidence of any attempts to obtain feedback on these issues other than emails dated in mid and late March 2013 requesting follow-up for the compliance review. The monitoring team was concerned that this pattern had continued over the span of a few years under the purview of several dental directors. The facility and medical directors need to further assess the etiology of this lack of clinical integration. <u>Dental Restraints</u> The number of individuals receiving pretreatment sedation and general anesthesia is summarized below. Individuals Requiring Sedation and General Anesthesia 2012 -2013 Oct / Nov / Dec / Jan / Feb / Mar Oral Sedation: 10 / 10 / 4 / 9 / 6 / 4 General anesthesia: 6 / 5 / 6 / 7 / 9 / 9 General anesthesia (community): -- / -- / -- / -- / -- / -- SASSLC began using TIVA in July 2012. The dental anesthesiologist provided services three days a month at SASSLC. The use of general anesthesia and sedation off campus was unknown from the documents submitted. <u>Strategies to Overcome Barriers to Dental Treatment</u> As previously noted, there was no information provided on strategies and interventions used to overcome barriers to treatment. There were two desensitization plans submitted since the last compliance review. The plans appeared individualized, but the implementation dates were not documented. Dental notes documented one desensitization visit for each individual in March 2013. The hygienist informed the monitoring team that the exact number of individuals with remaining needs was not known. The self-assessment stated that 59 individuals needed oral sedation and that was the trigger for requesting assessment from psychology. <u>Informed Consent</u> 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. A new consent policy was implemented. Beginning in January 2013, in the absence of a guardian, informed consent could be completed with the signatures of three doctors and	

#	Provision	Assessment of Status	Compliance
		the facility director. According to SASSLC policy, the facility director could order treatment or services under the "three doctor rule." For dental services, this required advice and consent of the dentist and two physicians, one of whom was "primary engaged in private practice." It did not appear that SASSLC was following this policy as written. Although there appeared to be some improvement in timeframes, record and document reviews continued to record delays in treatment based on a lack of consent. The dental director acknowledged that the new consent procedure was resulting in a decrease in delays, but improvement was still needed in this area. The dental clinic at SASSLC has a tremendous amount of work to do to achieve to begin to move towards obtaining substantial compliance. Stability in the position of the dental director was an encouraging start. However, the clinic will need to become more proactive in working with other clinical services. Over the period of two years, many of the deficiencies related to services were attributed to other departments. Accountability must begin within the dental department. The medical director should encourage greater integration and the facility director should provide support to the medical director in those efforts. This provision remains in noncompliance.	

Recommendations:

1. 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).

2. 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).

3. 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)

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

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

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

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

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Admissions List o Budgeted, Filled and Unfilled Positions list, Section I o Section R Presentation Book o Facility Self-Assessment, Action Plans and Provision of Information o Current SLPs (including contract staff), caseloads and ratios o Copies of SLPs of current license and ASHA certification o Continuing education and training completed by the SLPs since the last review o Communication policy o Master Plan o Facility list of new admissions since the last review o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o List of individuals with behavioral issues and coexisting severe language deficits o List of individuals with PBSPs and replacement behaviors related to communication o PBSP minutes and attendance rosters for the past six months o List of individuals with Alternative and Augmentative communication (AAC) devices o AAC-related database reports/spreadsheets o List of individuals receiving direct communication-related intervention plans o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o Documentation of Communication SAPs o Communication Assessment for individuals recently admitted to SASSLC: Individual #322, Individual #131, Individual #120, Individual #222, Individual #53, and Individual #305 o Communication Assessments and ISPs for the following individuals: • Individual #13, Individual #255, Individual #54, Individual #10, Individual #73, Individual #259, Individual #324, Individual #15, Individual #261, Individual #249, Individual #201, Individual #315, Individual #249,Individual #163, Individual #22, Individual #282, Individual #142, Individual #18, Individual #235, Individual #81, Individual #43, Individual #116, Individual #302, Individual #132, Individual #268, Individual #215, and Individual #141. o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: Individual #7, Individual #333, Individual #284, Individual #90, Individual #65, Individual #64, Individual #342, Individual #301, Individual #88, Individual #95, Individual #280, Individual #50, Individual #93, Individual #180, Individual #61, Individual #77, Individual #31, and Individual #234. 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 #213, Individual #144, Individual #204, Individual #198, Individual #325, Individual #333, Individual #189, Individual #317, Individual #106, Individual #259, Individual #226, Individual #228, Individual #54, Individual #149, Individual #135, Individual #193, Individual #277. o PNMP section in Individual Notebooks for the following: • Individual #213, Individual #144, Individual #204, Individual #198, Individual #325, Individual #333, Individual #189, Individual #317, Individual #106, Individual #259, Individual #226, Individual #228, Individual #54, Individual #149, Individual #135, Individual #193, Individual #277. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #213, Individual #144, Individual #204, Individual #198, Individual #325, Individual #333, Individual #189, Individual #317, Individual #106, Individual #259, Individual #226, Individual #228, Individual #54, Individual #149, Individual #135, Individual #193, Individual #277. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MS, CCC-SLP, Director of Habilitation Therapies o Allison Block Trammell, MA, CCC-SLP o Jessica Guerra, MA, CCC-SLP o Melissa Garcia, MA, CCC-SLP o Various supervisors and direct support staff o ISP Meeting for Individual #54 <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o NEO staff training by SLP

	Facility Self-Assessment: As in previous reviews, the Habilitation Therapies Director, Margaret Delgado-Gaitan, MA, CCC-SLP outlined specific activities, many 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 steps taken to effect changes. Benchmarks (in measurable terms) were included in addition to the descriptions of self-assessment activities in some cases. These benchmarks were used to assess progress and when inadequate progress was made, the analysis attempted to identify what steps were necessary to resolve problems. In some cases, this was not sufficient. For example, in R1 there was a review of current SLP staff and it was determined that the staffing was not adequate to meet this provision. There were no standards identified, such as recommended ratios based on an analysis SLP responsibilities. Responsibilities to consider include, but should not be limited to, conducting assessments, developing and implementing programs, providing staff training, coaching and modeling, and monitoring the implementation of programs. In R2 there had been a noted improvement in the on-time completion of communication assessments (though 45% was far from acceptable). It was stated that for this to be possible, it was necessary to decrease the number of assessments completed, likely due to an inadequate number of SLPs available for this role. Though 191 individuals had received comprehensive assessments, there were still 69 that were needed as of 3/1/13. The Master Plan continued to project well into 2014 to complete these, well outside the timeframes established by the Settlement Agreement and inconsistent with previous recommendations by the monitoring team. Other similar concerns were discussed with the director at the time of this review. In R4, issues related to compliance with implementation of AAC systems were noted via the communication monitoring conducted. Several actions were recommended to effect improvements, yet there was no real evidence of follow-up to determine if those actions actually impacted the subsequent findings. This should be a consistent aspect of self-assessment and analysis. Though continued work is needed, the monitoring team acknowledges the strides that Ms. Delgado-Gaitan and the speech department made during the last six months. The facility rated itself as not in compliance with all four items of section R. While the actions taken continue to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: Continued progress was made since the previous review. The majority of the most current assessments contained more than 70%, but less than 90%, of the elements considered key by the monitoring team. This was a significant improvement from the previous review. There was a continued increase in the provision of AAC systems. More work related to the application of AAC to adults with developmental disabilities and physical and cognitive challenges was needed.

	Implementation and integration into the home and day program activities were inconsistent. Observations were made in a variety of settings where AAC was intended for use. For example, in the Forever Young program, there was a clear need to improve staff awareness of meaningful communication opportunities throughout the day, rather than only as formal programs. The therapists and the SLPA should provide real time modeling across environments because doing this is not immediately intuitive for direct support staff. The clinicians were assigned responsibilities for communication and mealtimes, and PNMT/leadership roles for Ms. Trammel, making the caseload assignments significantly high. This may impact the ability of the speech clinicians to appropriately provide adequate supports and services in each area as noted below. The facility identified this as a concern in the Presentation Book, but there was no plan to address this. <u>The following samples were used by the monitoring team:</u> • Sample R.1: Individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals with assessments submitted by SASSLC as most current. • Sample R.3: Individuals admitted since the last compliance review. • Sample R.4: Individuals from R.1 above with AAC systems. • Sample R.5: Individuals receiving direct speech services • Sample R.6: Individuals from Sample R.1 with indirect communication supports (e.g., skill acquisition plans not directly provided by the SLP/SLPA, Communication Dictionaries).

#	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> Allison Block-Trammell, MA, CCC-SLP, Jessica Guerra, MA, CCC-SLP, Melissa Garcia, MA, CCC-SLP, and Roland Hoffman, MS, CCC-SLP were identified as SLPs and Lesley Bippert, AuD, CCC-A was identified as a contract audiologist. Each provided communication services. There were three positions budgeted and all were filled. There was one part-time contractor (Melissa Garcia). The facility recently approved a position for a full time SLPA. This position will be critical to adequate service provision at the facility and demonstrated a commitment toward substantial compliance. Responsibilities of the fulltime SLPs included, but were not limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication. The same duties were required for the provision of mealtime supports for these individuals as well. Allison Block-Trammell served on the PNMT and Melissa Garcia was assigned to provide staff training. The Presentation Book identified that these clinicians were to attend ISP and ISPA meetings and to serve as mentors for the risk process. Per the Master List submitted, there were at least 144 individuals across all of the homes (55% of the current census) who were identified as nonverbal and another 43	Noncompliance

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		individuals (16%) with limited verbal skills. Thus, approximately 71% of the total census had severe language deficits and would likely benefit from communication supports and services. At least 60% of these individuals also were identified with behavioral concerns, which would significantly complicate their communication needs. The SLPs were assigned caseloads as follows (totals based on individual list by home submitted in section I): • Allison Block Trammell: Homes 674 and 766 = 53 individuals (77% with severe language deficits) • Jessica Guerra: Homes 668, 670, and 673 = 100 individuals (92% with severe language deficits) • Roland Hoffman: Homes 665, 671, and 672 = 104 individuals (52% with severe language deficits) The clinicians were assigned responsibilities for both communication and mealtimes and, as such, the caseload assignments were significantly high. This may impact the ability of the speech clinicians to appropriately provide adequate supports and services in each area as noted below. The facility also identified this as a concern per the Presentation Book, but there was no plan to address this issue. <u>Qualifications:</u> • 4 of 4 SLPs (100%) were licensed to practice in Texas as verified online. • 4 of 4 SLPs (100%) held current ASHA certification. <u>Continuing Education:</u> Based on a review of continuing education completed in the last 12 months: • 4 of 4 SLPs staff (100%) had completed continuing education. CEUs were listed, but it was not clear if these were contact hours rather than actual CEUs. At any rate, the extent of continuing education for each clinician appeared to be adequate. Continuing education topics that appeared to be relevant to communication included: • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • AAC in the Schools, Report Writing and Funding • AAC Techniques and Strategies: Supporting Natural Speech Development in ASD and Other Disorders • An Overview of Low-Tech AAC Options and Practical Strategies for Use in the Classroom • Technology and Therapy: Using the Computer as a Context for Conversation	

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		• AAC and Aphasia • AAC in School Settings: What is the Role of the SLP? • Augmentative Communication: Assessment Strategies for Teens • Practicing AAC in Acute Care Settings • Practically Speaking: AAC strategies for Beginning Communicators • Dementia 101: How to Successfully Manage Dementia in Home Health • Evidence-Based Practices for AAC Evaluations – From A & P to REC: Building the Meaning Behind Acronyms More knowledge and experience was needed, however, in enhancing their understanding of AAC use with adults with developmental disabilities and physical and cognitive challenges. They appeared to rule out AAC as an option based on individual's cognition, limited used of the upper extremities, and initial lack of interest shown during the assessment, rather than recognizing the role of relevance, alternate access sites, environmental context, and meaningful contextual training opportunities as effective methods in the development of AAC for this population. <u>Facility Policy:</u> The facility had developed an operational policy, dated 2/1/13, Communication Services. The local policy should provide clear operationalized guidelines for the delivery of communication supports and services, including the following components: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Outlines assessment/update schedule including frequency and timelines for completion of new admission assessments (within 30 days of admission or readmission), timelines for completion of comprehensive assessments (within 30 days of identification via screening, if implemented), and timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within 5 days of identification as indicated by the IDT). • Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment. • Addressed a process for effectiveness monitoring by the SLP. • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution.	

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		The policy submitted generally addressed each of the areas identified above with the following exceptions: • Timeline for completion of a Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (within 5 days of identification as indicated by the IDT). • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution. This policy outlined the assessment schedule, yet stated that the timelines and strategies for completion of baseline Communication Assessments were dependent on SLP staffing and that when it was not possible to complete all needed assessments during a particular month, the assessments would be prioritized by need. This was a concern for the monitoring team. The clinicians should analyze the need for SLP supports and services and determine a reasonable number of FTEs/contract therapists to meet that need.	
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 facility developed a Master Plan for use to prioritize communication assessments. Each individual was to be provided a comprehensive assessment (or an annual update) at the time of his or her annual ISP unless a change of status warranted an assessment in the interim, as determined by the Screen for Change in Functional Communication Status, completed within five days of the IDT referral. For individuals identified with a significant need via screening, a comprehensive communication assessment would be completed within 30 days, or otherwise, an interim update could be completed at that time. Per the Master Plan, assessments were to be completed at the time of the annual ISP only, rather than on a faster track for completion. At that rate the assessments would not be completed until February 2014. The Master Plan outlined when updates were to be completed in the interim of a comprehensive assessment as per the facility policy. It appeared that according to the plan submitted, at least eight individuals who were identified with severe language deficits had not yet received a comprehensive assessment: Individual #110, Individual #75, Individual #69, Individual #310, Individual #90, Individual #144, Individual #178, and Individual #199. Five were listed with a PBSP (Individual #310, Individual #90, Individual #144, Individual #178, and Individual #199). Another 23 individuals had not received a comprehensive assessment since 2009 or 2010.	Noncompliance

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		At least 15 of these were Priority 1 or 2 individuals, nonverbal or with limited verbal skills, and nine had PBSPs. In some cases, updates had been completed for individuals since that time, but in other cases, there was no evidence (Individual #345, Individual #191, Individual #181, Individual #151, and Individual #314). The self-assessment reported that, as of 3/1/13, 191 individuals had received a comprehensive assessment with another 69 still requiring one. Fourteen individuals had received an assessment in the last three years, though all of the essential elements had not necessarily been addressed. A timeline for completion per the ISP schedule was established for 12/31/13. The clinicians were encouraged to complete these in a timelier manner in order to ensure that the communication needs of these individuals were fully met. A tracking log of assessment due dates and performed dates was submitted. The due dates were reflective of the facility policy of 10 working days prior to the ISP. Only 45% were completed on or before the designated due dates. The percentage of on-time assessments increased to 66% for assessments completed after 1/1/13 (41). This delay significantly impacts the ISP process because the necessary information is not available for appropriate discussion and decision-making for planning individual supports for the upcoming year. It could not be readily determined if an ISPA was conducted upon completion of each of these delinquent assessments in order that the findings and recommendations could be integrated into the plan at that time. The facility, however, reported that, although the 10-day requirement was not met, assessments were submitted prior to the annual ISP meeting. The self-assessment reported that there had been 94% compliance with on-time assessments in February 2013. <u>Assessments Provided</u> Communication assessments were submitted as requested for the following: • Sample R.1 = 15/17 individuals (no assessments were submitted for Individual #144 and Individual #198) • Sample R.2 = 20 individuals (three were duplicated in Sample R.1: Individual #226, Individual #193, and Individual #149). Thus, 32 of 34 individuals in Samples R.1 and R.2 (100%) were provided a communication assessment. Twenty-eight were current within the last 12 months. Twenty-two of those were identified as comprehensive. Six others were updates submitted with the associated comprehensive assessment. The update for Individual #317 (10/24/12), though current, was submitted without the associated Comprehensive Assessment. This assessment stated that it did not stand alone and referenced previous Comprehensive Assessments completed in 2011. The	

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		Comprehensive Assessment for Individual #135 was dated 2/9/12 with no more current assessment, though one was listed in the Master Plan. The Comprehensive Assessment for Individual #189 was dated 4/11/11, with no evidence of a more current assessment. He received communication supports so should have received at least an update in 2012. He was not included in the Master Plan. No assessments were submitted for Individual #144 and Individual #198, though each was provided communication supports that warranted a current one. Six individuals admitted to SASSLC in the last six months were included in Sample R.3. • 6 of 6 individuals admitted since the last review (100%) received a communication assessment within 30 days of admission, based on assessments submitted and the assessment log. The following metric was not applicable because, though a screening was provided for individuals with a change in status, per the facility policy, there was no evidence that these were provided during this review period: • If screenings were completed, ___ of ___ individuals identified with therapy needs through a screening (%), received a comprehensive communication assessment within 30 days of identification. • 1 of 1 individual (100%) in the sample of individuals who were provided direct communication supports and services (Sample R.5) was provided an assessment current within the last 12 months. Individual #31 had been provided a Comprehensive Assessment on 2/6/11, with subsequent updates on 1/30/12 and 1/29/13, consistent with the facility policy. It was of concern to the monitoring team, however, that only one individual was provided direct speech therapy of any kind. <u>Communication Assessment:</u> Based on review of the sample of comprehensive assessments submitted and completed since the previous review included in Samples R.1 and R.2, the comprehensiveness of the communication assessments were as follows: • 20 of 20 individuals' communication assessments (100%) were signed and dated by the clinician upon completion of the written report. • 8 of 20 individuals' communication assessments (40%) were dated as completed at least 10 working days prior to the annual ISP. This was a decrease from 48%. • 19 of 20 individuals' communication assessments (95%) included diagnoses and relevance of impact on communication. This was an improvement from 12%. • 20 of 20 individuals' communication assessments (100%) included individual preferences, strengths. This was an improvement from 88%. Though these were listed in each assessment, they were rarely used to guide the development	

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		of meaningful communication strategies or AAC systems. • 18 of 20 individuals' communication assessments (90%) included medical history and relevance to communication. This was an improvement from 12%. • 20 of 20 individuals' communication assessments (100%) listed medications and discussed side effects relevant to communication. This was an improvement from 12%. • 11 of 20 individuals' communication assessments (55%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was an improvement from 4%. • 20 of 20 individuals' communication assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. This was an improvement from 96%. • 16 of 20 individuals' communication assessments (80%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an improvement from 52%. • 5 of 16 individuals' communication assessments (31%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally. The dictionary was recommended, but most assessments did not discuss whether it required modifications or was accurate. This was an improvement from 8%. • 13 of 20 individuals' communication assessments (65%) included discussion of the expansion of the individuals' current abilities. This was an improvement from 40%. • 9 of 20 individuals' communication assessments (45%) provided a discussion of the individuals' potential to develop new communication skills. This was an improvement from 28%. • 0 of 18 individuals' communication assessments (0%) included the effectiveness of current supports, including monitoring findings. While effectiveness was discussed there was no reference to findings from monitoring or compliance. This remained the same as the previous review. • 12 of the 20 individuals' communication assessments (60%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC. This continued to be an area that needed improvement, and was a decrease from 68%. The rationale for not providing AAC was often weak. For example, in the case of Individual #149, the only rationale for not providing tech-based AAC was that she used some limited sign language. In the case of Individual #226, it was reported that she did not access a switch with her hand so AAC was ruled out.	

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		She was provided an environmental control device that she activated using her head. There was no rationale offered as to why head access for AAC was not considered. • 17 of 20 individuals' communication assessments (85%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 12%. • 15 of 18 individuals' communication assessments (83%) gave a comparative analysis of current communication function with previous assessments. This was a decrease from 92%. • 14 of 20 individuals' communication assessments (70%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was a decrease from 96%. • 15 of 18 individuals' communication assessment (83%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. • 20 of 20 individuals' communication assessments (100%) had a reassessment schedule. This was an improvement form 88%. • 15 of the 20 individuals' communication assessments (75%) supplied a monitoring schedule. This was an improvement form 0%. • 17 of 18 individuals' communication assessments (94%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits. This was an improvement from 72%. • 19 of 20 individuals' communication assessments (95%) made a recommendation about the appropriateness for community transition. This was an improvement from 8%. • 13 of 20 individuals' communication assessments (65%) included specific recommendations for services and supports in the community. This was an improvement from 8%. • 10 of the 18 individuals' communication assessments (55%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was a decrease from 84%. Additional findings related to the communication assessments were as follows: • 2 of 20 assessments contained 90% or more of the elements listed above. • 5 of 20 assessments contained 80% or more of the elements listed above. • 7 of 20 assessments contained 70% or more, but less than 80% of the elements listed above. • 3 of 20 assessments contained 60% or more, but less than 70% of the elements listed above.	

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		• 3 of 20 assessments contained 50% or more, but less than 60% of the elements listed above. • 6 of 8 updates (75%) had an associated comprehensive assessment that was consistent with the established format and content guidelines. There was no associated comprehensive assessment for the update contained in the individual records for Individual #317 (10/24/12) and Individual #213 (10/18/12). • 22% of the elements listed above were noted for 100% of the assessments reviewed. There was a system of assessment audits implemented by the department for the establishment of competency of the speech clinicians and to ensure continued compliance with the assessment guidelines. <u>SLP and Psychology Collaboration:</u> There were approximately 186 individuals listed with PBSPs and 20 of these were included in the Samples R.1 and R.2 identified above. • 16 of 17 communication assessments reviewed for individuals in Sample R.2 (94%) contained evidence of the individual's behavior challenges and any communicative intent of these behaviors. This was reported in the Behavioral Considerations section and the Analysis section. Four individuals in this sample of 17 did not have a PBSP. • For 4 of 14 individuals (29%) in Sample R.2 for whom current ISPs were submitted, communication strategies identified in the assessment were included in the ISP. • One individual in this sample (Individual #315) was listed with a PBSP and was provided a communication-related replacement behavioral objective. A different SAP was recommended in his Communication Assessment dated 12/27/12. While these were not contradictory, they were not consistent. The replacement objective stated that he would ask for his needs three times per week, while the communication SAP stated that he would repeat a short phrase to request a preferred object or activity three times per week. One suggested that he would initiate the request, while the other indicated that he would repeat a phrase modeled for him in order to make the request. His ISP included both objectives. For individuals in Sample R.1 for whom current PBSPs, ISPs, and communication assessments were requested and received, the following was noted: • For 4 of 9 individuals (44%), communication strategies identified in the assessment were included in the PBSP. Please note that while some aspect of the recommended strategies were included, not all were. For example, it was	

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		recommended in Individual #149's Communication Plan that staff were to use sign language and/or gestures when speaking to her or giving directions. Her PBSP instructed staff to use short, simple sentences and sign language use was not consistent with the communication assessment. Individual #54 had a communication folder and this was included in the PBSP, though there were no additional strategies provided in the communication assessment. As described above, there was no current assessment for Individual #135, Individual #198, or Individual #144. • For 4 of 7 individuals (57%) communication strategies identified in the assessment were included in the ISP. Based on review of the BTC meeting minutes from 10/9/12 to 3/18/13, participation by an SLP was noted in 8 of the 17 meetings (47%). A different SLP attended these meetings. It was not clear if this was based on the individuals discussed or rather a method to rotate attendance based on availability. This was an opportunity to promote collaboration between psychology and the SLPs for assessment and program development so SLP participation in these meetings should be increased.	
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 ISPs for 17 individuals in Sample R.1 the following was noted: • 16 of 17 ISPs (94%) were current within the last 12 months. The ISP submitted for Individual #311 was dated 2/13/12 and, as such, was not current at the time of this review. • In 9 of 17 ISPs reviewed (53%), there was evidence that a SLP attended the annual meeting. Each of these individuals presented with a need for communication supports. No pre-ISP information was submitted to determine who was required to be at any upcoming ISPs. • In 11 of 17 ISPs reviewed (65%), the type of AAC and/or other communication supports (may include, but not limited to, the Communication Dictionary, Communication Plan, and strategies for staff use) were clearly identified. This was limited to the communication strategies for staff use and in a few cases a type of device available for use by the individual. There was no evidence that the details of the Communication Dictionary were reviewed by the IDT for effectiveness or accuracy in any case. • Of the Communication Dictionaries provided to 16 of 17 individuals, 0 (0%) were reviewed at least annually by the IDT, as evidenced in the ISP. • 17 of 17 ISPs reviewed (100%) included a description of how the individual communicated. Most of these did not address AAC use by the individual. • 8 of 17 ISPs reviewed (47%) contained skill acquisition programs to promote communication. Only three of these involved participation related to program	Noncompliance

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		development by the SLP (Individual #226, Individual #204, and Individual #54). The functionality of a number of these programs was questionable. o Individual #226 was to activate a device (not identified) when the staff held the button close to the left side of her face. It was not specified what purpose or meaning this program had for her. The assessment indicated that this device would play a poem. o Individual #277 was to push a communication device with verbal prompts prior to his medication. It was not clear if this was to indicate that he was ready, to request his medication, or to convey some other message. Merely pushing a button did not constitute a functional communication program. Getting medication should also be a desired item in order to reinforce the request, otherwise there may be a functional reason to avoid this activity or it merely becomes a meaningless action prior to be being given medications, particularly if staff must assist him to do this. In fact, the communication assessment, dated 1/4/13, indicated that he should be encouraged to expand his verbal skills and there was no indication that a device was appropriate. Collaboration with regard to implementation of communication methods is essential to individual success. o For Individual #213, staff were to provide hand-over-hand assistance to do this. The communication assessment indicated that she had met this objective and it was recommended that she use a voice output device to request a snack. This was not included in the ISP, yet was likely far more reinforcing for her than requesting her medications. o This activity was observed for several individuals in the Forever Young program. Staff prompted the individuals to make the request as an exercise, rather than making the devices available prior to snack to promote spontaneous activation with immediate reinforcement of the request. Real time modeling by the SLPs was indicated to ensure that staff understood how to use these communication systems in a meaningful, functional manner. • In 0 of 17 ISPs reviewed (0%) information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP were included. <u>Individual-Specific AAC Systems:</u> There were approximately 70 individuals who were provided some type of AAC, including sign language. There were 23 additional individuals who used some level of sign language with no other AAC system. There were approximately 171 individuals who were provided a Communication Dictionary. Individuals who were provided AAC were also provided a Communication Plan. These plans also included individualized	

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		communication strategies for use by staff. Eighteen individuals had environmental control switches not necessarily related to communication, but rather access to their environment. This was essentially consistent with the provision of AAC for individuals living at SASSLC previously noted in the last onsite review. Of these, AAC was provided to 49 individuals who were considered to be Priority 1, 18 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. Though, as previously reported by the monitoring team, in some cases, AAC was dismissed when an individual failed to activate a switch during an assessment rather than incorporated into meaningful activities throughout their day. In some of those cases, there was no plan to provide SAPs or other supports to promote skill acquisition related to AAC, though this appeared to be improved. In other cases, the responsibility was placed on the home or day program staff with minimal supports from the therapists. As observed, these were not always implemented in a meaningful way by home or day program staff. Also, the speech clinicians continued to appear to consider only the hands as the primary 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. As previously reported, the assessments for the individuals in Sample R.1 did not consistently provide an adequate assessment of the individuals' potential for AAC use through direct intervention and trials occurring in the natural environment in situations that were most meaningful to the individual. There was very limited evidence of the use of training/teaching models to expose and promote interest and use of AAC across settings. It appeared that the clinicians only considered the use of a specific AAC system if the individual spontaneously showed ability or interest in the system presented. It was not clear that attempts were made for use in a setting over time that would spark interest such as to request a favorite item, food, beverage, music, vibration or massage, for example. As described above, collaboration across team members was not always evident as well. Implementation continued to be reported to be a concern by the clinicians. Observations were conducted in four homes and also in the dining areas for each of these for individuals in Sample R.4 with AAC. Findings included the following: • AAC systems for two of the four individuals observed in Sample R. 4 (50%) were present and in use during observations. The other six were not observed. Ten others were also noted with AAC, though only three were in use. Even in the cases that systems were noted to be in use, they were not used in the most functional manner (Individual #280, Individual #309, and Individual #61). In	

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		the case of Individual #65, an environmental control device was set up for him in his day program/work area, but it was not working properly when observed by the monitoring team. <u>General Use AAC Devices:</u> Though general use devices were noted in some areas, these were not quantified in the documentation submitted. <u>Direct Communication Interventions:</u> There was only one individual listed as participating in direct communication-related interventions provided by the SLP (Individual #31). Records related to the provision of direct intervention plans for him (Sample R.5) were reviewed. This included assessments, ISPs, ISPAs, SAPs and progress notes. Findings were as follows: • Per the assessment update (1/29/13), his computer-based communication system was to be discontinued because he did not use it consistently and that his direct therapy would shift from training related to that device to articulation therapy to improve the intelligibility of his spontaneous speech. This was integrated into his ISP dated 2/12/13. • Two of the notes submitted were in reference to AAC use. By report, he had mastered all three objectives. It was also reported that Individual #31 did not choose to keep his device on his wheelchair during the day and even when he did, he did not use the device unless prompted to do so. • There was no progress note for January 2013, with no explanation as to why therapy was not provided. • A Direct Therapy Plan was developed for improved articulation and intelligibility using a picture board. It was not clear when this plan was actually implemented following his ISP on 2/12/13. Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. Documentation of SLP review for Individual #31 (two progress notes dated 3/8/13 and 4/9/13) was generally comprehensive as per the indicators above. The clinician identified the measurable goals and reported baseline and performance for each. It was	

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		recommended that therapy continue without any changes to the plan. The rationale was documented in the plan itself. The only element that was incomplete related to the consistency of implementation. The plan indicated that he would participate in one and a half hours of therapy per month, but the notes reported that he participated in two sessions each month. It was not possible to determine if these were consistent. <u>Indirect Communication Supports:</u> Indirect communication supports for individuals in Sample R.6 generally included the communication dictionary and the communication plans provided to the individuals in the samples reviewed, as well as SAPs. The dictionaries and plans were inconsistently described in the ISPs. There was no evidence of consistent documentation for the individuals in this sample, related to the benefit and effectiveness of the supports, consistency of implementation, or recommendations related to necessary changes. SAP plans were submitted, but documentation related to implementation for the past six months was not. In two cases only (Individual #93 and Individual #301), completed data sheets were submitted for implementation of a program on four occasions, each only during March 2013, though the programs had been implemented for at least six months. There was no evidence of any review by the SLPs beyond the annual assessments. <u>Competency-Based Training and Performance Check-offs:</u> New employees participated in NEO classroom training and completed competency check-offs for foundational skills related to communication. It was not clear that this was done for foundational skills prior to assignment to a home. Per the schedule, the combined classes for deaf awareness and AAC were only four hours. A brief observation of the training was conducted by the monitoring team. The trainer was energetic and knowledgeable of the material presented. In a conversation with CTD staff, this training was characterized as not part of the required NEO training, but rather was provided as an aspect of home-based training. All aspects of communication training, including the competency check-offs provided to new employees should be a key part of NEO. A system to track which staff have been determined to be competent in each level of training should be a coordinated effort by the facility and include CTD, Habilitation Therapy, and residential leadership. This is critical to effective staff management to ensure assignment of properly trained staff to individuals for safety and optimal support of specific needs related to care and programming. New trainers participated in a process of observation, practice, co-teaching, independent teaching, and audits to establish and maintain competency. By report, every trainer was audited by the Habilitation Therapies Director annually. NEO training was provided by a licensed SLP. Though specialty training was provided by the PNMCs in other areas of PNM, training related to communication appeared to be provided by licensed professionals as well. No refresher training was completed in the area of communication.	

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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.	Monitoring System: A system of monitoring was established at SASSLC to include the following: • Communication equipment was present • Equipment was found in the correct location • Equipment was in working condition • Staff response to use of the device • Staff were able to describe the purpose of the device. • Tracking of the effectiveness monitoring of AAC systems that was conducted by the speech therapists or the IDT with documentation in the IPN or ISP. Individual monitoring was conducted related to implementation of the communication supports and services provided, but did not include the communication dictionary, but rather only Communication Plans designed for staff reference, AAC systems and environmental control devices used by the individuals. The Communication- Hearing-Environmental Control Equipment Observation Form (revised 6/25/12) and the Communication Supports Monitoring Tool (revised 9/1/12) were used and appeared to be the same. The speech policy indicated that monitoring would be conducted at least quarterly (or more frequently as needed) for condition, implementation, condition, staff knowledge and effectiveness, using the Communication Supports Monitoring Tool. The local speech services policy for monitoring of communication supports defined: • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials. • Monitoring for the working condition of communication adaptive equipment. • The frequency of monitoring. This policy, however, did not include the following key elements: • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. • A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). The facility monitoring data did not report on the following key compliance indicators: • Frequency of monitoring consistent with recommendations. • AAC used in various environments (it appeared that monitoring occurred predominately only in the home environment). • In the case a problem was identified, there was evidence of resolution (in the case that a problem was identified).	Noncompliance

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		Completed forms for communication-related monitoring conducted in the last month (51) were submitted for review. Twenty-six of these also included effectiveness monitoring by the SLPs. Others addressed compliance and equipment condition only. A number of forms reported that equipment was either not available to the individual (9) or not in working order (5). In some cases, the monitor checked "NA" for availability even when the device was missing or not working. Additional training was needed. Review of the completed monitoring forms identified the following: • 0 of 3 (0%) individuals included in the sample (R.1) who were provided AAC were monitored at least quarterly for the availability and working order of their communication system. None had received effectiveness monitoring at least quarterly in the last six months, though two had been monitored at least once (Individual #144 and Individual #54). • 2 of 5 individuals (40%) included in the sample (R.1) who were provided environmental control devices were monitored at least quarterly. Only one had received effectiveness monitoring at least quarterly in the last six months (Individual #226). Compliance monitoring was also conducted quarterly for Individual #226, yet on both occasions, the equipment was not available for her use. Two others had been monitored only once in the last six months for effectiveness and/or compliance. Monitoring was conducted for Individual #228 (four times) and once for Individual #135. The device monitored was not available to either individual on any occasion. • For 0 of 4 (0%) individuals included in the sample for whom an issue was identified on any monitoring form, there was evidence of problem resolution. Based on the existing tracking and review system of monitoring results, the facility continued to self-identify issues that required attention. A steady decline in the working order status and accessibility of communication-related equipment was reported from 9/1/12 through 2/28/13. More recent improvement was reported, though actions taken to address this were not highlighted in the self-assessment. The self-assessment reported that there had been an increase in the number of devices as more individuals were provided appropriate assessments and that there were ongoing challenges in maintaining these to ensure that they were available and in working order. Again, there were no strategies identified as taken to address this serious concern. A summary report indicated that planned actions included increased monitoring and purchasing of screwdrivers so that staff could replace batteries themselves. There was no evidence of review to determine if these strategies had been effective, rather there had been an increase in the number of spot checks conducted by speech technicians. Additional actions identified included PNMC inservices provided to home staff where	

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		individuals had communication supports and monitoring by residential supervisors. No documentation was submitted to report the effectiveness of these actions. Another element tracked via the self-assessment included error ratios. This related to errors identified by the monitor completing the form rather than errors noted in completion of the monitoring forms. Given a sample size of 75 to 106 forms, the self-assessment reported that errors had increased significantly in the last six months and averaged above the designated target of 20% at 25.5% from September 2012 through February 2013. Percentages for November 2012 through February 2013 averaged 33%. Ongoing support and re-training of staff and monitors was clearly indicated. A system of effectiveness monitoring had been initiated for quarterly review of AAC and other supports. As stated above, 26 of these were submitted. It was noted that in seven cases, the SLP marked "NA" related to whether observed interventions were effective. It was not clear how this could be counted as effectiveness monitoring.	

Recommendations:

1. Continue to pursue speech therapists for the provision of supports and services related to mealtime and communication (R1).
2. Address identified concerns via the existing assessment audit system (R2).
3. Integrate all communication interventions into the ISP (R3).
4. Clinicians are encouraged to consider revision of the current Master Plan timelines to the communication needs of individuals were fully met in a timelier manner (R2).
5. Stated timelines and strategies for completion of baseline Communication Assessments were dependent on SLP staffing and that when it was not possible to complete all needed assessments during a particular month, the assessments would be prioritized by need. This was a concern for the monitoring team. The clinicians should analyze the need for SLP supports and services and determine a reasonable number of FTEs/contract therapists to meet that need (R1 and R2).
6. More knowledge and experience related to the application of AAC to adults with developmental disabilities and physical/cognitive challenges is needed. The clinicians appeared to rule out this as an option based on cognition, limited used of the upper extremities, and initial lack of interest shown by the individual during the assessment, rather than recognizing the role of relevance, alternate access sites, environmental context and meaningful contextual training opportunities as effective methods in the development of AAC use in this population (R1-R3).
7. The therapists and the SLPA, soon to begin employment at SASSLC, should provide real time modeling across environments as how to do this is not intuitive for direct support staff (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:** Documents Reviewed: o Individual Support Plans (ISPs) for: • Individual #6, Individual #13, Individual #22, Individual #335, Individual #160, Individual #128, Individual #89, Individual #339, Individual #77, Individual #112, Individual #289, Individual #249, Individual #204, Individual #149, Individual #264, Individual #167, Individual #193, Individual #306, Individual #53, Individual #145 o Skill Acquisition Plans (SAPs) for: • Individual #6, Individual #22, Individual #335, Individual #160, Individual #128, Individual #89, Individual #339, Individual #77, Individual #112, Individual #289 o Monthly review of SAP progress for: • Individual #6, Individual #22, Individual #335, Individual #160, Individual #128, Individual #89, Individual #339, Individual #77, Individual #112, Individual #289 o Functional Skills Assessment (FSA) for: • Individual #6, Individual #22, Individual #128, Individual #89, Individual #339 o Personal Focus Assessment (PFA) for: • Individual #6, Individual #22, Individual #128, Individual #89, Individual #339 o Vocational assessments for: • Individual #6, Individual #22, Individual #128, Individual #89, Individual #339 o Dental Desensitization plans for: • Individual #227, Individual #114, Individual #17 o SASSLC Quality Assurance Report, March 2013 o Individual engagement data for each treatment site from April 2012 to March 2013 o List of individuals under age 22 with indication of the school attended (11 students) o ARD/IEP, ISP, ISD progress notes, and school-related ISPAs for: • Individual #118, Individual #279, Individual #113 o SAPs based upon ARD/IEP (nine) o Skills Acquisition (Formal Training) Observation Tool, undated o Engagement Monitoring Form, 4/1/13 o Graph of community based training objective data, March 2013 o Spreadsheet of community outings per home, August 2012-February 2013 o Listing of skill training in the community, August 2012-February 2013 o Listing of on-campus and off-campus day and work program sites, undated o Section S presentation book o Section S self-assessment, 4/12/13 o Section S action plans, 4/15/13

	Interviews and Meetings Held: o Gina Dobberstein, Music, Recreation, and Senior Program Director o Torrance Cheeves, Amanda Sada, and Larry Gilman, Active treatment coordinators o Juan Villalobos, Unit I Director; David Ptomey, Unit II Director ; Greg Vela, Unit III Director o Vinne Khamphoumanivong, QDDP, Eric Saenz, QDDP, Mary Ann Hall, psychologist, SASSLC liaisons to SAISD Observations Conducted: o Active treatment meeting o Individual Support Plan (ISP) meeting • Individual discussed: Individual #13 o Skill acquisition plan (SAP) treatment integrity session for: • Individual #263 o Observation of implementation of SAPs for: • Individual #281, Individual #263 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: As indicated in the last review, overall the self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared to be 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: • Expansion of the number of staff trained in the implementation of SAPs (S1) • Improvements in the percentage of SAPs reviewed with clear rationales for their selection (S1) • Improvements in individual engagement (S1) • Improvements in the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans (S2) • Expansion of the collection of SAP treatment integrity data (S3) • Initiation of graphing SAP outcomes to increase the likelihood of data based decisions concerning the continuation, revision, or discontinuation of specific SAPs (S3) • Modification of the community-training database (S3) • Increase in the number of individuals who are competitively employed in the community (S3) The monitoring team suggests that the facility focus on the following over the next six months: • Ensure that all SAPs are in the new format, and contain all the components necessary for learning discussed in the report (S1) • Ensure that dental desensitization or dental compliance plans are consistently written and implemented for individuals that refuse to attend the dental clinic (S1) • Expand the documentation of how the results of individualized assessments of preference, strengths, skills, and needs impacted the selection of skill acquisition plans to all individuals at SASSLC (S2) • Expand the graphing of outcome data to all SAPS 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)

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill	This provision item includes 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, there also had been some regression and 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	Noncompliance

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	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.	multiple skill acquisition plans. Skill acquisition plans (SAPs) at SASSLC consisted of training objectives. During the last review, SAPs were written and monitored by QDDPs and active treatment coordinators. Beginning in March 2013, however, the majority of SAPs were written and monitored by the active treatment coordinators and active treatment specialists. Vocational coordinators wrote and monitored vocational SAPS, while rehabilitation staff (e.g., occupational therapist, speech pathologists) and psychologists wrote some discipline related of SAPs. All 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 51 SAPs across 10 individuals. Twenty-two of the 51 SAPs reviewed (43%) were written in the old format and had no rationale for the selection of the SAP. This represented a regression from the last review when 28% of the SAPS reviewed were written in the old format. The new format was discussed in previous reports and was developed by the facility to ensure that all of components necessary for SAPS to be most effective were included. The facility now needs to ensure that all SAPS are written in the new format. In 22 of the remaining 29 SAPs reviewed (76%), the rationale appeared to be based on a clear need and/or preference. This represented a continued increase from the last two reviews when 55% and 68% of SAPs were judged to have a clear rationale. The following are examples of rationales that were judged to be based on a clear need and/or preference: • The rationale for Individual #112's communication SAP of pointing to pictorial representations of songs was "This objective was…. based on the identified need to increase communication skills. Individual #112 enjoys music and looking at pictures; this objective gives her the opportunity to recognize the relationship between a song and a picture." • The rationale for Individual #22's vocational SAP of independently completing a work task was "It was determined through observations, his annual vocational assessment, and trainer discussion that Individual #22 needs to improve his ability to follow the required sequence of towel assembly without prompting."	

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		On the other hand, an example of a rationale that was judged to not be specific enough for the reader to determine if it was practical and functional for the individual was: • The rationale for Individual #77's SAP of allowing nail care was "The focus of the training is to improve (Individual #77's) cooperation with nail care." 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 format SAP training sheets contained all of the above components. As discussed above, however, 43% of the SAPs reviewed were in an old format that did not include several of the above components (e.g., relevant discriminative stimuli, specific consequences for correct and incorrect responses, plans for maintenance and generalization). The maintenance and generalization plans in the new SAP format 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.	

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		Fifteen of the 29 SAPs reviewed that contained a generalization plan (52%) included a plan for generalization that was consistent with the above definition. This was a slight improvement over the last two reports when 42% and 49% of generalization plans were judged to be consistent with the above definition. Only six of the 29 new format SAPS reviewed (21%) included a plan for maintenance that was consistent with the above definition. This represented a decrease from the last review when 30% of maintenance plans reviewed were judged to be consistent with the above plan. An example of an acceptable generalization plan was: • The plan for generalization in Individual #89's SAP of making a purchase from a vendor in the community stated, "The skills involved in making a purchase can be used for all transactions involving the exchange of monies for goods and/or services." An example of an unacceptable plan for generalization was: • The plan for generalization in Individual #77's tooth brushing SAP stated, "Consistent training will improve (Individual #77's) dental health." Examples of good maintenance plans were: • The plan for maintenance in Individual #289's vocational SAP stated, "Once (Individual 289) has learned the skill, he will continue to work on this task as his primary job…." • The plan for maintenance in Individual #128's SAP of getting his medicated shampoo from the nurses' station stated, "Once (Individual #128) has mastered the skill of retrieving and using his medicated shampoo… It will become a part of his daily routine to prevent dandruff." An example of an unacceptable maintenance plan was: • The plan for maintenance in Individual #160's SAP of sorting her laundry stated "(Individual #160) will gradually make progress with sorting her clothes and will not need staff verbal prompts..." It is recommended that all SAPs contain generalization and maintenance plans that are consistent with the above definitions. At the time of the onsite review, the facility used various training methodologies, including total task training and forward and backward chaining. As discussed in the last report, however, additional training and monitoring of SAPs at SASSLC was necessary to ensure that they were implemented and documented as written (see S3).	

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		Dental compliance and desensitization plans Compliance and desensitization plans designed to teach individuals to tolerate dental procedures were developed by the psychology department. The psychology department recently initiated 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. The dental clinic, however, indicated that the psychology department did not follow-up on all individuals referred for missing or refusing routine dental evaluations. It is recommended that the facility initiate an interdisciplinary meeting to ensure that appropriate action occurs for all individuals who are refusing routine dental exams. A list of dental compliance and desensitization plans indicated that three formal desensitization plans were completed since the last review. All three were reviewed by the monitoring team and were not in the new SAP format. It is recommended that all formal desensitization plans be written in the new SAP format discussed above. Outcome data (including the use of sedating medications) from dental compliance and desensitization plans, and the percentage of individuals referred from dentistry with treatment plans, will be reviewed in more detail during future onsite visits. Replacement/Alternative behaviors from PBSPs as skill acquisition As discussed in K9 of this report, SASSLC included replacement/alternative behaviors in each PBSP. None of the replacement behavior SAPs reviewed were written in the new SAP format. The training of replacement behaviors that require the acquisition of a new skill should be incorporated into the facility's general training objective methodology, and conform to the standards of all skill acquisition programs listed above. Communication and language skill acquisition The monitoring team was encouraged to encounter several new communication SAPs during this review. The facility's self-assessment indicated that 47% of individual's records reviewed contained communication SAPs. It is recommended that the facility continue to expand the number of communication SAPs for individuals with communication needs. Also, see section R. Service objective programming The facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). 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).	

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		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 treatment sites. For example, in the vocational workshop the staff and individuals appeared to be consistently engaged, and enjoying, the work activity. On the other hand, in some of the homes, staff and individuals appeared less enthusiastic with the process of active treatment. The facility continued to utilize monthly active treatment meetings with active treatment coordinators, active treatment specialists, and DCP supervisors. In the active treatment meeting observed by the monitoring team, March 2013 engagement data for each treatment site were discussed, and suggestions for improving engagement were presented. The average engagement level across the facility was 56%, a sharp increase over the last review (45%), and approaching engagement levels reported in previous reviews (i.e., 61% and 59%). Although engagement was improving, an engagement level of 75% is a typical target in a facility like SASSLC, indicating that the engagement of the individuals at SASSLC continued to have room to improve. The engagement data collected by the facility revealed a substantially higher engagement level than that collected by the monitoring team. For example, the combined engagement level of all home and day treatment sites during March 2013 collected by the facility, averaged 91%. As discussed in the last review, one likely explanation for the differences between the facility's data and the monitoring team's could be due to differences in how engagement data were collected. As described above, the monitoring	

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		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 facility's observers watched a particular individual for three 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. Although it is unlikely that both methods would yield the same percentages of engagement, they should both reflect changes in engagement across the facility. At this point, it is recommended that engagement targets for each home and day program be established, and sites that do not achieve these targets be provided plans for improvement. Engagement Observations: Location / Engaged / Staff-to-individual ratio Home 672 2/2 2:2 Home 672 4/9 3:9 Home 672 5/7 3:7 Home 671 3/6 3:6 Home 671 4/6 3:6 Home 670 1/6 2:6 Home 670 1/4 2:4 Home A-37 2/2 2:2 Home A-12 3/6 3:6 Home A-12 2/9 2:9 Vocational Workshop 15/17 4:17 Vocational Workshop 10/11 3:11 Vocational Workshop 10/10 2:10 Home 672 4/7 2:7 Home 670 1 /2 1:2 Home 670 2/13 2:13 Home 670 6/7 1:7 Home 668 3/5 1:5 Home 670 2/6 1:6 Home 766 3/4 1:4 Home 766 0/4 1:4 Home 665 1/4 2:4 Home 673 2/6 3:6 Home 673 1/1 1:1 Home 673 1/3 1:3	

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Home 674	0/2	1:2
Home 670	3/10	3:10
Home 671	3/7	1:7
Home 671	3/5	1:5
Home 671	0/3	2:3

Educational Services

Eleven individuals at SASSLC attended public school. This was a slight reduction from 13 at the time of the previous review, due to graduations. All individuals who were entitled to an educational program were enrolled and were attending school. The students attended one of two high schools. Two students were 16 years old, one was 17, and the others were 19 or older.

Vinne Khamphoumanivong, QDDP, Eric Saenz, QDDP, and Mary Ann Hall, psychologist, were the SASSLC liaisons to SAISD. They were active in the public school programming of the individuals on their caseloads. This included regular contact with school teachers, monthly visits to the schools, attending all ARD/IEP meetings, participating in a monthly meeting with special education administrators, and attending emergency ARD/IEP meetings. This was a very good level of involvement from the QDDPs and psychologist.

They reported a continued good relationship with the school district, including a particularly good relationship with Highland High School. Staff from this high school occasionally visited the SASSLC campus for meetings or observations.

The QDDPs included relevant content from the ARD/IEP in the SASSLC ISP. This was even more evident in the more recent ISPs. Every student had at least one or two SAPs taken directly from the skills he or she was working on at school, such as reading, reading comprehension, writing, pointing, and community/vocational activity.

The QDDPs reviewed school progress reports and usually held an IDT ISPA meeting after public school progress reports were issued.

The monitoring team has no further recommendations regarding educational services other than a suggestion that the QDDPs and psychologist be offered some inservicing on special education laws.

#	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. Although improving, this item was rated as being in noncompliance because not all individuals had preference assessments, and it was not clear that assessments were consistently used to develop SAPs. At the time of the onsite review, all individuals at SASSLC 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 every individual had a vocational assessment and approximately 36% of individuals had a completed preferences and strengths inventory (PSI). This represented an improvement from the last review when 63% of individuals had a FSA and 87% had a complete vocational assessment. It also represented a decrease in the percentage of individuals with a completed PSI from the last review (50%). All individuals should have assessments of preferences and strengths. To assess compliance with this item, the monitoring team reviewed ISPs, FSAs, PSIs, and vocational assessments for five individuals. 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 are considerable data that demonstrate 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 in any of the FSAs reviewed. There were several examples of how assessments and preferences were used to develop some SAPs. For example: • Individual #6's ISP and vocational assessment indicated that he was dependent	Noncompliance

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		on verbal prompts to complete his vocational tasks. As a result of this assessment, a vocational SAP was developed which specified that staff would avoid verbal interaction with Individual #6 and only use gestural prompts to achieve completion of work tasks. • Individual #22's ISP indicated that his SAP of using a picture board to initiate a conversation was based on a communication assessment that concluded that he needed a communication device as a back-up when his attempts at communication broke down. This represented an improvement over the last review when none of the ISPs or assessments reviewed documented how assessments impacted the development of individual SAPs. In the majority of SAPs reviewed, however, ISPs and assessments did not consistently document how assessments impacted their development. The following were typical: • Individual #6's ISP identified his communication need and suggested that he would, therefore, benefit from learning to use a voice output device. The ISP further articulated the teaching of the use of this device would be most successful if he initially learned to request preferences, such as cokes and snacks. His resulting SAP, however, consisted of teaching Individual #6 to operate a voice activated device stating "I need new batteries, please." It was not clear why he would be taught to ask for batteries when the ISP indicated it would be most successful if he requested preferences. No assessment data indicated that he preferred batteries. • Individual #339 had a SAP to learn how to put on his socks, however, there was no rationale for this SAP in his ISP, and his FSA indicated that he was independent in putting his socks on. • Individual #22 and Individual #128 had money management SAPs. There was nothing in their ISPs, FSAs, or PSIs that indicated a preference and/or need for this SAP for either individual. • Individual #89 had a SAP to do his laundry, but no mention in his ISP of any assessment results (e.g., FSA or PSI) that suggested that this was a practical SAP for him. The facility should ensure that assessments are consistently used, and documented, to select individual skill acquisition plans.	

#	Provision	Assessment of Status	Compliance
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	There was progress in this provision item, however, in order to attain substantial compliance, 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. Since the last review, SASSLC transitioned from quarterly SAP reviews to monthly SAP reviews. Fifty-one monthly reviews of SAP data were evaluated to determine compliance with this provision item. Twenty-one of the 51 monthly SAP data reviewed (41%) contained graphed data. This represented an improvement from the last review when none of the SAP data summaries reviewed contained graphed data. Only one (2%) of the data summaries reviewed (i.e., Individual #339's vocational SAP), however, clearly demonstrated data-based decisions to continue, discontinue, or modify a SAP, based upon outcome data. Several SAP summaries, on the other hand, resulted in decisions that appeared to be incompatible with the SAP outcome data. The following examples were typical: • Individual #339's SAP of putting on socks appeared to be achieved in December 2012, but continued to be implemented through February 2013 • Individual #128's summary indicated no improvement in his vocational SAP for nine months, however, the SAP continued to be implemented without modification It is 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. SASSLC continued with the training of DCPs in the implementation of individual SAPs. At the time of the onsite review, 162 of 210 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. For one SAP reviewed (Individual #281's communication goal of activating a switch), there	Noncompliance

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		appeared to be some confusion over what training step was used. The DCP initially indicated that Individual #281 activated the switch with a verbal cue. As the result of questions concerning the training cue by the monitoring team, the DCP indicated that it should be recorded as a gestural cue. The only way to ensure that SAPs are implemented and documented as written is to conduct regular integrity checks. This represented another area of improvement. During the last review the facility had introduced treatment integrity. At the time of this onsite review, treatment integrity had been expanded to all day treatment sites and recently begun in selected homes. It is now recommended that treatment integrity be expanded to all treatment sites. The monitoring team reviewed the treatment integrity tool, and observed a treatment integrity session for Individual #263's toothbrushing SAP. The treatment integrity tool used by the facility (referred to as the skills acquisition observation tool) included several questions concerning the SAP such as "why is this person working on this objective." It also included a direct observation of the implementation of the SAP, and a rating of if it was implemented as written. The monitoring team found the tool to represent a potentially useful measure of treatment integrity. Additionally, the monitoring team was impressed that the treatment integrity session included two observers (allowing for interobserver agreement measures), and by the observers' knowledge of Individual #263's SAP and of the treatment integrity tool. The integrity observation prompted a productive discussion of the possible need for clearer operational definitions of training cues. At this point, it is recommended that measures of treatment integrity are extended to all SAPs, acceptable treatment integrity levels are established, and that the facility document that they have achieved those integrity levels.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SASSLC enjoyed 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 minimal acceptable frequencies of recreational activities per home, and demonstrate that those established levels of community recreational activities and training are consistently achieved. SASSLC recently developed a new community-training database. The self-assessment, however, indicated there had been reliability problems with the recording of community training prior to March 2013. As reported in the last review, SASSLC established community-training goals in each home. The community based training data for March 2013 indicated that only one of the eight homes achieved their community training goals. There was no evidence of	Noncompliance

#	Provision	Assessment of Status	Compliance
		community recreation goals for each home. It is recommended that the facility establish minimal acceptable levels of community recreational activity per home. Additionally the facility needs to ensure those levels of community recreational activities and training is achieved. At the time of the review, two individuals at SASSLC were competitively employed in the community. This is an improvement from the last review when no individuals were competitively employed in the community.	

Recommendations:

1. Ensure that all SAPS are written in the new format (S1).
2. Ensure that each SAP contains a rationale for its selection that is specific enough for the reader to understand that the SAP was practical and functional for that individual (S1).
3. All SAPs should contain generalization and maintenance plans that are consistent with the above definitions (S1).
4. Initiate an interdisciplinary meeting to ensure that appropriate action occurs for all individuals who are refusing routine dental exams (S1).
5. All formal desensitization plans should be written in the new SAP format (S1).
6. All behavioral replacement behavior SAPs should be written in the new SAP format (S1).
7. Continue to expand the number of communication SAPs for individuals with communication needs (S1).
8. Engagement targets for each home and day program should be established, and sites that do not achieve these targets be provided plans for improvement (S1).
9. Provide the QDDPs and psychologist who are the liaisons to the public school with some inservicing on special education laws (S1).
10. All individuals should have complete PSIs (S2).
11. Ensure that assessments are consistently used and documented to select individual skill acquisition plans (S2).
12. All monthly SAP data reviews should include graphed data (S3).
13. Ensure that graphed data summaries of individual SAP progress is used to make data based decisions concerning the continuation, discontinuation, or modification of skill acquisition plans (S3).

14. Treatment integrity should be expanded to all treatment sites (S3).
15. Treatment integrity data should be tracked and acceptable treatment integrity levels established and achieved (S3).
16. Establish acceptable percentages of individuals participating in community activities and demonstrate that these levels are achieved (S3).
17. Demonstrate that established levels of SAP training in the community are achieved (S3).

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and attachments (exhibits) o DRAFT revised DADS SSLC Policy: Most Integrated Setting Practices, attachments, January 2012 o SASSLC facility-specific policies regarding most integrated setting practices • SASSLC facility-specific policy, 300-21A, Facility Most Integrated Setting Practices, 12/1/11 o SASSLC organizational chart, undated, but likely March 2013 o SASSLC policy lists, 3/1/13 o List of typical meetings that occurred at SASSLC, undated but likely March 2013 o SASSLC Self-Assessment, 4/12/13 o SASSLC Action Plans, 4/15/13 o SASSLC Provision Action Information, most recent entries 4/12/13 o SASSLC Admissions and Placement Department Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/29/13 o Community Placement Report, last six+ months, 9/1/12 through 4/30/13 o List of individuals who were placed since last onsite review (12 individuals) o List of individuals who were referred for placement since the last review (18 individuals) o List of individuals who were referred <u>and</u> placed since the last review (3 individuals) o List of total active referrals (15 individuals), as of 4/30/13 o List of individuals who requested placement, but weren't referred (5 individuals) • Documentation of activities taken for those who did not have an LAR (0 of 4 individuals) • Those who requested placement, but not referred due to LAR preference (1 individual) o List of individuals who were not referred solely due to LAR preference (data were incorrect) o List of rescinded referrals (5 individuals) • ISPA notes regarding each rescinding (5 of the 5) • Special Review ISPA Team minutes for each rescinding (0 of the 5) o List of individuals returned to facility after community placement (none) • Related ISPA documentation (n/a) • Root cause analysis (n/a) 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 (4 of 12 individuals who moved since 5/1/12, i.e., 1 year since placement) o List of individuals who died after moving from the facility to the community since 7/1/09 (none, 0

	since the last review) o List of individuals discharged from SSLC under alternate discharge procedures and related documentation (2 individuals) o Graphs of most integrated setting related data (placements, referrals, provider fair, self-monitoring tool), undated probably March 2013 o APC weekly reports • Statewide weekly enrollment report (3/5/13-3/29/13) ▪ Example of email distribution of this report, 4/26/13 • Detailed referral and placement report for senior management (none) • Example of inclusion of APC in facility morning clinical services meeting, 1/4/13 o APC Department meeting minutes (none) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair, (1), 3/19/13 ▪ Monthly planning meeting schedule, announcements, sample evaluation, graphs • Community tours, 9/7/12 through 4/30/13 (20 for 57 individuals including some tours only for family members/LARs; many individuals went more than once) ▪ Examples of one page reports about each group tour (9/28/12, 3/12/13) • Meetings/trainings with local LA (1), 3/3/13 • Example of collaborative work with the LA, 3/17/13 • Facility-wide staff trainings ▪ New employee orientation (none) ▪ Community transition and CLDPs, part of OTJ for new QDDPs (2) • Self-advocacy meeting presentation (1), 2/20/13 • Family association meetings (1), 12/8/12 • Brochure and facility newsletter (1 each) o Description of how the facility assessed an individual for placement o List of all individuals at the facility, indicating the result of the facility's assessment for community placement (i.e., whether or not they were referred), obstacles were included o New blank CLDP format shell o List of individuals who had a CLDP completed since last review (the referral list) o Blank checklist used by APC regarding submission of assessments for CLDP, and completed checklists (none) o DADS central office written feedback on CLDPs (2) o For the three statewide monitoring tools for section T: • Blank forms • Completed forms for living options discussion at ISP meeting (3) • Graphs of living option discussion self-monitoring tool o Data and presentation information from the QA report, section T, October 2012-March 2013 o Notes from 1:1 meetings (1 from previous subgroup format, 11/14/12) o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o Facility obstacles graph, 1 page, 226 individuals, undated

	o PMM tracking sheet, undated o Post move monitoring helpful hints, May 2013 o Blank new post move monitoring form o Transition T4 materials for: • Individual #232 o ISPs for: • Individual #73, Individual #150, Individual #32, Individual #235, Individual #105, Individual #222, Individual #302, Individual #240, Individual #201, Individual #89 o Pre-ISP draft used during the pre-ISP meeting: • Individual #169 o Draft ISP used during the ISP meeting: • Individual #13 o CLDPs for: • Individual #131, Individual #245, Individual #123, Individual #11, Individual #51 (new format) o Draft CLDP for: • (none) o In-process CLDPs for: • Individual #168, Individual #140 o ISPAs for these individuals who were already referred: • Individual #97, Individual #344, Individual #195, Individual #22 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 #272: 45, 90 (inclusive in 90-day report) • Individual #159: P, 7, 45, 90 (inclusive in 90-day report) • Individual #223: P, 7, 45, 90 (inclusive in 90-day report) • Individual #216: P, 7, 45, 90 (inclusive in 90-day report) • Individual #184: P, 7, 45, 90 (inclusive in 90-day report) • Individual #319: P, 7, 45, 90 (inclusive in 90-day report) • Individual #63: P, 7, 45, 90 (inclusive in 90-day report) • Individual #295: P, 7, 45, 90 (inclusive in 90-day report) • Individual #11: P, 7, 45 (inclusive in 45-day report) • Individual #123: P, 7, 45 (inclusive in 45-day report) • Individual #245: P, 7, 45 (inclusive in 45-day report) • Individual #51: P • Individual #131: P o Documentation that described additional post move monitoring follow-up for: • Individual #245, Individual #131

	Interviews and Meetings Held: o Loren Williams-Jones, Admissions Placement Coordinator o Darlene Morales, Post move monitor o Gevona Hicks, Human Rights Officer o Group home staff and managers at NIME agency, and Daybreak agency Observations Conducted: o CLDP Meeting for: (none) o CLDP assessment review meeting for: (none) o ISP Meeting for: • Individual #13, Individual #259 o ISP preparation meeting for: • Individual #169 o Community group home and day program visits for post move monitoring for: • Individual #245, Individual #131 o Community group home visits for: • Individual #223, Individual #123 o Self-advocacy meeting, 5/1/13
	Facility Self-Assessment The APC self-rated T1c3, T1h, T2a and T4 to be in substantial compliance. The monitoring team agreed with T1c3, T1h, and T2a, and also rated T1c2 and T2b to be in substantial compliance. The monitoring team, however, found T4 to be in noncompliance. The APC's self-assessment needed improvement if it was to be useful to her and her department. The two primary problems were an over reliance on the three statewide monitoring tools, and a failure to include in her self-assessment all of the aspects of section T that the monitoring team looks at and includes in this report. In some places, the self-assessment questioned the reliability of the living options tool, but in other places accepted the data from this tool without questioning its reliability. T1b3 seemed to expect all individuals to be referred; that was not the intent of this provision. T1c through T1e referred to a CLDP monitoring tool, which the monitoring teams understood was not being used at SASSLC. In T1d, data from this CLDP tool reported that 100% of the assessments were done within 45 days, but then the self-rating stated noncompliance because they were not done within 45 days. There was no rationale for this discrepancy. Note, however, that the monitoring team also looks at the quality of, and recommendations that are in, these discharge/transition assessments as part of T1d. The T1e self-assessment merely looked at the presence of post-move supports in the CLDP, not whether the list was comprehensive, correct, individualized, or worded adequately.

	Summary of Monitor's Assessment SASSLC again continued to make progress across most of section T. The most notable being the increase in the number of individuals referred and placed, however, there were problems with many of the placements. The numbers of individuals who were placed had increased to an annualized rate of 9% (it was 1% at the last review). Approximately 6% of the individuals at the facility were on the active referral list. Twelve individuals were placed in the community since the last onsite review, 18 individuals were referred for placement since the last onsite review, and 15 individuals were on the active referral list. Some, but not all, of the assessments for all of the individuals included an applicable statement or recommendation for referral. Most included an independent recommendation from the professionals on the team to the individual and LAR. Living options were thoroughly discussed during both ISPs observed and an adequate description of a thorough discussion was evident in half of those reviewed. Few ISPs included an action plan to address/overcome obstacles identified. Some, but not all, activities related to the education of individuals, LAR, and staff were occurring. Educational plans were included in some ISPs, tours continued to be offered, and a provider fair was recently held. Section T1b2 details 9 activities that were to occur. CLDPs were initiated right after referral. Most, but not all, indicated ongoing activity regarding the individual's transition planning. None clearly identified a comprehensive set of specific steps to ensure community staff provider training and collaboration with community clinicians. A CLDP meeting did not occur during the onsite review and an audiotape of a CLDP meeting was never sent to the monitoring team. The content of the assessments needed much improvement, especially regarding the provision of guidance and recommendations for the individual's new community settings, day programs, residence, etc. The list of pre-move and post-move supports had not improved at all since the last onsite review. This must be addressed by the time of the next onsite review. Post move monitoring had improved. Since the last review, 29 post move monitorings for 11 individuals were completed. This was a considerable increase in post move monitoring activity. All post move monitoring was documented in the proper format and done correctly and thoroughly. Most individuals had some difficulties after moving. Some were relatively minor and addressed by the provider with support from the PMM and facility. A number, however, had serious problems with transition or with receiving the supports that were detailed in their CLDPs. Examples of problems included failure to obtain psychology, psychiatry, speech, and other services; failure to provide preferred activities and items; behavior problems that may or may not have been handled correctly; and problems with the environment, such as need for better clothing and furniture. Thus, additional follow-up, assertive action, and activities were required of the PMM. In all cases, she took action, but sometimes waited until the end

	of the 90-day period before calling an IDT meeting or before doing more than merely asking the provider to follow-up. Going forward, and to maintain substantial compliance, the PMM must demonstrate more immediate action when a support was not provided by a provider. The monitoring team was quite disappointed that so many providers in the San Antonio area struggled to provide high quality services to the individuals from the facility.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	SASSLC again continued to make progress across most of section T. The most notable being the increase in the number of individuals referred and placed, however, as noted in section T2 below, there were problems with many of the placements. The progress was due, in large part to the work of the APC, Loren Jones, who was in this role for less than a year. In addition to engaging in many activities herself, she supervised and coordinated the work of the post move monitor, Darlene Morales, and two transition specialists. Thus, with four staff devoted to this provision, there was an increased focus, additional educational activities, and more involvement by and with IDTs, family members, and LARs. The placement department staff's excitement about all of these transitions was palpable and reflected in the APC's description of move day as being like a wedding day. The specific number of individuals who were placed had increased to an annualized rate of 9% (it was 1% at the last review). Approximately 6% of the individuals at the facility were on the active referral list, about the same percentage as during the last review, however, given that more individuals were placed, this indicated that more individuals were being referred. Below are some specific numbers and monitoring team comments regarding the referral and placement process. • 12 individuals were placed in the community since the last onsite review. This compared with 1, 2, 5, 1, 3, and 5 individuals who had been placed during the periods preceding the previous reviews. o The number of community transitions showed an increasing trend. o This was the highest number of placements during any period since monitoring began. • 18 individuals were referred for placement since the last onsite review. o This compared with 9 and 8 who were newly referred at the time of the previous reviews. o 3 of these 18 individuals was both referred and placed since the last onsite review. o This indicated that IDTs were continuing to make referrals.	Noncompliance

		• 15 individuals were on the active referral list. This compared with 15, 10, 9, 4, and 3 individuals at the time of the previous reviews. o The number of community referrals showed a stable/increasing trend. o 5 of the 15 individuals were referred for more than 180 days. ▪ This compared with 6 individuals who were referred for more than 180 days during previous monitoring reviews. ▪ 2 of the 5, however, were scheduled for placement within the next month or two. ▪ 0 of the 5 was referred more than one year ago. • 5 individuals were described as having requested placement, but were not referred. This compared with 7, 5, and 7 individuals at the time of the previous reviews, respectively. o Of the 5 individuals who requested placement, but were not referred, 1 individual had an LAR who made this decision. o Of the remaining 4 individuals, an appropriate review and/or appeal was reported to have been conducted for all 4, however, documentation was provided for none (0%). Three were described as not being referred due to behavioral/psychiatric reasons. One was described as not being referred because he was exploring community options. As recommended in the previous report, some sort of placement review or placement appeals process needs to occur. • The list of individuals not being referred solely due to LAR preference contained more than 100 names (compared to a list with 1 individual at the time of the previous reviews). o This was not an accurate count and needs to be completed correctly by the facility. • The referrals of 5 individuals were rescinded since the last review. This compared to 2, 4, 2 and 3 at the time of the previous reviews. o Documentation was provided for 5 of the 5 individuals (100%) regarding the reasons for the rescinding, including ISPA notes. If any of these individuals did not have an LAR, and if any of them still requested referral (this was not clear in the ISPAs regarding the rescindings), their request should also then go through the review/appeal process described above. o Three were due to increased behavioral problems, including pica and aggression. There was, however, no indication of why the IDT determined that pica would preclude continued referral and search for a capable provider for that individual. o Another was due to a broken leg that prevented the individual from actively participating in choosing a provider. This sounded more like a temporary rescinding and he would likely be referred again once rehabilitation and healing were completed.	

		o The third was due to the LAR's decision based primarily on medical-nursing needs. o An adequate review to determine if changes in the referral and transition planning processes at the facility was not conducted for the rescinded referrals. If done and if actions were recommended, the monitoring team would look for indication of implementation of actions. • 0 individuals were returned to the facility after community placement. This compared with 0 individuals at the time of the previous reviews. • Data for individuals who were hospitalized for psychiatric reasons, incarcerated, had ER visits or unexpected hospitalizations, transferred to other group homes or to a different provider, who had run away from their community placements, and/or had other untoward incidents continued to be tracked and recorded (but not yet graphed). These data were now being obtained for at least a one-year period after moving. o Of the 12 individuals who moved in the past 12 months, 4 were reported to have one or more untoward events (33%). All four involved police contact due to behavior problems. The facility's PMM, APC, and IDT were involved and provided support and assistance to the provider, even past the 90 day post move monitoring period. o Of these, an adequate review was not conducted in any of the cases to determine if changes in the referral and transition planning processes at the facility should be made. This should not be a complicated or overly time consuming activity. The benefits may be very helpful to the APC, PMM, and transition specialists. If this were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions. • 0 individuals had died since being placed since 7/1/09. • 2 individuals were discharged under alternate discharge procedures (see T4). The monitoring team suggests that APC create a set of relevant graphs. A list of suggestions is provided below. The printouts can have more than one small graph on each page (e.g., three or four) to make the set of graphs easier to manage for the APC and for the reader. These graphs could then be part of the APC's QA program participation, such as in 1:1 meetings, QA reports, and QAQI Council (see sections E and T1f). • Number of individuals placed each month • Number of new referrals each month or six-month period • Number of individuals on the active referral list as of the last day of each month • Number of individuals on the active referral list for more than 180 days, as of the last day of each month • Pie chart showing the status of all of the active referrals (e.g., CLDP planned, move date set, exploring possible providers)	

		• Number of individuals who have requested placement, but have not been referred, as of the last day of each month • Percentage of individuals who have requested placement (who do not have an LAR), but have not been referred, for whom a placement appeal process has been completed, as of the last day of each month • Number of individuals not referred solely due to LAR preference as of the last day of each month • Number of individuals who had any untoward event happen after community placement each month o Cumulative number of each type of untoward event for all placements • Number of rescinded referrals each month or each six-month period • Number of returns from the community in each six-month period • Number of deaths in each six-month period • Number of alternative discharges (T4) • From T1b1 below: number of individuals whose ISPs identified obstacles to referral and placement, and whose ISPs identified strategies or actions to address these obstacles • From T1b2 below: number of individuals who went on a community provider tour each month <u>Other activities</u> None reported. <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. The monitoring team looks for indications in each professional's assessment, in the written ISP that is completed after the annual ISP meeting, and during the conduct of the annual ISP meeting. In assessments: Of the 8 ISPs reviewed (that had assessments attached), all of the assessments for 0 individuals (0%) included an applicable statement/recommendation. On the other hand, some of the assessments for all (100%) of the individuals included an applicable statement/recommendation. That is, all assessments done by medical, nursing, OTPT, speech and language included a specific statement and recommendation. Some, but not all, vocational and day program assessment included a statement and recommendation. Psychiatry assessments sometimes commented on community living, but did not include a recommendation. Psychology assessments typically included a statement such as "behaviors do not preclude community placement," however, this was not a statement of the professional's opinion about community referral. The other	

		assessments did not include a statement or recommendation. In the written ISPs: Of the 10 ISPs reviewed, 9 (90%) included an independent recommendation from the professionals on the team to the individual and LAR. Of these 10, each professional's opinion was given and described in 4. Observation of ISP meetings: Of the 2 ISPs observed, 0 (0%) included an independent recommendation from each of the professionals on the team. Individuals referred: In reviewing the 5 CLDPs, 5 (100%) individuals and/or LARs did not oppose transition to the community. <u>Referrals and Transitions</u> There were no systemic issues delaying referrals (at the facility/local level) identified during this onsite review. Funding availability was not cited as a barrier to individuals moving to the community. Senior management at the facility was kept informed of the status of referral, transition, and placement statuses of all individuals on the active referral list via a weekly emailed report from the APC and by the APC's presentation once each week at the daily morning medical-clinical services meeting. This was all good to see. The monitoring team suggested that the APC occasionally give an update on positive outcomes that individuals have experienced after moving to the community. Transitions were occurring at a reasonable pace. The state's expectation was that once a referral was made, the transition to the community should occur within 180 days. The IDT was required to meet monthly to review and address the obstacle to transition after the 180-day window. The ISPA was then to be sent to state office. • Of the 12 individuals placed since the time of the last onsite review, 3 (25%) were placed within 180 days of their referral. The placements of the other 9 were longer than 180 days. The placement of these long-standing referrals demonstrated the excellent efforts of the (relatively new) APC, her staff, and the IDTs. • At the time of the review, 15 individuals had been referred for community transition. 5 of these 15 individuals had exceeded the 180-day timeframe. o Of these, 0 individual had exceeded one year. o 2 of the 5 were scheduled to move within the next month or two. o The other 3 were less than one month past the 180 days. • The number of 180-day/1-year referrals was decreasing. • There were reasonable activity and actions related to the transition and placement for 3 of the 5 (60%) individuals (Individual #344, Individual #22,	

		Individual #15). • There were gaps of time (e.g., multiple months) during which little or no activity occurred for 2 of the 5 (40%) individuals (Individual #316, Individual #146). • It may be that documentation regarding the above two bullets, in ISPA format or otherwise, might have been maintained elsewhere and not submitted to the monitoring team.	
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 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. Thus, there was not a state policy that adequately addressed all of the items in section T of the Settlement Agreement. 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. Thus, at this time, there were not facility policies that adequately supported the state policy for most integrated setting practices. The rating for T1b is based solely on the development of adequate state and facility policies. Sections T1b1 through T1b3 are stand-alone provisions that require implementation independent of T1b or any of the other provision items under T1b.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such	SASSLC had received state training and consultation on the newest iteration of the ISP process (also see section F). Further training was expected, especially given that the state was focusing upon two other facilities to further refine this new ISP process. <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. DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in section F of this report, substantial compliance was not found for F1d, F2a1, and F2a3. Of the 5 CLDPs reviewed by the monitoring team, documentation indicated that the IDTs for 0 individuals (0%) included SAPs, and other supports, that were chosen with the individual's upcoming transition in mind. • The monitoring team recommends that, upon referral, the APC, PMM, and/or transition specialist seek out the IDT, and the active treatment coordinator to	Noncompliance

	obstacles.	talk about what SAPs might be considered now that the individual was referred for placement. <u>Obstacles to Movement</u> Of the 10 ISPs reviewed, 10 should have had obstacles defined. Of these 10 ISPs, 10 (100%) included an adequate list of obstacles to referral. Of the 2 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 2 (100%). Of the 10 ISPs, 2 (20%) included an action plan to address/overcome obstacles identified. Of these 2, 2 (100%) were individualized, were measurable, and included expected timelines. Of the other 8, 4 only contained plans for tours and community outings, and 4 did not have plans to address obstacles to referral at all. Of the 2 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 2 (100%). Of these, 2 (100%) were adequate. <u>Preferences of individuals and LARs</u> Of the 10 ISPs, 10 (100%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). All but two of these individuals could not adequately express a preference. The ISP indicated this and what the IDT had done to try to make this determination. Of the 2 annual ISP meetings observed, the individual's preference for where to live was adequately described in 2 (100%), and this preference appeared to have been determined in an adequate manner for 2 (100%), that is, that they were unable to give a clear indication of preference. Of the 10 ISPs, 10 (100%) included an adequate description of the LAR's preference and how that preference was determined by the IDT, or indicated that there was no LAR. Of the 2 annual ISP meetings observed, there was an appointed LAR for one (she and other family members attended the meeting). Family member preference was discussed in both meetings.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families	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 addressing some of these activities.	Noncompliance

	or guardians to enable them to make informed choices.	1. Individualized plan • There is an individualized plan for each individual (e.g., in the annual ISP) that is o Individualized and specifies what will be done over the upcoming year 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. SASSLC status: In reviewing 10 recently completed ISPs, 3 (30%) had a plan that addressed education about community options. Of these 3, 3 (100%) were adequate, because they were written in measurable terms, however, 0 (0%) appeared to address the specific educational needs of the individual (e.g., many said take on tours without specificity of what type of tours, no specificity of the educational activities addressing behavioral or medical needs). Of the remaining 7, 3 referred to tours, the provider fair, and/or community activities, but were not written in measurable terms and did not appear to address the individual's specific needs. 2. Provider fair • 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 SASSLC status: The facility did hold a provider fair within the past 12 months (March 2013). The facility did not, however, provide information regarding conduct the above bulleted activities. It appeared that an evaluation form was given to attendees (a sample completed evaluation was submitted), but there was no indication of overall attendance, summary of evaluations, and recommendations for future fairs. 3. Local Authority (LA) • Regular SSLC meeting with local LA • Apparent good communication and working relationship with LA • Quarterly meetings between APC/facility and LA • Agenda topics are relevant SASSLC status: The facility maintained good communication and a good working relationship with the LA, participated in quarterly meetings with the LA (though there was only one over the past six months), and ensured relevant topics were on the agenda for the LA meetings. The meeting minutes indicated good discussion of the need for training on community options and the CLDP process at the facility. 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. • Tours are for individuals or no more than 4 people • Individual's response to the tour is assessed (need methodology and indicators) SASSLC status: One to two tours continued to be available each month. Two sample one-page reports were given to the monitoring team, however, they were for tours with family members and with facility staff. There was no indication of any type of report for each individual, and/or if any information was sent along to the IDT. By the monitoring team's count, it seemed that there were 20 tours and 57 individuals went on these tours. Many individuals went on more than one tour, so the number of different individuals who went on tours was less than 57. The APC should have a way of ensuring that everyone who should go on a tour does indeed have the opportunity to do so. Thus, even though lots of work went into these tours (and should continue), some simple data collection will be needed, as indicated below. o The facility did not have an adequate system to track and manage tours of community providers, that is, one that identified all individuals for whom a tour was appropriate, what type of tour was appropriate, and whether or not each went on a tour that was appropriate to his or her needs. o Because all of the individuals at the facility for whom a tour was appropriate still needed to be determined at SASSLC, the percentage who went on a tour appropriate to their needs within the past year could not yet be determined. 6. Visit friends who live in the community SASSLC status: Since the last onsite review, there were not visits by individuals to friends who had moved to the community. Of the 10 ISPs reviewed, visits to friends appeared to be appropriate for perhaps 2. These types of visits were not offered to any individuals. This should be a relatively simple activity to add into the activities of those individuals for whom this would be appropriate. 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: Since the last onsite review, other educational activities for individuals and LARs/family members did occur during self-advocacy meetings, were being planned to occur during house meetings for individuals, and did occur during a family association meeting. 8. A plan for staff to learn more about community options SASSLC status: Since the last onsite review, educational activities for DSPs did not appear to have occurred at least once. Since the last onsite review, educational activities for clinicians did not appear to have occurred at least once. Since the last onsite review, educational activities for managers and administrators did not appear to have occurred at least once. o The APC created and distributed a flyer about her department, and she wrote a periodic article in the facility staff newsletter. o Living options and admissions/placement activities were part of new employee orientation for new QDDPs. 9. Individuals and families who are reluctant have opportunities to learn about success stories SASSLC status: Since the last onsite review, there was no plan or actions for information about successful community placements to be shared with (a) individuals who were reluctant to consider community placement and (b) LARs who reluctant to consider community placement.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the living options discussion at the annual ISP meeting. In addition, a listing was given to the monitoring team showing every individual and up to three obstacles to referral, taken from the ISP form. To meet substantial compliance with this provision item, the facility will need address the following four items to show that: • Professionals provided their determination regarding the appropriateness of referral for community placement in their annual written assessments. o 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 was not occurring regularly and consistently. • Living options for the individual were thoroughly discussed during the annual	Noncompliance

		ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o Living options were thoroughly discussed during both ISPs observed (100%) and an adequate description of a thorough discussion was evident in 5 of the 10 ISPs reviewed (50%). The living options discussion observed at the ISP for Individual #13 was very interesting. The parent/LAR and family members were opposed to any discussion or consideration of referral. During a pause in that part of the meeting, the home supervisor, Valenia Thomas, asked the parent why she was opposed. This then led to about 15 minutes of meaningful discussion about community placement during which there was engaging participation from Ms. Thomas, Chris Pope and other direct support professionals, the QDDP Barbara Eureste, and the family. o The monitoring team's findings differed from the APC's self-monitoring tool for the living options discussion in which she found nearly constant 100% good performance. It may be that the APC's tool assessed the occurrence, but not the quality, of the living options discussion. • 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 The set of ISPs reviewed by the monitoring team included good statements about the decision made by the entire team for 5 of the 10 reviewed (50%).	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	The APC submitted 5 CLDPs completed since the last review. This was 42% of the 12 CLDPs completed since then. A set of in-process CLDPs was also reviewed. <u>Initiation</u>: 5 of the 5 (100%) CLDPs, and 2 of the 2 (100%) in-process CLDPs, seemed to be initiated right after the referral. The monitoring team looks for this to occur within 10 calendar days of referral. The SASSLC CLDPs included the data that the CLDP was initiated/created. <u>Timeliness</u>: 2 of the 5 (40%) CLDPs included documentation to show that they were updated throughout the transition planning process. These were the two of the more recent referrals and placements. The other three were referred a year or more ago and there were long periods of time without much activity, however, with the addition of the new APC, PMM, and transition specialists, this had been corrected over the past six months. Therefore, the monitoring team considers this aspect of this provision item to now be in substantial compliance. 1 of the 2 (50%) in-process CLDPs indicated ongoing activity (Individual #168).	Noncompliance

		IDT member participation: 3 of the 5 (60%) CLDPs included documentation to show that IDT members actively participated in the transition planning process (i.e., visited potential homes and day providers, thoroughly discussed each potential provider, made changes in planning if necessary, responded to any problems exhibited by the individual). For the other 2, there was no mention of IDT involvement, though there may have been (as there had been during all previous onsite reviews). Coordination with LA: 5 of the 5 (100%) CLDPs included documentation to show that the facility worked collaboratively with the LA.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The 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. 0 of the 5 CLDPs reviewed (0%) clearly identified a comprehensive set of specific steps that facility staff would take to ensure a smooth and safe transition by including documentation to show that all six of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. There was very little information about the training of community provider staff. Some CLDPs merely had a single pre-move support referring to inservices needing to be completed with no further detail. Instead, it should indicate who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), the method of training (e.g., didactic classroom, community provider staff shadowing facility staff, or demonstration of implementation of a plan in vivo, such as a PBSP or NCP), and a competency demonstration component, when appropriate. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). This was not indicated in any of the CLDPs. • Assessment of settings by SSLC clinicians (e.g., OTPT, psychology, training and recreation). This was not indicated in any of the CLDPs, however, the APC reported that this was being done by the OTPTs, when needed. • Collaboration between provider day and residential staff is ensured. This was not described in any of the CLDPs. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). This was not indicated. The IDT needs to consider this. • Collaboration between Post-Move Monitor and Local Authority staff. This was likely occurring, but not indicated in the CLDP.	Noncompliance

		Day of move activities: 5 of the 5 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and all 5 indicated the responsible staff member. None (0%), however, indicated that the activities did indeed occur. CLDP meeting prior to moving: A CLDP meeting was not observed during the onsite review. The monitoring team offered to review an audiotape of a CLDP meeting that was to occur during the week subsequent to the onsite review, but it was never submitted to the monitoring team. For future CLDP meetings, the facility should demonstrate the following: • Attendance by all relevant IDT members, community providers, and LA • Individual preparation occurred prior to the CLDP meeting, if appropriate • DSP preparation occurred prior to the CLDP meeting, if appropriate to do so • Individual participation occurred, or was facilitated, if needed • There was active participation by team members • All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved • The post move monitor actively participated to ensure that supports were adequately defined and required evidence specified. During the onsite review, no other CLDP, pre-CLDP, or transition meetings occurred.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs indicated the staff responsible for certain actions and activities and the timelines for these actions. This included pre- and post-move supports and other pre- and post-move activities. In 5 (100%) of the CLDPs, the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and/or title for each support. In 5 (100%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support. In 0 (0%) of the CLDPs, signatures of facility director/APC, provider, and LA were included. This was likely due to computer print outs of the CLDP being sent to the monitoring team instead of the original signature page. For the next onsite review, please submit the signature page for this item. In 5 (100%) of the CLDPs, other activities, names, and timelines/dates for other community living monitoring activities were included.	Substantial Compliance

	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	4 of the 5 CLDPs (80%, not evident for Individual #51), included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by • Signatures on CLDP • Narratives in the CLDP	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.	The APC continued the process that was in place at the time of the last review, that is, in preparation for the CLDP meeting, assessments were updated and summarized. These assessments were then fully inserted into the CLDP document and they were attached to the CLDP. For 4 of the 5 CLDPs reviewed (80%), all necessary assessments were completed. For 4 of the 5 CLDPs reviewed (80%), all assessments were completed no more than 45 days prior to the date the individual moved to the community. For 4 of the 5 CLDPs reviewed (80%), all assessments were available to the APC and IDT prior to the final CLDP meeting. The content of the assessments needed much improvement, as also indicated in the last report. The APC needs to ensure each assessment contains the following: • A summary of relevant facts of the individual's stays at the facility. o This was done sufficiently in the assessments. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o This was insufficient. Most assessments did not provide direction to the team in determining specific supports for the CLDP. • Assessments specifically address/focus on the new community home and day/work settings; there are recommendations for the community residential and day/work providers. o The assessments made no attempt to focus on the new community home and day/work settings; there were no recommendations for the community providers. o The assessments were from the most recent ISP, or were updated from the most recent ISP. Recommendations were broad and meaningless to the IDT (e.g., continue PBSP, receive nursing services, move to the community). • Assessments identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. o Similar to the above bullet, this was not addressed at all.	Noncompliance

		Each section of the CLDP should contain the APC's summary of the discussion and deliberations in a way that captures the content and intent of the participants. This was not the case in these CLDPs.	
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.	The list of pre-move and post-move supports (previously called essential and nonessential supports) had not improved at all since the last onsite review. This must be addressed by the time of the next onsite review. The APC and her staff did not use any type of checklist or guide to help ensure all supports were included. The monitoring team recommends that they do so. A checklist of items for this type of activity was suggested in the previous monitoring report. Further, the bulleted standards below could be used as a checklist by the APC and her staff. The list of pre- and post-move supports should meet the following standards. • The list should be comprehensive and inclusive, demonstrated by: o Sufficient attention paid to the individual's past history, and recent and current behavioral and psychiatric problems. o All safety, medical, healthcare, risk, and supervision needs addressed. o What was important to the individual was captured in the list. o The list thoroughly addressed the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. o There were supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. o There were ENE supports for the provider's <u>implementation</u> 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. o Topics included in training had a corresponding ENE support for implementation. Each of the 5 CLDPs was missing many very important supports. This was rather disappointing given that this topic was raised in every previous monitoring report. Therefore, rather than commenting on each of the above 8 open bullets, the monitoring team's comments are below regarding supports that were missing from each CLDP: o Individual #131: history of violent behavior, learning replacement behaviors including problem solving, stuttering, working in food service, tooth brushing, home chores, social activities, and weight management. o Individual #51: serious behavior history, tardive dyskinesia, CHF and	Noncompliance

		COPD, constipation, a ground diet, use of placemat and foot stool, balance issues and Parkinson's disease, her preference to sleep late and take naps, Wheel of Fortune, having a pet, and Spanish speaking staff. o Individual #245: blood pressure monitoring, Clozaril blood monitoring, and workshop employment. o Individual #123: ground diet, being read to aloud, set ups for personal hygiene, and weight management. o Individual #11: learning to communicate his wants and needs, special shampoo, chips and soda, chopped diet, chocolate milk and Kool-Aid, and components of his BSP to remove triggers and communicate his needs. o There were no references to any positive reinforcement or other motivating components that contributed to the individual's success while at SASSLC. o There were few supports for learning new skills at home. There were no supports for any skills to be taught at any day or work programs. o There was no relationship between what was to be trained during inservicing and what was included as supports to be implemented by the provider's staff. • The wording of every support is in appropriate, measurable, and observable terms. o The supports were not written in a way that was measurable so that the provider and PMM knew how much, how long, how many, etc. In other words, there was need for observable reportable outcomes and a criterion for each support. • Any important support identified in the assessments or during the CLDP meeting that was not included in the list of supports, should have a rationale as to why it was not included. o This was not done. It could be done in the deliberations sections. • Every support should include a description of what the PMM should look for when doing post move monitoring (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. o This was not done. The wording of much of the evidence was inadequate and would be unusable by the PMM or would not provide a valid indication of the provision of the support by the provider. Examples of the way evidence was described included observing, discussion, and the presence of a document, such as the PBSP. There was little regarding the actual implementation of a support. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. A pre-move site review was conducted for all individuals. The PMM conducted the	

		reviews and included lots of good detail. Some of the pre move site reviews, however, indicated that each essential support was <u>not</u> in place (e.g., Individual #245, Individual #63's staff inservice documentation) or that the support could not be evaluated until the day the individual moved in (e.g., Individual #51). There should be some way of making sure that each pre-move support is in place, even if some of this review occurs on the day of the move. • Each of the nonessential supports needs to have an implementation date. Each nonessential support in the CLDP did have an implementation date.	
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 APC continued to engage in some activities related to this provision, however, a more organized system of quality assurance is required in order to obtain substantial compliance. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. Data/information were being collected, however, only for the living options discussion, not for all of the portions of the CLDP process. Data were reviewed, summarized, and analyzed for the living options tool. These data were included in the facility's QA program. The monitoring team suggests that a quality assurance process be more than just the living options tool and a soon-to-be-developed CLDP tool and include: • Tools regarding all aspects of the referral and placement process • Graphs of these tools • Graphs of other outcomes noted throughout this report, especially in T1a • Section T QAD-SAC 1:1 meeting summaries and monthly data submissions • The provision T section of the QA report • Presentations to QAQI Council • Corrective actions and/or corrective action plans	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	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review	Noncompliance

	obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • <u>Definitions</u>: Section T.1.b.1 of the Settlement Agreement required that the facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The state's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." • <u>Referrals</u>: As indicated on page 3, if a team did not refer an individual for transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • <u>Transitions</u>: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • <u>Data</u>: It was concerning that valid and complete data were not available. In addition, the plans included in the facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • <u>Assessment</u>: The facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely	

		stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives, however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). The SASSLC-specific portion of this report included some data directly from ISPs. Of most interest, was the final page in which the APC described some of her plans for increasing educational opportunities for individuals and LARs, including the development of an individualized plan each year, presumably as part of the ISP (see T1b2 above). These appeared to be reasonable first steps to address this need.	
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	The monitoring team was given a document titled "Community Placement Report." It was dated for the (more than) six-month period, 9/1/12 through 4/30/13. 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

	services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living 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	SASSLC achieved substantial compliance with this provision item, though some additional work will be needed for the time of the next onsite review. Since the last review, 29 post move monitorings for 11 individuals were completed. This was a considerable increase in post move monitoring activity compared to 3 post move monitorings for 3 individuals at the time of the last review. The post move monitoring reports were completed in a cumulative manner and only the most recent reports (i.e., 90-day or 45-day) were submitted to the monitoring team for review. Even so, the monitoring team was able to determine much of the required information for completing this section of the report. For future monitoring reviews, however, please submit each of the reports. Also, please note that attachments and supporting documentation do not need to be submitted, unless there is any documentation in particular that the APC and/or PMM would like for the monitoring team to see. Considering that the reports were submitted in a cumulative manner, the monitoring team reviewed completed documentation for all 29 (100%) post move monitorings. Of the 29, all 29 were completed by the post move monitor Darlene Morales	Substantial Compliance

	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.	<u>Timeliness of Visits</u>: For the 11 individuals, 29 reviews should have been completed since the previous review. Of the 29 required visits, 29 (100%) were conducted and 29 (100%) were completed on time. <u>Locations visited</u>: For the 29 post move monitorings conducted, 29 (100%) of the sites at which the individual lived and worked/day activity (e.g., day program, employment, public school) were visited. <u>Content of Review Tool</u>: 11 (100%) of the post move monitorings (only cumulative reports were submitted) were documented in the proper format, in line with Appendix C of the Settlement Agreement. 11 (100%) of the post move monitoring report forms were completed correctly and thoroughly, as evidenced by: • The checklist was completed in a cumulative format across successive visits. • Supports were verified, such as by indication of the evidence examined and the results of this examination. • There was adequate justification for findings for each support. • Detail/comment was included in the evidence boxes at the end of each of the supports sections. Every support received some narrative comments. o The monitoring team wishes to acknowledge the detail that the post move monitor provided in these descriptions. She did not hesitate to include a lot of detail regarding what she observed and what she found. This was excellent and helped the reader to understand her many activities and, most importantly, the status of the individual and what the facility and provider were doing (or not doing) to support the individual. o For many of the supports, the PMM struggled to adequately identify how the provider was to show that each support was being provided. As a result, she determined what was necessary for the provider to show. This was due, in large part, to inadequately worded pre- and post-move supports as noted above in section T1e. • LAR/family satisfaction with the placement (question #9) and the individual's satisfaction (question #11) were explicitly stated in the comments section in 29 of the 29 reviews (taking into account that some individuals did not have LAR or family involvement). • An overall summary statement of the post move monitor's general opinion of the residential and day/employment placements could easily be determined from the narrative comments provided by the PMM and/or was specifically indicated	

		at the end of the report. The monitoring team recommends that the PMM include a list of the staff who were interviewed on the first page of the report to help the reader understand which staff were interviewed during the post move monitoring. <u>General status of individuals</u> Based upon the monitoring team's review, of the 11 individuals who received post move monitoring, 8 (72%) ultimately transitioned very well and appeared to be having good lives. The other three individuals continued to exhibit problems or problems continued with their placements, providers, and/or supports (Individual #245, Individual #159, Individual #272). The monitoring team visited four individuals in four different group homes during the week of the onsite review. There were serious problems with one of the placements (Individual #245, see T2b) and although the others could be described as having good lives (based on verbal and written reports of the APC, PMM, and IDT), during the monitoring team's visits, two of the three were not engaged in any apparently meaningful activities or with staff (Individual #223, Individual #123). As discussed with the APC, a root cause type of review needs to be done of any individuals whose placements failed or who had the kinds of problems noted in T1a. <u>Use of Facility's best efforts when there are problems that can't be solved</u>: In 22 of the 29 (76%) post move monitorings, additional follow-up, assertive action, and activities were required of the post move monitor. These were for 9 of the 11 individuals (81%). Examples of problems included failure to obtain psychology, psychiatry, speech, and other services; failure to provide preferred activities and items; behavior problems that may or may not have been handled correctly; and problems with the environment, such as need for better clothing and furniture. The monitoring team was quite disappointed that so many providers in the San Antonio area struggled to provide high quality services to the individuals from the facility. This was evident not only from the post move monitoring reports, but from the monitoring team's observations at four different group homes managed by two different providers. For three individuals, documentation in the post move monitoring reports and/or ISPA notes showed that the PMM called an IDT meeting to discuss whether the team should look for a new provider for the individual. Of the 9 individuals for whom additional efforts were needed, the post move monitor took assertive action for all 9 (100%). In some cases, however, the PMM waited until the end of the 90-day period before calling an IDT meeting or before doing more than merely	

		asking the provider to follow-up. • Going forward, and to maintain substantial compliance, the PMM must demonstrate more immediate action when a support was not provided by a provider. She should also demonstrate that she quickly obtained intervention and involvement from the DADS HCS caseworker, the APC, and/or the facility director at SASSLC when working directly with the provider proved to be ineffective. 2 individuals were described as having had problems (hospitalization, behavior problems, roommate issues) after the 90 days of post move monitoring were completed (Individual #216, Individual #63). The APC, PMM, and IDT maintained involvement and provided additional assistance to the provider. Both individuals were described as now stable and doing OK. This was great to hear. The monitoring team requests receiving any documentation that may be available of these activities for future reviews. <u>ISPA meetings after each post move monitoring visit</u>: An ISPA meeting should occur after every post move monitoring during which a problem or concern was noted by the PMM. An ISPA meeting was held and there were minutes/documentation of the meeting following 5 of the 29 (17%) post move monitorings. ISPA meetings were not held following post move monitorings during which a problem or concern was noted by the PMM. This was problematic especially given that there were problems for which the PMM needed direction from the IDT. The IDT would likely have had some suggestions, comments, or interventions for the provider, including phone conferences, document sharing, and onsite visits to the provider.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team observed two post move monitorings. The PMM, Darlene Morales, did a thorough and complete job post move monitoring. This was based on observation of the PMM's: • Examination and verification of every ENE support • Review of documents • Direct observation of the individual and staff • Staff interview • Individual Interview (as much as possible) • Gathering of information by directly observing/examining, not only by provider staff report • Professional interaction style • No use of leading questions • Assertive and tenacious in obtaining information	Substantial Compliance

		The day program and home of Individual #245 were visited for the 45-day review, and the home of Individual #131 was visited for the 7-day review. The provider was NIME for Individual #245 and Daybreak for Individual #131. At both homes, staff did not appear to be informed about the individual and his or her needs. At NIME, in response to the PMM asking if he had been trained on the individual's needs, the staff member said, "We signed some stuff, so there's evidence" even though he could not answer basic questions about the individual's needs. In addition, Individual #245's home was dirty, there were no programming or activities occurring, his meal seemed inadequate (some cut up fish sticks and some canned beans [not his preferred Mexican food], sat alone at the table), his health did not appear to be attended to adequately, and a checklist created by the PMM was never implemented. Individual #131's home, on the other hand, was beautiful and she was highly engaged during the visit to her home. She and her housemates were finishing a nice family style dinner and were planning other activities for the evening. There was documentation that her staff member was trained only a few days prior (this visit occurred only two days after her move), and she was described as a good staff member (even though she was unable to adequately answer the PMM's questions about the individual). The APC and PMM took these observations very seriously and immediately spoke with the supervisors of both homes, reported the problems, and asked for follow-up to occur the next day. In fact, the APC told the director at NIME that if these problems were not corrected, the IDT would meet to discuss whether they should find a different provider. The next day, the APC reported that Individual #245's IDT supported his placement there and their decision to choose this provider for the individual. The monitoring team has no intention or authority to question their decision, however, it is unlikely that any member of the IDT would have been satisfied with what was observed by the PMM, APC, and monitoring team. Follow-up and ongoing monitoring will be important and was already occurring as evidenced in documentation submitted to the monitoring team in the two weeks following the onsite visit.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum 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	This item does not receive a rating.	

	determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	There were two individuals whose discharges required this provision's discharge and transfer requirements. Only one of the two (50%) was submitted to the monitoring team, even after an onsite request and an additional request in the weeks following the onsite review. Therefore, the monitoring team cannot find substantial compliance without having received this second individual's discharge information. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summaries completed for Individual #232 (the one of the two discharged individuals whose information was submitted to the monitoring team) it did not contain the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. These include a summary of the individual's developmental, behavioral, social, health, and nutritional statuses. In general, although the discharge summary provided the reason for transfer to another SSLC, rather than including the summaries as required, it instead contained an assortment of assessments and ISP information apparently cut and pasted from other documents. This was not the intent of this provision T4. For future T4 discharges, the documentation should indicate the following: • The Facility has documentation in the individual's record that the individual was transferred or discharged for good cause: • The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): • At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: • With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies: • The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment:	Noncompliance

Recommendations:

1. The APC and her department should do a review (e.g., root cause analysis) of each rescinded referral, each failed placement/re-admission to the facility (if any), 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).

2. Conduct some sort of placement review or placement appeals process for individuals who did not have an LAR, who requested placement but were not referred (T1a).

3. Create a correct list of individuals who were not referred solely due to the LAR preference (i.e., the IDT would have otherwise referred) (T1a).

4. Create a set of graphs of referral and placement activities, and include them in the facility's QA program (T1a, T1f).

5. 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).

6. Document reasons for any referral that takes longer than 180 days for placement to occur (T1a).

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

8. Upon referral, the APC (or one of his staff) should seek out the IDT and others as noted in T1b1 to talk about what SAPs might be considered now that the individual was referred for placement (T1b1).

9. Action plans to address/overcome each individual's obstacles need to be measurable and with expected timelines (T1b1).

10. Implement the many activities required in T1b2

11. Thoroughly describe the living options discussion in the ISP, including the IDT's decision regarding referral (T1b3).

12. Ensure gaps in time are thoroughly explained and the participation of the IDT in the transition process is described in whatever document that facility determines is appropriate to do so (T1c).

13. Provide more information on the training of provider staff (e.g., to whom, method, demonstration of competency), and regarding collaboration with community and provider clinicians (T1c1).

14. Document the completion of the day of move activities (T1c1).

15. Conduct complete and thorough CLDP meetings (T1c1).

16. Assessments for discharge need to specifically address/focus on the new community home and day/work settings, and identify supports that might need to be provided differently or modified in a community setting (T1d).

17. Ensure a list a list of pre- and post-move supports is comprehensive and inclusive (much detail in provided in the report) (T1e).

18. The APC should consider a self-assessment prior to finalization of the list of the CLDP supports. A suggested list of items for a self-assessment of supports is discussed T1e (T1e).

19. Ensure that all pre-move required supports are in place on the day the individual moves. Many items were not (and could not) be in place during the pre-move site review because the reviews were conducted prior to the move. Therefore, some system is needed to ensure that these supports are in place (T1e).

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

21. Improve the facility and statewide reports and assessments of obstacles (T1g)

22. The PMM should intervene sooner than she had been doing when there are problems identified at the placement (T2a).

23. Conduct an ISPA meeting after each post move monitoring if there were any problems or concerns noted by the PMM (T2a).

24. Alternative discharge process and paperwork need to be completed as required (T4).

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SASSLC Policy: Rights and Restrictive Practices 10/11/12 o SASSLC Policy: Consent and Authorization for Treatment and Services 10/11/12 o SASSLC Policy: Human Rights Committee 10/11/12 o SASSLC Need for Advocate/Guardian Priority Summary Form o SASSLC Self-Assessment and Provision Action Information for section U o ISPs and Rights Assessments for: • Individual #32, Individual #201, Individual #249, Individual #105, Individual #222, Individual #167, Individual #150, Individual #302, Individual #53, and Individual #235. 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 Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QDDPs in homes and day programs o Charlotte Fisher, Director of Behavioral Services o Karla Baker, Acting QDDP Coordinator o Gevona Hicks, Human Rights Officer Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 4/29/13 and 5/2/13 o Annual ISP meetings for Individual #13 and Individual #259 o Pre-ISP meetings for Individual #88 and Individual #82
	Facility Self-Assessment: SASSLC submitted its self-assessment. 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 facility self-assessment described criteria used to evaluate compliance for each item and details on specific findings. For example, for item U1, the HRO observed 14 ISP meetings for individuals without LARs to determine if teams were discussing individuals' ability to make informed decisions, reviewed a sample of ISPs and rights assessments, reviewed right's assessment submission tracking data, and reviewed facility policy.

	Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The facility self-rated U1 and U2 as not in compliance. The monitoring team agreed with the facility's compliance ratings for U1 and U2.
	Summary of Monitor's Assessment: The facility had not yet developed an adequate assessment process for determining the need for guardianship. IDTs were in the beginning stages of holding adequate discussion at the annual IDT meeting to determine if individuals had the ability to make decisions and give informed consent. This assessment process will need to be fully implemented for 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 facility had not developed a priority list of individuals needing an LAR. IDTs continued to need training to determine each individual's functional capacity to render informed decisions. • 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. A priority list of those in need of a guardian had been developed, and the facility was moving forward with procuring guardianship for individuals with a prioritized need. The human rights officer worked very closely with individuals and their IDTs to ensure protection of rights at the facility. She was actively involved with every department at the facility and served as an valuable resource to IDTs.

#	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	The facility had not developed a prioritized list of individuals lacking both functional capacity to render a decision and a LAR to render such a decision. Steps taken to address compliance with the requirements of section U included: • The facility had contacted community groups regarding recruitment of volunteer advocates. • Guardianship information was provided to families. • The facility had developed new policies regarding rights and restrictions. The HRO had trained staff on the new policy. • The HRO had begun tracking data regarding ISP discussion on legal status, communication, decision making, and the need for an advocate or guardian. A sample of ISPs and relevant assessments was reviewed to determine the adequacy of	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	IDT discussion regarding individuals' ability to express their own wishes or make determinations regarding their health or welfare. None of the ISPs in the sample documented adequate discussion regarding guardianship and decision making skills. None included an adequate discussion of the individual's ability to express his or her own wishes or make determinations regarding his or her own health or welfare. For example, • The ISP for Individual #53 noted that he was unable to give informed consent. He did not have a guardian, though his family actively advocated on his behalf. The team did not discuss his need for guardianship. • The ISP for Individual #302 did not include documentation of a discussion regarding his need for guardianship. It was noted in his living option discussion that he "had a difficult year with weight loss issues, hospitalizations, and G-tube placement." The team reported that he did not speak and required support in determining his preferences. ISP documentation stated that he did not have a guardian or family to advocate on his behalf. He did have a friend that advocated for him, but was not present at his ISP meeting. No referral was made for guardianship. The annual IDT meetings were observed for Individual #13 and Individual #259. Both individuals had guardians. For each individual, the QDDP reviewed the rights assessment with the team. Both teams agreed that the individuals did not have the ability to give informed consent. Progress had not been made towards meeting compliance with this provision. IDTs were not holding thorough discussions regarding the need for guardianship and ability to make decisions and give informed consent. The facility was not yet in compliance with this provision.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the	New guardianship had not been obtained for any of the individuals at the facility. The human rights officer was actively assisting families to renew guardianship on an annual basis for those individuals whose families were guardians. 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. The facility continued to offer self-advocacy opportunities for individuals at the facility, including a very active self-advocacy group. 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.	Noncompliance

#	Provision	Assessment of Status	Compliance
	primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The facility had not made progress in this area. Compliance with U2 will be contingent on the development of an adequate assessment process. It will be important for the human rights officer to continue to work with IDTs to ensure assessments are completed and teams engage in an adequate discussion of each individual's needs.	

Recommendations:

1. Ensure all teams are discussing and documenting each individual's ability to make informed decisions and need for an LAR (U1).
2. Develop a prioritized list of individuals that need a guardian based on IDT recommendations (U1).
3. Explore new ways to support the rights of individuals while working through the guardianship process such as developing training outcomes to develop and/or improve communication and decision making skills (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, 300-10, 5/1/10 • Protection and management of client records, 300-45, 2/24/10 o SASSLC organizational chart, undated, but likely March 2013 o SASSLC policy lists, 3/1/13 o List of typical meetings that occurred at SASSLC, undated but likely March 2013 o SASSLC Self-Assessment, 4/12/13 o SASSLC Action Plans, 4/15/13 o SASSLC Provision Action Information, most recent entries 4/12/13 o SASSLC Recordkeeping Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 4/29/13 o Emails regarding change of department name to Unified Records Department o List of all staff responsible for management of unified records o Training powerpoint slides and staff sign-in for recordkeeping practices, April 2013 o Sample colored sheet for individual notebooks o Emails regarding the filing of MARs/TARs that have missing entries, April 2013 o Checklist used to ensure new admissions have a unified record o Form used to randomly check for availability of active records and individual notebooks o List of other binders or books used by staff to record data (none) o Description of the SASSLC shared drive, undated o Tables of contents for the active records, individual notebooks, and master records, no changes o A six-page spreadsheet that showed the status of state and facility policies for each provision of the Settlement Agreement, 4/1/13 o Description/data regarding staff training on state and facility policies (none) o Policy Review Committee log, 4/25/13 o Blank tools used by the URC (checklist forms and statewide form), not updated recently o One page description of how audits are conducted, responsible staff notified, and follow-up conducted, undated o Medical consultation information: emails, spreadsheet o List of individuals whose unified record was audited by the URC (or home record clerk), October 2012 to March 2013 o Completed unified record audit tools for 25 individuals (some repeated), from October 2012 through March 2013 (0 to five per month): • Active record and individual notebook • Master record

	• Statewide self-monitoring tool (for some, but not all) • V4 interviews (none) o Completed statewide self-monitoring tools for additional individuals each month, completed by the QA department o Emails from URC requesting corrections be made, October 2012 through March 2013 (only four of these months were included) o Documentation indicating if an error was corrected (only for the February 2013 reviews) o Graphic presentations for each month, from the QA report section V (all six months) o Description and table regarding how SASSLC addressed section V4 (none) o Completed V4 interview forms o Copies of the questions/answers regarding V4 from the completed statewide self-monitoring tools o Active records and/or individual notebooks of: • Individual #171, Individual #6, Individual #288, Individual #173, Individual #37 o Master records of: • Individual #125, Individual #154, Individual #104 <u>Interviews and Meetings Held</u>: o Noemi Cardenas, URC o Janet Prince-Page, Coordinator of Unified Records o Yvette Pratt, Home Record Clerk o Joanne High, Home Supervisor o Brenda Campbell, Active Treatment Specialist <u>Observations Conducted</u>: o Records storage areas in residences o Overflow and master records storage area
	Facility Self-Assessment The content and procedures of the self-assessment remained almost identical to the self-assessment from the previous monitoring review (perhaps due to the recent turnover in the URC position). Therefore, no additional comments are provided here. The URC and the CUR should refer to the previous report. The monitoring team again recommends that the self-assessment contents line up directly with the contents of the monitoring team report. That is, there should be a self-assessment of each aspect of each of the four provisions of section V that the monitoring team comments upon (e.g., active record, individual notebook, master record, purple/pink binders, existence of policies, training on policies, components of the V3, implementation of the audit, presentation of results, follow-up, each V4 component). 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: Progress in many areas stalled since the last review due primarily to the resignation of the newly hired URC. Recordkeeping staff, however, remained hard working throughout this period. A system was created to ensure that a unified record was created for all new admissions. A new training packet of powerpoint slides was created for staff. The active records continued to improve due in large part, to the work of the record clerks. There was a new/revised process for how the ISP got into the active record. The content of the IPNs was improved. There were fewer items misfiled in the wrong individual's active record. Problems with legibility and signatures continued to be evident. There were still documents missing from many of the active records. Individual notebooks continued to be used, however, during times individuals were at home, their individual notebooks were locked in offices, cabinets, or file cabinets and not available to direct support staff. Furthermore, some of the information in the individual notebooks was not current and some was missing. The monitoring team recommends that the QAQI Council consider developing a PIT. A master record existed for every individual at SASSLC. Not all master records had been converted over to the newest format. There was no progress in resolving what to do about items that should be in the master record, but were not. SASSLC maintained the same spreadsheet as during the last onsite review. It had been recently updated. Not all state policies were in place yet, though continued progress was evident. A review of five unified records did not occur each month as required. The tools used by the URC to conduct the audit reviews needed to be updated. The typical number of errors found in a table of contents review was around 15 per record. There were only a few items that were frequently scored as "no" in the statewide self-monitoring tool. These were legibility, signature, and no gaps. Data were summarized in a number of graphs that were included in the monthly QA report. Recommendations were made for improvements to the graphs and presentation of data. No new work was done regarding the requirements of V4.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Progress in many areas of this provision stalled since the last review due primarily to the resignation of the newly hired URC. Fortunately, the previous URC, Noemi Cardenas, returned to this position, but only a month or so before this onsite review. It was unfortunate that SASSLC could not maintain the progress seen over the past monitoring reviews, however, with Ms. Cardenas back in her role as URC, progress is very likely to occur for the next review.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Recordkeeping staff remained hard-working throughout this period. During the time there was no URC in place, home record clerks stepped up and completed some of the monthly reviews, the department coordinator managed the audit-review system, and the QA department conducted additional reviews. As suggested in the previous report, the department changed its name to the Department of Unified Records and, thus, the department head, Janet Prince-Page, was now the Coordinator of Unified Records (CUR). State policy and facility-specific policies remained the same as in previous reviews. To repeat from the previous two reports, given that a number of changes and improvements had been made in recordkeeping practices over the past few years, the URC and CUR should update their facility-specific policies, #300-10 and #300-45, which had not been revised in almost three years. SASSLC recordkeeping staff, to help ensure the establishment and maintenance of a unified record engaged in these activities: • A system was created for recordkeeping staff to ensure that a unified record was created for all new admissions. • A new training packet of powerpoint slides was created for staff. The content of the materials was reasonable and appropriate. Signature sheets with 43 names were submitted. The CUR reported that this training was for DSP managers. • The URC was going to begin conducting random checks to see if active records were available and if individual notebooks were available. The availability of the individual notebooks was particularly problematic at SASSLC (see below). Data from these checks should be included in her data and in her QA report, perhaps as part of the V4 set of data. <u>Active records</u> The active records continued to improve due in large part, to the work of the record clerks, under the supervision of Ms. Prince-Page. The monitoring team reviewed active records in a number of the homes across the SASSLC campus. Aspects in which improvement was noted. • There was a new/revised process for how the ISP got into the active record. The plan was for the QDDP to forward the completed ISP to the QDDP director. The QDDP was then to conduct a quality check (see section F). The QDDP director was then to forward the ISP to the CUR. The recordkeeping department was then to track the date of ISP, the date and time it was received by recordkeeping department, and date that the home record clerk put it into the active record.	

#	Provision	Assessment of Status	Compliance
		This information was then to be summarized and put into an excel spreadsheet that went to the facility director who then sent it to state office. o It was unclear if this process was also to include all related ISP documents, such as the IRRF, IHCP, assessments, and SAPs. These related documents should be included in this process, too. o The process did not (but should) include ensuring that the ISP and related documents made it into the individual notebook (see below). • The content of the IPNs was improved and the many non-IPN documents that had been in the IPN section were no longer observed to be there. This was good progress. State IPN guidelines were never disseminated, but the facility apparently took good action. • SAPs appeared to be adequately included in the active record. • The facility quickly and adequately resolved a question about the requirement for MARs/TARs to be filed, even if they had blanks. • There were fewer items misfiled in the wrong individual's active record. None were found during the monitoring team's review. • The active record contents appeared to be purged and thinned more adequately and thoroughly than in the past. Aspects that needed attention/improvement: • See above open bullets regarding the process for dissemination and filing of ISPs and related documents. • Problems with legibility and signatures continued to be evident. Adequate data were not collected or presented in order to determine if this was improving (it may very well have been improving), remaining the same, or getting worse. • There were still documents missing from many of the active records. Examples included rights addendum forms, rights acknowledgement forms, some consents (e.g., photo consents), ISP monthly/quarterly reviews, pharmacy annual evaluation, FSAs, PBSPs, and psychological updates. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. The notebooks were to follow the individual throughout the day. This was the case when the monitoring team visited home 668 in the mid-afternoon. None of the individual notebooks were present because the notebooks went with the individuals to their day programs. The recordkeeping staff also changed the green instruction sheets each quarter to a different color to help highlight the information on the instruction sheet. Even so, there were two serious problems with individual notebook use at SASSLC. One was their availability. This was noted in previous reports, but did not appear to have	

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		been addressed. For the most part, during times individuals were at home, their individual notebooks were locked in offices, cabinets, or file cabinets and not available to direct support staff. Thus, ISPs, ISP-related documents, PBSPs, PBSP data collection sheets, replacement behavior sheets, SAPs, PNMPs, aspiration-trigger data sheets, and so forth were not available. The second problem was that some of the information in the individual notebooks was not current and some was missing. A majority of individual notebooks contained the old ISP from the previous year, did not contain ISP-related documents (e.g., IRRF, IHCP), and did not have behavior data collected timely. It seemed that although there was a process to get the ISPs into the active record, there was not an adequate system to get them into the individual notebooks. Further, the URC monthly audits did not pick up on the out of date ISPs (i.e., the audits all reported that the ISPs were current). To address these two problems: • The monitoring team recommends that the QAQI Council consider developing a PIT. The solution may be complicated and take some time to develop, but it is likely that QAQI Council and the Unit QAQI groups can come up with some good options. The URC and CUR might also consider talking with other facilities about how they addressed this common challenge. For example, some facilities had behavior data cards that staff carried for easy recording of behavior data. • The URC planned to do random occasional checks at homes to see if the active record and the individual notebooks were available to staff. This was a good idea and might be included as part of the PIT (if a PIT is created). <u>Other binders/logs</u>: Data were not recorded in any other binders or logs at SASSLC. As discussed onsite with the URC and CUR, the previous report's recommendation regarding the medication diet treatment record in the audit process has been withdrawn by the monitoring team. <u>Master records</u> A master record existed for every individual at SASSLC. Not all master records had been converted over to the newest format. There was no progress in resolving what to do about items that should be in the master record, but were not. The audit checklist being used by the URC was not in line with the newest format for the master records. This should be corrected. <u>Shared drive</u>	

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		The shared drive was described to the monitoring team. The recordkeeping department reported that all information in the shared drive also appeared in hard copy in the active record and/or individual notebook. <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 maintained the same spreadsheet as during the last onsite review. It had been recently updated. 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: • Note the list of job categories to whom training should be provided. • Define, for each policy o who will be responsible for staff 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.) • Include timeframes for when training needed to be completed and re-implemented. Some trainings occur only once, while others require annual refreshers. • Include a system to track which staff completed which training. • Include 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. o It would be helpful to include an "as of" date so that the reader knows that the training data were valid/correct as of a certain date.	Noncompliance
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in	The change in recordkeeping staffing also impacted the department's progress on this provision. After the resignation of the URC in December 2012, the home record clerks conducted reviews in February 2013 and March 2013. A review of five unified records did not occur each month as required. Five reviews were conducted in five of the six months, that is, in every month except for January 2013 when none were conducted. Going forward the URC planned to do five each month. Given her recent re-appointment, she could only complete three for April 2013.	Noncompliance

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	Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	Further, although not a requirement for substantial compliance, the monitoring team suggests that the URC not re-audit a unified record if it had been audited it within the previous 12 months. In this way, it is likely that a larger number of unified records at SASSLC can be audited across the next few years. Further, re-auditing a unified record that was recently audited (and in which corrections were made) does not make the best use of the URC's limited time to conduct audits. SASSLC's goal was to conduct five URC reviews each month (table of contents review of all three components of the unified record, statewide self-monitoring tool, and V4 interview). In addition, the QA department had a goal to complete six statewide self-monitoring tools (two of the six were done for inter rater agreement, the other four were included in the recordkeeping department's data). The monitoring team recommends that the QA department collect inter rater agreement on the table of contents tools occasionally, too, perhaps even once per month or once every other month. The tools used by the URC to conduct the audit reviews needed to be updated. They were old and did not reflect the many changes and modifications that occurred to all of the components of the unified record over the past year or so. Furthermore, there were many items that probably should be asterisked that were not (e.g., PNMT evaluation, behavior support committee, diet orders). There also appeared to be multiple lines that described the same item, such as the annual physicians summary, annual physicians examination, and examination. The active medical problem list should probably be moved to the front of the physicians orders. The content of the dental section of the tool should also be fixed to better reflect what's in the dental tab of the active records. In addition to correcting the above items, an updated tool might incorporate both the table of contents tool and the statewide tool and might even include items for rating whether the active record and individual notebook were accessible, locked when appropriate to do so, and properly thinned and stored. The URC and CUR described problems in maintaining the medical consultation database. During the onsite review, however, the monitoring team found that the medical department had a usable database. The URC reported that she will begin using this database during her future audits. Use of this database will allow the URC to go back perhaps as many as six months, rather than only going back to 3/18/13, as discussed during the onsite review. The findings from the URC's table of contents audit (of the active record, individual notebook, and master record) and the statewide self-monitoring tool were handled differently. After completing the month's set of audits, she color-coded the table of	

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		content audit reports with each color representing a different department. Then she emailed the color-coded reports to all relevant departments with a request for corrections to be made. Then, over the subsequent two months, she handwrote on the same audit report to indicate as each item was corrected. This was a reasonable way to manage this task. The typical number of errors found in a table of contents review was around 15 per record, though this varied across records and across the past six months. The errors were primarily missing documents, out of date documents, or documents that should have been taken out of the active record. There were only a handful of items that were frequently scored as "no" in the statewide self-monitoring tool. These were legibility, signature, and no gaps. The findings from the self-monitoring tool were not shared, and there was no correction requested for these. Data were then summarized in a number of graphs that were included in the monthly QA report. It was wonderful to see that the recordkeeping department had created a set of data that were regularly presented and in an understandable format. This was a good accomplishment for the department. The monitoring team comments below on this set of data along with providing suggestions for a more comprehensive and useful set of data graphs. • Page one had two graphs. The first was the current month's score for each of the statewide self-monitoring tools conducted by the URC and by the QA staff in a bar graph. The scores were presented as a percentage of items scored yes. The month's tools were then averaged and a single point for the month was added to a month-to-month line graph. o Because most of the 20 or so items on this tool were always scored yes, the monitoring team recommends that the URC choose only those four or five items that are sometimes scored no and only graph those. This will help focus upon those important areas. Otherwise, the score regularly reads as more than 80%, which leads to a lack of corrective action. o The recordkeeping department should determine how many errors are required for an item on the statewide self-monitoring tool in order for the item to be scored "no." For instance, if there are only two signatures that were not legible in a full month's IPNs and observation notes, would that be enough for a score of "no?" • Page two had the results of the active record portion of the table of contents review. Again, two graphs were presented. One was for each of the audits conducted in the current month (percentage of documents present, percentage that were current and correct). The second graph was a month-to-month line	

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		graph. o The monitoring team recommends that the graphs present the actual number of errors (i.e., corrections needed) rather than presenting the percentage of items that were correct. The tool had approximately 135 items. Therefore, a score of 90%, for example, although appearing high, could mean that there were a dozen items missing. Also, many items were not applicable to many individuals, so to do a proper percentage, these would have to be taken into account. It was not clear if this was done in this set of data. • Pages three and four were the same types of data as in the above bullet, but for the individual notebook and for the master record. The same comments as in the open bullet, above, apply to these two pages, too. • Data should be added to indicate the percentage of errors that were corrected in the active record, individual notebook, and master record table of contents audits. The URC could graph this for all three components together, or she could provide the data separately for all three. • Develop a data set for V4 activities. Also, once data are being collected, summarized, and graphed adequately, the CUR and URC (along with the QA department) should review these data to identify unresolved issues, analyze the data in more depth to identify specific issues or departments requiring more attention, and develop corrective actions, as appropriate, to address them. This would then be incorporated into the 1:1 meetings, QA report, and QAQI Council presentations.	
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.	In previous monitoring reports and during previous onsite reviews, the monitoring team detailed the six types of activities that the facility was expected to engage in to demonstrate substantial compliance with provision item V4. The monitoring team reviewed all six with the URC and CUR. At this point, they were engaging in two activities related to V4. One was the V4 interview. This had been going on now for a number of years. No completed interview tools were given to the monitoring team. The other was the URC's answering of two questions on the statewide self-monitoring tool. Every completed statewide self-monitoring tool, however, had a yes answer to these questions. There was no indication how this was determined. Below, the six areas of this provision item are again presented, with some comments regarding SASSLC's status on each.	Noncompliance

#	Provision	Assessment of Status	Compliance
		1. Records are accessible to staff, clinicians, and others The monitoring team observed that: • Similar to what was reported in section V4 of the previous monitoring report, and as noted in V1 above in this report, records were not readily available for staff, especially the individual notebooks for direct support staff. • Individual notebooks were very often behind locked doors and, therefore, not accessible to direct support staff. This hindered access to PBSPs, PNMPs, behavior data sheets, and so forth. • Records were available during psychiatry clinic and staff referred to them and reviewed documentation. • Records were available to the habilitation clinicians. • In those notebooks that were observed by the monitoring team, both a current ISP and IHCP were available in 38% of individual notebooks in the sample. 2. Data are filed in the record timely and accurately 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 observed that: • ISPs, however, were filed timely in the active record. • Many of the documents in the individual notebook were not current, such as the ISPs. • Documentation of the effectiveness of PNMPs was not generally included in the active record, but rather on separate monitoring sheets that were maintained in the habilitation department only. • The facility reported that 15 (17%) of 86 ISPs were filed more than 30 days after the annual ISP meeting from November 2012 through February 2013. 3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure) The monitoring team observed that: • Less than 50% of behavior data sheets reviewed had data collected with the previous 30 minutes. • Data sheets were used for documentation of treatment sessions for OT/PT. • Data were not consistently chosen to determine psychotropic medication efficacy. 4. IPNs indicate the use of the record in making these decisions (not only that there are entries made) The monitoring team observed that: • The facility reviewed IPNs to confirm that justification was provided when	

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		single-agent chemical restraint was ineffective. This review highlighted that in two of the five incidents of ordering multi-agent restraints there was a previous failure with a single-agent chemical restraint during crisis intervention as summarized in the report. <u>5. Staff surveyed/asked indicate how the unified record is used as per this provision item</u> • Interviews were conducted, but as noted above, the monitoring team could not determine staff responses to these interviews because the documents were not submitted. • The pharmacy department submitted a one page detailed description of how the pharmacy staff utilized the unified record. This was helpful and might be something that could be obtained from each department. Then, the URC could check to see if what the department described was indeed occurring. <u>6. 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 intent of this item is for the record to be present and available, and that it is used when, and if, needed, such as if there is a question about data, diagnoses, incidents, etc. Many times, there is no need to open the record because IDT members do not need to access additional information. In other words, it is possible to satisfactorily meet this component if the record is present, not used, and no examples of it failing to be used when it should have been used. Further, the recordkeeping department might take advantage of asking others who are already observing the ISP meetings for other purposes (e.g., for sections T or F) to collect some simple data for the recordkeeping staff so that they do not have to also attend a meeting. The monitoring team found the following: • At the ISP and pre-ISP meetings, the active record was available. • The QDDP provided IDT members with a draft ISP and IHCP at the annual team meetings observed. Data from assessments were entered into these two forms so that team members could reference current assessments when developing necessary supports. • During Individual #169's pre-ISP meeting, the active record was used by the PCP during the meeting. The nurse checked the record for information from his last hearing assessment. Further, a participant asked about the data on his vocational objective. The staff checked for it, which was good to see, however, there were no current data available in the active record. That was not good to see.	

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		• The active record was available at Individual #13's annual ISP. It was used to check on the content of the most recent QDRR. • The active records were available during the PNMT meetings for reference or documentation as required. • The new psychiatric staff was learning the new cases assigned and orchestrating the components necessary to conduct the IDT integrative meeting. The paper work task placed upon the psychiatry team was apparent. Recommendations of reconstructing the psychiatric clinic process to facilitate documentation and sharing between disciplines was outlined in the monitoring report.	

Recommendations:

1. Update facility-specific policies #300-10 and #300-45 (V1).
2. Include all ISP-related documents in the ISP tracking system (V1).
3. Address legibility and signatures (V1).
4. Address documents that are missing from the active record (V1).
5. Ensure that the individual notebook contains the documents it should contain and that these documents are current (V1).
6. Ensure the individual notebook is available to and accessible by direct care staff (V1).
7. Ensure that ISPs and IHCPs are filed and accessible to staff implementing the plan within 30 days of development (V1, section F).
8. Consider developing an individual notebook PIT (V1).
9. Finish conversion of all master records to the newest format (V1).
10. The master records should include documentation whenever the recordkeeping department has been unable to obtain a document after conducting a document search as per their own procedures (V1).
11. Complete state and facility policies for all provisions of the Settlement Agreement (V2).
12. For state and facility policies, indicate what type/method of training is needed (e.g., classroom training, review of materials, competency demonstration), what type of documentation is necessary to confirm that training occurred and where this documentation is stored and summarized, the number of staff who are supposed to have received training, and the number of staff who did receive training (with an "as of" date) (V2).

13. Conduct five quality assurance audits each month (V3).

14. When choosing the five unified records for the monthly audit, do not choose a unified record if it was audited within the previous 12 months (V3).

15. Update the tool (or tools) used by the URC to conduct the audits (V3).

16. For the findings from the statewide self-monitoring too, only graph those four or five items that are sometimes scored "no" (V3).

17. Determine how many errors are required for an item on the statewide self-monitoring tool to be scored "no" (V3).

18. For the findings from the table of contents reviews of the active record, individual notebook, and master record, the graphs should present the actual number of errors (i.e., corrections needed) rather than the percentage of items that were correct (V3).

19. Report on the percentage of items that were corrected within the pre-determined time frame (e.g., two months) (V3).

20. Engage in valid activities to determine whether the requirements of V4 were being met. Recruit assistance from QAQI Council (V4).

21. Develop a data set for 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
CM	Case Manager
CMA	Certified Medication Aide
CMax	Concentration Maximum
CME	Continuing Medical Education
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
CMQI	Continuous Medical Quality Improvement

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
DBW	Desirable Body Weight
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
EOC	Environment of Care
EPISD	El Paso Independent School District
EPS	Extra Pyramidal Syndrome
EPSSLC	El Paso State Supported Living Center
ER	Emergency Room
ER	Extended Release
ERC	Employee Reassignment Center
FAAA	Fellow, American Academy of Audiology
FAST	Functional Analysis Screening Tool
FBI	Federal Bureau of Investigation
FBS	Fasting Blood Sugar
FDA	Food and Drug Administration
FFAD	Face to Face Assessment Debriefing
FLACC	Face, Legs, Activity, Cry, Console-ability
FLP	Fasting Lipid Profile
FMLA	Family Medical Leave Act
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
GIB	Gastrointestinal Bleed
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)
IA	Intelligent Alert
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
ICO	Infection Control Officer
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
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITB	Intrathecal Baclofen
IV	Intravenous
JD	Juris Doctor
K	Potassium
KCL	Potassium Chloride
KG	Kilogram
KPI	Key Performance Indicators
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
LLL	Left Lower Lobe

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
MCER	Minimum Common Elements Report
MCG	Microgram
MCP	Medical Care Plan
MCP	Medical Care Provider
MCV	Mean Corpuscular Volume
MD	Major Depression
MD	Medical Doctor
MDD	Major Depressive Disorder
MDRO	Multi-Drug Resistant Organism
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
NFS	Non Foundational Skills
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
OH	Oral Hygiene
OHI	Oral Hygiene Index
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
PA	Physician Assistant
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
PDR	Physicians Desk Reference
PECS	Picture Exchange Communication System
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)
POC	Polypharmacy Overview Committee
POI	Plan of Improvement
POT	Post Operative Treatment
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
PUSH	Pressure Ulcer Scale for Healing
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
RLL	Right Lower Lobe
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
SBO	Small Bowel Obstruction
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
SIS	Second Injury Syndrome
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SOTP	Sex Offender Treatment Program
S/P	Status Post
SPCI	Safety Plan for Crisis Intervention
SPD	Sensory Processing Disorder
SPI	Single Patient Intervention

SPO	Specific Program Objective
SSLC	State Supported Living Center
SSRI	Selective Serotonin Reuptake Inhibitor
ST	Speech Therapy
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
TFT	Thyroid Function Tests
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
UR	Unified Record
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