United States v. State of Texas

Monitoring Team Report

San Antonio State Supported Living Center

Dates of Onsite Review: October 21-25, 2013

Date of Report: December 20, 2013

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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 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 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, did a great job, before, during, and after the onsite review. He was again available, responsive, and helped ensure that the monitoring team was able to conduct its activities as needed. His assistant Nercy Navarro was also extremely helpful to the monitoring team.

Second, management, clinical, and direct support professionals continued to be eager to learn and to improve upon what they did each day to support the individuals at SASSLC.

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 25 restraints used for crisis intervention involving eight individuals between 4/1/13 and 9/31/13. This compared with 27 restraints during the previous review period. Individual #304 accounted for 15 (60%) of the restraints
- The facility continued to make progress in the documentation and monitoring of restraints used for crisis intervention.
- Little progress, however, had been made in addressing restraints used for medical/dental procedures and protective mechanical restraints.

Abuse, Neglect, and Incident Management

- There were six confirmed cases of physical abuse, two confirmed cases of verbal/emotional abuse, and 16 confirmed cases of neglect between 4/1/13 and 8/29/13. These were the result of 95 DFPS investigations of 180 allegations (81 allegations of physical abuse, 22 allegations of verbal/emotional abuse, two allegations of sexual abuse, 73 allegations of neglect, and two allegation of exploitation). The facility reported that 33 other serious incidents were investigated by the facility during this same time period.
- There were 1080 injuries between 4/1/13 and 8/31/13. These injuries included 14 serious injuries resulting in fractures or sutures. Injury trends were being generated per individual and made available to IDTs for access on the shared drive.
- The facility was found in substantial compliance with 16 out of 22 provisions, compared to 18 during the last review.

Quality Assurance

- The QA program at SASSLC made good continued progress. The QA department embarked on a new activity to create a list of key indicators for each of the 20 sections. This was a very good activity, but as a result, the QA department was now managing three disparate lists: the data list inventory, the list of key indicators, and the QA matrix.
- The QA director should describe, for each section, possibly in the notes from the QAD-SAC 1:1 meetings, how data were being collected and presented to identify trends across the variables described in the wording of E1.
- There were frequent references to root cause analyses, intense case analyses, continuous quality improvement, etc. The QA department and the section leaders will need training, guidance, and mentoring in order to implement root cause analyses that meet the generally accepted professional standard.
- Data from 17 of the 20 (85%) sections of the Settlement Agreement were summarized and graphed showing trends over time, but only a few (3 of 20 [15%]) analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals.
- A facility QA report was created for six of the last six months. Since the last onsite review, the QAQI Council met at least once each month.
- The facility needs to ensure that CAPs outcomes look at whether the problem for which the CAP was created had improved.

Integrated Protections, Services, Treatment, and Support

- There was progress evident with the ISP process. At two ISP meetings, one pre-ISP meeting, and one ISPA meeting observed by the monitoring team, it was noted that significant progress had been made towards integrating the risk identification process into the ISP process and engaging in adequate discussions regarding community living options.
- IDTs were holding a much more integrated discussion with input from all team members.
- It was not evident, however, that meetings were resulting in the development of a comprehensive ISP that incorporated all recommendations and needed supports.
- All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and are available to all team members for review.
- IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection.
- All team members need to ensure that supports are monitored for consistent implementation and adequacy.

Integrated Clinical Services

- Throughout the conduct of the review, the monitoring team found some evidence of integration of clinical services. There were no new major initiatives specifically related to the integration of clinical services. However, some meetings were expanded or included more discussions that had the potential to improve integration of clinical services.
- The medical director reported on integration activities, but the discussion was limited to the meetings of the disciplines. The monitoring team has stressed that meetings do not guarantee that services are delivered in an integrated manner and the monitoring team expects to learn of the outcomes of the meetings
- Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted.

Minimum Common Elements of Clinical Care

- There was minimal progress observed in this provision. The facility implemented a local policy. The policy, which was unsigned, provided no date of adoption or implementation.
- The facility continued to track assessments centrally. Each department also tracked assessments. There was no information available on the quality of assessment and tools had not been developed. Interval assessments were not addressed.
- The facility continued its Medical Quality Improvement Committee and much of section H was linked to data derived from that committee. The quality program, however, was rudimentary and required a great deal of revision.

At-Risk Individuals

- There was some progress. The facility was taking a more integrated approach to looking at risk. This was particularly evident at the two ISP meetings observed and at the morning clinical review meetings.
- Some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions.
- Teams were not using the IHCP to track the completion of assessments and document resulting recommendations. 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.
- IHCPs were not found in individual notebooks, so staff working directly with individuals did not have access to action plans developed through the ISP process.

Psychiatric Care and Services

- SASSLC was found to be in substantial compliance with three provisions. Since the last monitoring visit, there had been challenges due to a turnover in psychiatric clinic staff.
- 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 monitoring team observed two psychiatric clinics. There was participation in the discussion and collaboration between the disciplines. There were improvements with timeliness of quarterly psychiatric medication reviews.
- The monitoring team identified paucity of combined assessment and case formulation as evidenced by the fact that only 35% of comprehensive psychiatric evaluations per Appendix B had been completed.
- 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.

Psychological Care and Services

- The facility, however, maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance. Improvements since the last review included the development of a schedule for collecting data collection reliability, interobserver agreement (IOA) and treatment integrity data based on the severity and frequency of the target behavior, and the establishment of minimum levels of data collection reliability, IOA, and treatment integrity. There was evidence that the individual books containing target and replacement data sheets were more accessible to direct support professionals. There was more consistent use of simplified graphs of target behaviors, and that when an individual was not making expected progress, the progress note consistently indicated that some activity to address the lack of progress had occurred. There were improvements in the quality of the functional assessments, and in the comprehensiveness of psychological services other than PBSPs treatment plans.

- More work was needed to ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors, and that replacement behavior are collected and graphed. The facility needs to ensure that the collection of data collection reliability, IOA, and treatment integrity measures are consistent across all staff. Data need to be consistently available and graphed at interdisciplinary meetings to ensure that data based decisions are made. All PBSPs need to contain replacement behaviors that are functional, or an explanation why functional replacement behaviors are not possible or impractical.

Medical Care

- There was little progress seen within the medical department. The monitoring team was somewhat disconcerted with the level of disorganization within the department and to learn that the status of many projects remained no different than they were six months ago. The databases were still reported works in progress and the department was unable to fulfill many of the document requests for this review. Items submitted in the past were no longer available or were in formats that were not usable.
- Individuals received basic care consisting of preventive care, vision, and hearing screenings. Compliance with some cancer screenings was quite low based on data submitted and records reviewed. As noted in the previous review, the facility suspended PSA screenings based on the USPTF guidelines even though almost all major organizations have supported factoring the preference of the patient into the decision making process.
- It was difficult to determine if some services were provided as needed because the facility was unable to adequately track clinic appointments. This was a significant deficit because it undercut the basic obligation to provide health care services in a prompt and timely manner.
- The monitoring team encountered difficulty determining the provision of neurological care because documentation regarding clinics was inadequate. Overall, it appeared that the number of neurology appointments was small and services were not adequate to meet the needs of the individuals. There were several examples of individuals who were seen in clinic and did not return for the recommended follow-up.
- External and internal audits were completed. While the monitoring team received hundred of pages of data, there was no concise summary of findings. It appeared that the data were not generated and utilized, thereby calling into question the utility of the medical audits.
- There were attempts to enhance the mortality review system by adding additional levels of review. Immediate reviews were completed following deaths and an external physician began conducting death reviews as well. However, none of the mortality reviews identified any issues related to medical care. The facility should seize every opportunity to make improvements, related to the health, safety, and well being of the individuals.
- Although some progress was also seen in the development an implementation of policies and procedures, this was another example where the complete lack of organization or failure to note requirements of the provision impacted

progress. The facility could provide no documentation that the appropriate training was provided relative to the new policies and procedures that were developed.

Nursing Care

- The nursing department had turnover in three nursing leadership positions: Chief Nurse Executive, Nursing Operations Officer, and the RN Case Manager Supervisor.
- There were improvements in the submission of timely nursing assessments, however, assessments did not sufficiently summarize the individuals' health status regarding whether their conditions were improving or regressing. Health care plans were not representative of the individuals' current health status.
- The facility made little improvement in the development of individualized IHCPs derived from the nursing assessments.
- The Nurse Educator had made significant progress in organizing the nurse education program to include the development of a tracking log for documenting compliance of nursing education.
- SASSLC was not following its own Medication Variance Policy in documenting, monitoring, and providing corrective actions sufficiently for its medication variances. The monitoring team was also concerned with the discrepancy between the number of un-reconciled medications and medication variances.

Pharmacy Services and Safe Medication Practices

- San Antonio State Supported Living Center faced unique challenges because medications were dispensed at the San Antonio State Hospital (SASH) and not the facility.
- Physician orders at the facility presented major challenges to such a degree that a decision was made to implement changes that allowed some orders to be clarified without contacting the prescribers. Intelligent Alerts were implemented in December 2012, but the prescribers frequently opted to not follow the monitoring guidelines.
- Quarterly drug regimen reviews were completed and for the most part were done well. The monitoring team noticed a new trend of stacking information or failing to remove outdated information, which affected the accuracy of the evaluations.
- The facility continued to have considerable problems with the completion of the MOSES and DISCUS evaluations for the use of non-psychotropic medications and neither could facility staff.
- There was no evidence that the medical staff had appropriately reviewed the ADRs. There was no consistent IPN documentation and the ADR forms were not signed.
- The medication variance system was ineffective and hampered by disorganization, poor record keeping, and staff that required additional training in several areas.

Physical and Nutritional Management

- A tremendous amount of work had been done in this area. There was a fully constituted PNMT. During the meetings observed, the team demonstrated excellent discussion and problem solving. Their assessments and other documentation, however, did not clearly and concisely reflect that.
- It is critical that the IDTs initiate timely referral for individuals who meet the established criteria.
- The Mealtime Coordinators were now in place and appeared to understand their role. Homes 673 and 674 generally were improved based on observations made by the monitoring team, but need to continue to be diligent related to food textures and proper positioning.
- There continued to be errors in diet texture not caught by the kitchen staff in the home, the tray line staff and staff at the table. The monitoring team had to intervene several times for individuals who were not served the correct diet texture.
- Hygiene was also an issue that needs to be evaluated (particularly in home 668). The methods used to clean the tables, placemats, mealtime cards, and table cloths between individuals were sloppy posing great risk for cross contamination.
- Positioning continued to improve, but not sufficiently in the day programs and active treatment areas in the homes.

Physical and Occupational Therapy

- A tremendous amount of work had been done in this area. The therapists demonstrated continued efforts to implement a more effective evaluation process to identify properties needed for support and function.
- There was significant improvement in the quality of OT/PT assessments for this review period.
- There was a clearly established audit system in place that should address the deficits noted. The primary concern, however, was the timeliness of assessments, which was calculated at 63% for the sample reviewed.
- Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs, though this may have been a function of the timeliness issues. Attendance by Habilitation Therapy staff was inconsistent and the pre-ISP designations did not appear to be based on a sound rationale related to services provided and individual need.
- The frequency and documentation of effectiveness monitoring by the clinicians should be reviewed, with remedies identified for resolution.

Dental Services

- Overall, there was progress noted in the provision of dental services. Individuals were completing annual assessments in a timely manner and being assessed for use of sedation and TIVA when needed to complete more extensive work, such as restorations and extractions.
- Oral hygiene continued to present challenges for the facility. Individuals were seen in clinic for prophylactic treatments and returned a few months later with a heavy build up of tartar, calculus, and mouth debris. There was no evidence that there was a facility level plan to address the problem.
- Several individuals continued to have delays in care related to the consent process. The delays now were mostly due to the need to have HRC approval for the use of sedation. There were several examples of unacceptable delays in care.

Communication

- There was continued, steady progress. There were a large number of communication plans and SAPs in place for individuals with communication needs and for those with behavioral concerns in combination with severe communication deficits.
- The therapists were encouraged to identify when the typical prompt hierarchy approach would not be the most effective way to promote communication skill acquisition. Clinicians should consider the measurable objectives and the data collected, and then collaborate with the day programs to develop these in a creative way.
- Assessments were not consistently completed 10 days prior to the ISP, but were consistently completed prior to the meeting. The content aspect of assessments was substantially improved with compliance with the 23 essential elements averaging approximately 97%.

Habilitation, Training, Education, and Skill Acquisition Programs

- The facility, however, maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance. Improvements since the last review included the development of a schedule for collecting data collection reliability, interobserver agreement (IOA) and treatment integrity data based on the severity and frequency of the target behavior, and the establishment of minimum levels of data collection reliability, IOA, and treatment integrity. There was evidence that the individual books containing target and replacement data sheets were more accessible to direct support professionals. There was more consistent use of simplified graphs of target behaviors, and that when an individual was not making expected progress, the note consistently indicated that some activity to address the lack of progress had occurred. There were improvements in the quality of the functional assessments.
- More work was needed to ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors, and that replacement behavior are collected and graphed. The facility needs to ensure that the collection of data collection reliability, IOA, and treatment integrity measures are consistent across all staff. Data need to be consistently available and graphed at interdisciplinary

meetings to ensure that data based decisions are made. All PBSPs need to contain replacement behaviors that are functional, or an explanation why functional replacement behaviors are not possible or impractical.

Most Integrated Setting Practices

- SASSLC made progress in some areas of section T, primarily in the continued transition and placement of individuals into the community. Staffing changes competed with the facility's ability to progress in many areas of section T.
- 11 individuals had been placed in the community since the last onsite review. 27 individuals were on the active referral list. This was by far the largest number of individuals ever to be on the active referral list at SASSLC.
- Of the 22 individuals who moved in the past 12 months, 6 were reported to have had one or more untoward events that occurred within the past six months (28%). Of these 6, all 6 (100%) were successfully resolved or managed.
- IDTs were not specifically identifying what it was that was an obstacle to referral. If they did, perhaps an appropriate action plan would be developed. Consider that many stated that individual choice was an obstacle, even though the obstacle was LAR preference.
- There was a thorough living options discussion during the ISPs observed, but an adequate description of a thorough discussion was not evident in the written ISPs.
- More information and detail regarding the training of provider staff, and preparation of the provider were necessary (T1c1). Discharge assessments were completed for all relevant disciplines, however, they did not focus upon the needs of the individual in his or her new setting and how supports might be provided in the new home and day settings.
- The lists of pre-move and post-move supports were identified in the CLDPs. More work was needed to ensure that these lists were comprehensive and worded in measurable, verifiable terms (T1e).
- A quality assurance program for CLDPs and section T was not yet in place, however, the APC had made some good progress in assembling a set of relevant data regarding referral, transition, and placement activities.
- Post move monitoring continued to be implemented as required and maintained substantial compliance. 36 post move monitorings for 16 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed up when action was needed.

Guardianship and Consent

- Progress was made towards compliance, including improved policies regarding consent for treatment and rights and restrictive practices. Section U corrective action plans were implemented July 2013. One IDT from each of the three residential units had received training on the need for guardianship discussion.
- SASSLC, however, had not developed a priority list of individuals needing an LAR based on an adequate assessment process.
- 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.

Recordkeeping Practices

- The recordkeeping department at SASSLC maintained the status of where it was at the last review. Eighteen of 18 (100%) individuals' records reviewed included an active record, individual notebook, and master record.
- The simple tasks of properly and legibly signing and dating entries continued to be a problem. Missing documents continued to be a problem. Approximately 10 of these types of errors per active record.
- The content of the individual notebooks was appropriate and complete, however, some were missing PBSPs and, in many cases, data were not recorded in a timely manner.
- In the master records, a project to obtain missing Medicare cards resulted in obtaining missing cards for approximately 100 individuals through September 2013.
- The URC completed five quality assurance review audits in each of the previous six months.
- For V4, no work was done; the facility was in substantial compliance with none of the six items (0%).

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
o Training Curriculum: Restraint Monitor
o SASSLC Self-Assessment
o SASSLC Provision Action Information Log
o SASSLC Section C Presentation Book
o Restraint Trend Analysis Reports for the past two quarters
o Section C QA Reports for the past two quarters
o Sample of IMRT Minutes from the past six months
o Restraint Reduction Committee minutes for the past six months
o List of all restraint monitors and date training was completed
o List of all restraint by Individual in the past six months
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 individual that were restrained off the grounds of the facility (0)
o List of all injuries that occurred during restraint
o SASSLC “Do Not Restrain” justification
o List of individuals with crisis intervention plans
o List of individuals with desensitization plans (0)
o Sample #C.1: 10 records of physical or chemical restraint used in a crisis intervention for six different individuals, drawn from the list provided in response to II.6 of the Document Request. Records drawn for this sample included: restraint checklist form, face-to-face/debriefing form, the individual’s Crisis Intervention Plan (CIP), if applicable, the documentation of any and all reviews of this use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. The restraint incidents in the sample were:
<table>
<tr><td>#304</td><td>Physical</td><td>6/25/13</td></tr>
<tr><td>#304</td><td>Physical</td><td>8/30/13 @ 9:30 am</td></tr>
<tr><td>#304</td><td>Physical</td><td>8/30/13 @ 9:36 am</td></tr>
<tr><td>#304</td><td>Chemical</td><td>8/30/13 @ 9:59 am</td></tr>
<tr><td>#304</td><td>Physical</td><td>9/12/13</td></tr>
<tr><td>#16</td><td>Physical</td><td>8/15/13</td></tr>
<tr><td>#148</td><td>Physical</td><td>5/23/13</td></tr>
</table>
</td></tr>
</table>

#8	Physical	6/11/13
#9	Chemical	8/25/13
#225	Chemical	9/6/13

- Sample #C.2: The following documentation was requested for a selected sample of 23 staff:
  - Their start dates
  - The dates they were assigned to work with individuals
  - Their training transcripts showing date of most recent:
    - PMAB training;
    - Training on use of restraints; and
    - Training on abuse/neglect/exploitation; and
  - The signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect.

- Sample #C.3 chosen from the list provided in response to document request II.5.b of 50 restraint reports involving medical/dental restraint for 43 individuals, between 4/1/13 and 9/31/13. The sample of 16% of the 50 restraint episodes or 8 records was drawn, involving eight individuals. Records for this sample included: the restraint checklist. For the following:

Individual	Date
#166	8/15/13
#13	8/15/13
#156	8/13/13
#239	8/13/13
#158	8/12/13
#95	8/5/13
#57	8/13/13
#121	8/26/13

- A sample of the last 10 medical/dental restraints was requested by the monitoring team to include: the physicians' orders for the restraint including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred, any reviews of this use of restraint, and any applicable desensitization plan.
  Documentation for two instances of pretreatment sedation submitted by the facility were not used as part of the sample. It was determined that sedation in these two instances were used for more invasive procedures not considered routine medical appointments.
- Sample #C.4 (a subsample of #C.1) chosen from II.5a in response to the document request. The total number of chemical restraints for crisis intervention was six, involving three individuals. Sample size was three, involving three individuals, or 50% of the chemical restraints and 100% of the individuals. Records requested included: the restraint checklist, Face-to-face/debriefing form, any reviews of the use of this restraint, and evidence of contact between the psychologist and physician prior to the use of the restraint. For the following:

Individual	Date
#304	8/30/13
#95	8/25/13
#225	9/6/13

- Sample #C.5: There was no restraints off-campus. No sample was drawn.

- Sample #C.6: The following documentation for a selected sample of individuals who were restrained more than three times in a rolling 30-day period:
- Positive Behavior Support Plans (PBSPs) for:
  - Individual #304
- Crisis Intervention Plans for:
  - Individual #304
- ISPA meeting minutes for:
  - Individual #304

- Sample #C.7 was chosen from the list of individuals for whom protective mechanical restraints for SIB were used. This included review of Protective Mechanical Restraint Plans, Individual Support Plan (ISP), ISP Addendums, and ISP Action Plan.

Individual	Restraint type
#314	Abdominal binder and bodysuit
#349	mittens

<u>Interviews and Meetings Held</u>:
- Informal interviews with various direct support professionals, program supervisors, and QIDPs in homes and day programs
- Charlotte Fisher, Director of Behavioral Services
- Megan Lynch, Incident Management Coordinator
- Gevona Hicks, Human Rights Officer

<u>Observations Conducted</u>:
- Observations at residences and day programs
- Incident Management Review Team Meeting 10/21/13
- Morning Unit Meeting 10/22/13
- QA/QI Meeting 10/22/13
- Morning Clinical Review Team Meeting 10/21/13
- Annual IDT Meeting for Individual #241 and Individual #55
- Rights Assessment Meeting for Individual #111
- Pre-ISP Meeting for Individual #282

	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 4/1/13 through 9/31/13 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. The facility self-assessment commented on the overall compliance rating for each provision item based on assessment findings. The facility assigned a self-rating of substantial compliance to C2, C3, C5, C6, C7, and C8. The facility found that restraint documentation did not adequately demonstrate that restraints were not used in the absence of adequate treatment and/or programming (C1). Additionally, the self-assessment found that ISPs reviewed did not include adequate discussion regarding the need for desensitization strategies to minimize the use of medical/dental restraints (C4). The monitoring team found substantial compliance with C2 and with C8 regarding adequate review of restraint incidents. Based on the samples reviewed, the monitoring team could not confirm compliance with C3, C5, and C6.
	Summary of Monitor's Assessment: Based on a list of all restraints provided by the facility (document II.5), there were 25 restraints used for crisis intervention involving eight individuals between 4/1/13 and 9/31/13. The number of restraint incidents had decreased since the last onsite review when it was reported that there had been 27 restraints during the review period. Individual #304 accounted for 15 of the 25 (60%) restraints used for crisis intervention. A log of all dental/medical restraints provided by the facility included 50 instances of dental/medical restraint from 4/1/13 through 9/31/13 involving 43 individuals. This was a significant reduction from the 103 restraints reported during 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. The facility continued to make progress in the documentation and monitoring of restraints used for crisis intervention. Little progress, however, had been made in addressing restraints used for medical/dental procedures and protective mechanical restraints.

<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>According to a list of all restraints implemented at the facility (Document II.5),

<table>
<tr><th>Type of Restraint</th><th>October 2012-April 2013</th><th>April 2013-Sept 2013</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>23</td><td>19</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>6</td><td>6</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>29</td><td>25</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>10</td><td>8</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>4</td><td>6</td></tr>
<tr><td>Medical/dental restraints</td><td>103</td><td>50</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>80</td><td>43</td></tr>
<tr><td>Protective mechanical restraints</td><td>8</td><td>8</td></tr>
</table>

<u>Prone Restraint</u>
a. Based on facility policy review, prone restraint was prohibited.

b. Based on review of other documentation (list of all restraints between 4/1/13 and 9/31/13) prone restraint was not identified.

A sample, referred to as Sample #C.1, was selected for review of restraints resulting from behavioral crises between 4/1/13 and 9/31/13. Sample #C.1 was a sample of 10 restraints for six individuals, representing 35% of restraint records over the last six-month period and 86% of the individuals involved in restraints. The sample included seven physical restraints and three chemical restraints. Sample #C.1 included the three individuals with the greatest number of restraints, as well as three individuals who were subject to some of the most recent application of restraints.

c. Based on a review of the restraint records for individuals in Sample #C.1 involving five individuals, zero (0%) showed use of prone restraint.

d. Based on questions with five direct support professionals, five (100%) were aware of the prohibition on prone restraint.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Other Restraint Requirements e. Based on document review, the facility and state 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; and for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: f. In 10 of the 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. g. For the 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 10 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. h. 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. i. Facility policies identified a list of approved restraints. j. Based on the review of 10 restraints, involving six individuals, 10 (100%) were approved restraints. k. In 10 of 10 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. l. The facility reported that there were nine individuals subjected to restraints classified as PMR-SIB. Two restraints were reviewed that were considered to be protective mechanical restraints for SIB by the facility, (Sample C.7). Of these, zero (0%) followed state policy regarding the use, management, and review of PMR. The facility had developed a protective mechanical restraint plan (PMRP), as required by state policy #001.1 regarding the Use of Restraints. The plan included a description of the individual's self-injurious behaviors, the type of restraint to be used, the restraint's maximum duration, and when to apply and remove the restraint. Staff were documenting routine release from restraint and monitoring of the restraint. The IDT, including the PCP, for both Individual #349 and Individual #314 met and determined that a one-to-one Level of Supervision was not necessary for these individuals.	

#	Provision	Assessment of Status	Compliance
		One restraint was reviewed that was considered to be protective mechanical restraint to prevent involuntary dangerous behavior/injury (Individual #249). The state did not yet have a policy to establish guidelines for the use of protective mechanical restraints used to prevent involuntary dangerous behavior/injury. A list of individuals at the facility who were wearing protective mechanical restraints to prevent injury (e.g., helmets for falls) was not available. The facility was not consistently documenting and monitoring these restraints. IDTs were not addressing alternate strategies to reduce the use of protective equipment. The facility needs to focus on protective mechanical restraints, including the development of strategies to reduce the amount of time in restraint, eliminate restraint when possible, and/or consider the use of the least restrictive restraint necessary. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation. The facility made progress towards compliance with C1 regarding the documentation of restraints used for crisis intervention. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The facility will need to adhere to the state policy's requirements for one-to-one supervision while in restraint for those individuals subject to protective mechanical restraints for SIB. 2. Ensure that all IDTs are holding adequate discussion regarding the use of protective mechanical restraints. Plans will need to be developed to address level of supervision while in restraint, schedule of restraint use and release, application and maintenance of the restraint, and documentation.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The seven physical restraint records involving the four individuals in Sample #C.1 were reviewed. Two individuals in the sample had a Crisis Intervention Plan that defined the use of restraint. a. For the individuals involved in physical restraint who had a Crisis Intervention Plan (Individual #304 and Individual #83), five of five (100%) restraint checklists included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. b. For two individuals who did not have Crisis Intervention Plans, two of two (100%) included sufficient documentation to show that the individual was released according to facility policy or as soon as the individual was no longer a danger to him/herself. Based on this review, the facility maintained substantial compliance with C2.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. a. Review of the facility's training curricula revealed that it did include adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. Sample #C.2 was randomly selected from a current list of staff. b. A sample of 23 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 21 of the 23 (91%) had current training in RES0105 Restraint Prevention and Rules. • There was evidence that 11 of the 17 (65%) employees with current training who had been employed over one year had completed the RES0105 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 23 of the 23 (100%) had completed PMAB training within the past 12 months. • There was evidence that 19 of the 19 (100%) employees hired over a year ago completed PMAB refresher training within 12 months of previous restraint training unless documentation indicated that the employee was on leave. c. Based on responses to questions, five direct support professionals answered the following questions correctly: • Describe two verbal or redirection techniques (100%); • Describe two approved restraint techniques. (100%); and • How would you supervise an individual in restraint? (100%). d. In 10 of the 10 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. Based on this review, the facility was not in substantial compliance with the requirement for annual restraint training.	Noncompliance

#	Provision	Assessment of Status	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	a. Based on a review of 10 restraint records (Sample #C.1), in 10 (100%) there was evidence that documented that restraint was used as a crisis intervention. b. All individuals in the sample had a Positive Behavior Support Plan in place. In review of Positive Behavior Support Plans for six individuals in the sample, 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) (100%). c. In addition, facility policy did not allow for the use of <u>non-medical</u> restraint for reasons other than crisis intervention. d. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list maintained by the facility. e. Restraints from Sample #C.3 were reviewed. In 10 of 10 restraint records reviewed (100%), there was evidence that the restraint used was not in contradiction to the individual's medical orders according to the "Do Not Restrain" list. f. In six of eight restraint records reviewed in Sample #C.1 (75%), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan. Individual #239's ISP indicated that he did not require the use of pretreatment sedation for routine exams. He received pretreatment sedation on 8/13/13 for his dental exam and cleaning. Individual #121's ISP indicated that he did not require the use of pretreatment sedation for routine appointments. He received pretreatment sedation for a routine appointment on 8/26/13. In reviewing documentation (Sample #C.3) for eight individuals for whom restraint had been used for the completion of medical or dental work: • g. Five (63%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC)) approval and adequate consent; o There was no evidence that HRC approval had been requested for Individual #239, Individual #121, or Individual #158 • h. 0 (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. The facility indicated that there were no formal desensitization plans or other individualized strategies in place for individuals who required the use of medical/dental restraints. The annual IDT meeting for Individual #55 was observed by the monitoring team. TIVA was recommended for routine dental work due to his history of refusing treatment.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The psychologist recommended some desensitization strategies to minimize his refusals. The team stopped short of formalizing strategies to be included in his ISP. • i. 0 (0%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. Based on this review, the facility was not substantial compliance with C4. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • Desensitization or other individualized strategies will need to be considered for all individuals who require the use of pretreatment sedation for routine medical and dental appointments. The ISP should document discussion regarding the consideration of supports that may minimize the need for restraint during routine medical and/or dental appointments.	
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	a. Review of facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint. b. This training was competency-based. Seventy-five staff had been deemed competent to monitor restraints. c. Based on review of document request II.19, for staff that performed the duties of a restraint monitor, nine (90%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint on 9/10/13. One restraint monitor was on leave when training occurred. This included the campus supervisors, campus administrators, home supervisors, and psychologists. Based on a review of 10 restraint records (Sample #C.1), a face-to-face assessment was conducted: • d. In zero out of 10 incidents of restraint (0%) by an adequately trained staff member. New training for restraint monitors was provided September 3013. • e. In nine out of 10 instances (90%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. o Restraint documentation for Individual #255 dated 9/6/13 indicated that the restraint monitor arrived three hours after the restraint was initiated. • f. In 10 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • g. In 10 instances (100%), the documentation showed that an assessment was completed of the consequences of the restraint.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	A sample of ___ records for which physicians had ordered alternative monitoring schedules was reviewed. (The facility reported that an alternative monitoring schedule had not been ordered for any of the restraints in the sample.) • h. In ___ out of ___ (___%), the extraordinary circumstances necessitating the alternative monitoring were documented; and • i. In ___ out of ___ (___%), the alternative monitoring schedules were followed. Based on a review of 10 restraint records for restraints that occurred at the facility (Sample #C.1), there was documentation that a licensed health care professional: • j. Conducted monitoring at least every 30 minutes from the initiation of the restraint in nine (90%) of the instance of restraint. The nurse attempted to assess Individual #304 while restrained on 6/25/13. The individual refused monitoring of vital signs. No further attempt to assess her was documented following the restraint incident. • k. Monitored and documented vital signs in nine (90%). • l. Monitored and documented mental status in 10 (100%). Based on documentation provided by the facility, no restraints had occurred off the grounds of the facility in the last six months. • m. Conducted monitoring within 30 minutes of the individual's return to the facility in __ out of ___ (__%). Records that did not contain documentation of this included: (not applicable) • n. Monitored and documented vital signs in ___ (___%). Records that did not contain documentation of this included: (not applicable) • o. Monitored and documented mental status in ___ (___%). Records that did not contain documentation of this include: (not applicable) Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. For these individuals, p. In eight out of eight (100%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • q. In zero out of zero (N/A), the physician specified the type of monitoring required if it was different than the facility policy. o r. In zero out of eight of the medical restraints (0%), appropriate monitoring was completed either as required by the Settlement Agreement, facility policy, or as the physician prescribed. None of the restraint checklists in the sample indicated that vital signs were taken with the frequency and/or duration required by state policy. These were:	

#	Provision	Assessment of Status	Compliance
		▪ A restraint checklist was not completed for Individual #121 on 8/26/13. ▪ Monitoring by a nurse was not documented prior to the appointment for Individual #166 on 8/15/13, Individual #13 on 8/15/13, Individual #156 on 8/13/13, Individual #158 on 8/12/13, Individual #95 on 8/5/13, and Individual #57 on 8/13/13. ▪ The appointment time was not documented for Individual #239 on 8/13/13, thus it was not possible to verify adequate monitoring prior to his appointment. Based on this review, the facility was not in substantial compliance with this provision. To gain substantial compliance with the requirements of C5, the facility will need ensure that: • Post restraint assessments by nursing staff commence within 30 minutes of the initiation of the restraint and are adequately documented with the frequency recommended by the physician or 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 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	A sample (Sample #C.1) of 10 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: • a. In 10 (100%), continuous one-to-one supervision was provided; • b. In 10 (100%), the date and time restraint was begun; • c. In 10 (100%), the location of the restraint; • d. In nine (90%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. o The restraint checklist did not document behaviors leading to restraint for Individual #148 on 5/23/13. • e. In 10 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8. • f. In 10 (100%), the specific reasons for the use of the restraint • g. In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • h. In seven (70%), the names of staff involved in the restraint episode; o The exceptions were the restraint checklists for Individual #304 dated 8/30/13. • Observations of the individual and actions taken by staff while the individual was in restraint, including: o i. In eight (80%), the observations documented every 15 minutes and at release (at release for physical or mechanical restraints of any duration).	Noncompliance

#	Provision	Assessment of Status	Compliance
	documented consistent with Appendix A.	The longest restraint in the sample was 10 minutes. ▪ Exceptions were the restraint checklists for two physical restraints for Individual #304 dated 8/30/13. DADS reported that documentation was completed to indicate required observations by staff while in restraint in the original restraint documentation. o j. In ___ (____%) of those restraints that lasted more than 15 minutes, the specific behaviors of the individual that required continuing restraint; (there were none) o k. In ___ (____%), the care provided by staff during restraint lasting more than 30 minutes, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. (there were none) • l. In 10 (100%), the level of supervision provided during the restraint episode; • m. In seven physical restraints (100%), the date and time the individual was released from restraint; and • n. In 10 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. o. In a sample of 10 records (Sample #C.1), restraint debriefing forms had been completed for 10 (100%). p. A sample of four individuals subject to medical restraint was reviewed (Sample #C.3), and in 0 (0%), there was evidence that the monitoring had been completed as required by the physician's order or state policy. See comments in C5 regarding restraints that were not monitored in accordance to state policies. Sample #C.4 was a subsample of the three chemical restraints included in Sample #C.1. q. In three (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist or psychiatrist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Based on this review, the facility was not in substantial compliance with the requirements of C6 regarding documentation of post restraint monitoring for pretreatment sedation restraints.	

#	Provision	Assessment of Status	Compliance
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;	This item continues to be in substantial compliance. 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 is the same as the last review when one individual was placed in restraint more than three times in a rolling 30-day period. This individual (i.e., Individual #304) was reviewed by the monitoring team to determine if the requirements of the Settlement Agreement were met. Her 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 #304's adaptive skills and biological, medical, and psychosocial factors. Additionally, the ISPA indicated that no adaptive skill deficits, or medical, biological, or psychosocial factors appeared to consistently be factors related to the target behaviors provoking restraint.	Substantial Compliance
	(b) review possibly contributing environmental conditions;	This item continues to be in substantial compliance. 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 clear environmental conditions affected Individual #304's dangerous behaviors that provoked restraints.	Substantial Compliance
	(c) review or perform structural assessments of the behavior provoking restraints;	This item continues to be in substantial compliance. 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 #304's behaviors that provoked restraint. Individual #304's treatment team concluded there were no consistent antecedents to her dangerous target behaviors.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(d) review or perform functional assessments of the behavior provoking restraints;	This item continues to be in substantial compliance. 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 variables that may be maintaining the behaviors provoking restraints. Individual #304's ISPA reflected a discussion that concluded that her target behaviors that provoked restraint were not consistently affected by environmental consequences.	Substantial 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;	This item continues to be in substantial compliance. 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 is the same as the last review when one individual was placed in restraint more than three times in a rolling 30-day period. This individual (i.e., Individual #304) was reviewed by the monitoring team to determine if the requirements of the Settlement Agreement were met. Her 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 #304's adaptive skills and biological, medical, and psychosocial factors. Additionally, the ISPA indicated that no adaptive skill deficits, or medical, biological, or psychosocial factors appeared to consistently be factors related to the target behaviors provoking restraint.	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 continues to be in substantial compliance. 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 #304's behaviors that provoked restraint. Individual #304's treatment team concluded there were no consistent antecedents to her dangerous target behaviors.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(g) as necessary, assess and revise the PBSP.	This item continues to be in substantial compliance. 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 #304's behaviors that provoked restraint. Individual #304's treatment team concluded there were no consistent antecedents to her dangerous target behaviors.	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 take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	A sample of documentation related to 10 incidents of non-medical restraint was reviewed (Sample #C.1), this documentation showed that: • a. In 10 (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. • b. In 10 (100%), the review by the IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and/or Debriefing Form. • c. In 10 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • d. In 10 (100%), the review conducted by the restraint monitor and/or psychologist was sufficient to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. • e. The IMRT did not document recommendations from their review for any of the restraints in sample #C.1. The IMRT should document any recommendations made during review of the restraint incident. o The IDT met to review supports for Individual #304 following three restraints on 8/20/13. The team agreed to change her level of supervision. • f. Of the ___ referred to the team, in _____ (0%) appropriate changes were made to the individuals' ISPs and/or PBSPs. (none were referred) A review of ISPAs for the individuals in the sample indicated that IDTs routinely met following restraint episodes and implemented changes in supports when appropriate. Based on this review, the facility was in substantial compliance with review requirements. An adequate review process was in place, however, any recommendations made during the restraint review should be documented and tracked for follow-up.	Substantial Compliance

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 QAQI Data Summary May 2013 o Information used to educate individuals/LARs on identifying and reporting unusual incidents o Incident Management Review Committee meeting minutes for each Monday of the past six months o Training transcripts for 23 randomly selected employees o Acknowledgement to report abuse for 23 randomly selected employees o Acknowledgement to report abuse for all employees hired within the last 2 months (55) o Training and background checks for the last three employees hired o List of DFPS investigators assigned to complete investigations at SASSLC (9) o Training transcripts for all facility investigators (6) 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 Data summary regarding employees who were terminated or not hired based upon background checks o ISPs for: • Individual #198, Individual #225, Individual #35, Individual #188, Individual #340, Individual #151, Individual #164, Individual #75, Individual #47, and Individual #203. 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 incidents and injuries since 4/1/13 o List of all ANE allegations since 4/1/13 including case disposition o A list of all investigations completed by the facility in the last six months. 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 (2) o List of staff who have alleged retaliation for reporting A/N/E (0) 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
#42839556	Neglect	Confirmed	8/19/13 11:53 am	8/20/13 10:50 am	9/5/13
#42836634	Neglect (3)	Unconfirmed (2) Confirmed (1)	8/15/13 2:59 pm	8/16/13 3:20 pm	8/30/13
#42827304	Neglect	Unconfirmed	8/6/13 4:02 pm	8/8/13 1:38 pm	8/15/13
#42818546	Physical Abuse	Unconfirmed	7/29/13 10:01 am	7/29/13 5:20 pm	8/8/13
#42816311	Physical Abuse	Unconfirmed	7/25/13 10:18 pm	7/26/13 3:54 pm	8/2/13
#42810427	Physical Abuse	Inconclusive	7/19/13 6:43 pm	7/20/13 2:22 pm	7/29/13
#42808439	Physical Abuse	Confirmed	7/18/13 8:05 am	7/19/13 8:47 am	7/24/13
#42797247	Physical Abuse (2)	Inconclusive (2)	7/5/13 6:27 pm	7/5/13 7:36 pm	7/15/13
#42796270	Neglect Physical Abuse	Unconfirmed Inconclusive	7/4/13 11:58 am	7/6/13 6:00 pm	7/14/13
#42771982	Physical Abuse	Confirmed	6/9/13 12:09 am	6/11/13 5:30 pm	6/19/13
#42823945	Neglect	Referred Back	7/27/13 3:05 pm		8/2/13
#42823945	Neglect	Referred Back – Clinical Issue	8/2/13 3:53 pm		8/6/13
#42716386	Physical Abuse	Referred Back – Clinical Referral	4/17/13 4:14 pm		4/27/13
Sample D.2	**Type of Incident**	**Date/Time Incident Occurred**	**Date/Time Incident Reported**	**Date Completed**	
#13-078	Encounter with Law Enforcement	8/30/13 9:30 am	8/30/13 9:30 am	9/2/13	
#13-076	Unauthorized Departure	8/25/13 11:30 am	8/25/13 11:35 am	8/26/13	
#13-073	Death	8/9/13 3:19 pm	8/9/13 3:21 pm	8/10/13	
#13-071	Serious Injury	8/6/13	8/6/13	8/12/13	

		9:15 pm	9:45 pm		
#13-070	Serious Injury	8/5/13 9:10 am	8/5/13 9:45 am	8/8/13	
#13-068	Unauthorized Departure	8/1/13 5:21 pm	8/1/13 5:30 pm	8/2/13	
#13-065	Serious Injury - Peer to Peer Aggression	7/26/13 6:40 am	7/26/13 6:45 am	7/26/13	

Interviews and Meetings Held:

- Informal interviews with various direct support professionals, program supervisors, and QIDPs in homes and day programs
- Charlotte Fisher, Director of Behavioral Services
- Megan Lynch, Incident Management Coordinator
- Jessica Rodriguez, Facility Investigator
- Leticia Jaloma, Facility Investigator
- Gevona Hicks, Human Rights Officer
- Joan O'Connor, ADOP
- Rhonda Sloan, QIDP Coordinator

Observations Conducted:

- Observations at residences and day programs
- Incident Management Review Team Meeting 10/21/13
- Morning Unit Meeting 10/22/13
- QA/QI Meeting 10/22/13
- Morning Clinical Review Team Meeting 10/21/13
- Annual IDT Meeting for Individual #241 and Individual #55
- Rights Assessment Meeting for Individual #111
- Pre-ISP Meeting for Individual #282
  ISPA regarding falls for Individual #47

Facility Self-Assessment:

SASSLC submitted its self-assessment. Along with the self-assessment, the facility had two other documents that addressed progress towards meeting the 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. A sample of completed investigations was reviewed monthly using the statewide section D audit tool. Additionally, the facility looked at other documentation relevant to each provision. The facility's review of its own performance found compliance with 22 of 22 provisions of section D. The monitoring team found the facility to be in substantial compliance with 16 of the 22 provision items. The monitoring team was unable to confirm compliance with the requirements that: • The facility ensured that all employees completed training on identifying and reporting abuse, neglect, and exploitation annually (D2c) • Investigations provided clear evidence to support the investigator's conclusions (D3f) • Investigations be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent (D3g) • Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident (D3h) • The facility will implement action to prevent similar incidents from occurring promptly and thoroughly, and track and document such actions and the corresponding outcomes (D3i) • Sufficient corrective action was taken to address trends of incidents and injuries (D4). The facility should note findings by the monitoring team for each provision found not to be in substantial compliance and consider further review of those provisions using similar methods used by the monitoring team.
	Summary of Monitor's Assessment: According to a list provided by SASSLC, DFPS conducted 95 investigations involving 180 allegations at the facility between 4/1/13 and 8/29/13, including 81 allegations of physical abuse, 22 allegations of verbal/emotional abuse, two allegations of sexual abuse, 73 allegations of neglect, and two allegation of exploitation. Of the 180 allegations, there were six confirmed cases of physical abuse, two confirmed cases of verbal/emotional abuse, and 16 confirmed cases of neglect. The facility reported that 33 other serious incidents were investigated by the facility during this same time period. There were a total of 1080 injuries reported between 4/1/13 and 8/31/13. These 1080 injuries included 14 serious injuries resulting in fractures or sutures. This was a slight increase from the 1046 injuries reported the previous two quarters. Injury trends were being generated per individual and made available to IDTs for access on the shared drive. During this review, the monitoring team found the facility to be in substantial compliance with 16 out of 22 provisions of Section D, as opposed to the 18 provisions that were in substantial compliance during the last review. Provision items found not to be in compliance included: • D.2.c: Staff were completing annual retraining within required timeframes. • D.3.f: Facility investigations reviewed in sample #D.2 did not include sufficient evidence to support

	the investigator's conclusions. • D.3.g: The facility review did not identify problems with investigations identified in D.3.f. • D.3.h: Facility investigations did not meet the minimal requirements outlined in D.3.f. • D.3.i: The facility was not tracking outcomes to ensure that protections implemented following investigations were sufficient to reduce the likelihood of similar incidents from occurring. • D.4: The facility was still not adequately developing action plans to address trends on a systemic or individual level. The facility made general recommendations regarding issues that were identified in the quarterly incident trend reports. Recommendations did not include measurable outcomes and follow-up to recommendations was not documented. The incident management department had recently begun providing incident and injury trend information to residential units and individual IDTs. The process remained in the initial stages and adequate action plans and follow-up to action plans to track outcomes were not yet occurring. IDTs will need additional training on analyzing and addressing trend information.

#	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:		

#	Provision	Assessment of Status	Compliance
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	The policy further required that an investigation would be completed on each unusual incident using a standardized Unusual Incident Report (UIR) format. This was consistent with the requirements of the Settlement Agreement. According to a list of all abuse, neglect, and exploitation investigations provided in response to document request III.125, there were 95 investigations involving 180 allegations of abuse, neglect, or exploitation were conducted by DFPS at the facility between 4/1/13 and 8/29/13. From these 180 allegations, there were: • 81 allegations of physical abuse including, o 6 confirmed o 53 unconfirmed o 15 inconclusive o 1 referred back to the facility for further investigation o 1 pending outcome • 22 allegations of verbal/emotional abuse including, o 2 confirmed o 14 unconfirmed o 2 inconclusive o 4 referred back to the facility for further investigation • 2 allegations of sexual abuse including o 1 unconfirmed o 1 inconclusive • 73 allegations of neglect including, o 16 confirmed o 23 unconfirmed o 19 inconclusive o 15 referred back to the facility for further investigation • 2 allegations of exploitation o 2 referred back to the facility for further investigation. According to a list provided by the facility, there were 33 other investigations of serious incidents not involving abuse, neglect, or exploitation. This included: • 15 serious injuries/determined cause, • 3 serious injuries from peer-to-peer aggression, • 0 serious injury/undetermined cause • 0 sexual incidents,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• 1 choking incident, • 2 encounters with law enforcement, • 6 unauthorized departures, • 5 deaths, and • 1 other (unknown). From all investigations since 4/1/13 reported by the facility, 20 investigations were selected for review. The 20 comprised two 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 (13 cases). • Sample #D.2 included investigations the facility completed related to serious incidents not reportable to DFPS (seven cases). Metric 2.a.1: Based on the Monitoring Teams' review of DADS revised policies, including Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy #002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements. Metric 2.a.2: According to SASSLC Protection from Harm Policy, staff were required to report abuse, neglect, and exploitation immediately by calling the DFPS 800 number. This was consistent with the Settlement Agreement requirements. Metric 2.a.3: With regard to unusual/serious incidents, the facility's Incident Management Policy required staff to report unusual/serious incidents within one hour. The process for staff to report such incidents required staff to follow reporting requirements detailed on the Exhibit B – Unusual Incidents Reporting Matrix. This policy was consistent with the Settlement Agreement requirements. Metric 2.a.4: Based on responses to questions about reporting, seven of eight (88%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for abuse, neglect, and/or exploitation. One staff person reported that she would tell her supervisor. Metric 2.a.5: Based on responses to questions about reporting, eight of eight (100%) staff responsible for the provision of supports to individuals were able to describe the reporting procedures for other unusual/serious incidents.	

#	Provision	Assessment of Status	Compliance
		Based on a review of the 13 investigation reports included in Sample #D.1: • Metric 2.a.6: 12 (92%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to DFPS within one hour of the incident or discovery of the incident as required by DADS/Facility policy. o DFPS case #42836634 involved a confirmed incident of neglect that occurred on 8/13/13. It was reported to DFPS on 8/15/13. • Metric 2.a.7: Ten (77%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. o 13 of 13 (100%) indicated the facility director or designee was notified of the incident within one hour. o 13 of 38 (100%) indicated OIG or local law enforcement was notified within the timeframes required by the facility policy when appropriate. o 10 of 13 (77%) documented that the state office was notified as required. ▪ In DFPS cases #42827304, #42816311, and #42797247; the UIR did not contain documentation of state office notification. • Metric 2.a.8: For the allegations for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, 0 UIRs (0%) included recommendations for corrective actions. Based on a review of seven investigation reports included in Sample #D.2: • Metric 2.a.9: Seven (100%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. • Metric 2.a.10: seven (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. • Metric 2.a.11: For the unusual/serious incidents for which staff did not follow the IM Policy and Reporting Matrix reporting procedures, _____ UIRs/investigation folders (___%) included recommendations for corrective actions. (N/A – all were reported as required by state policy) Metric 2.a.12: The facility had a standardized reporting format. 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. Metric 2.a.13 Based on a review of 20 investigation reports included in Samples #D.1 and #D.2, 20 (100%) contained a copy of the report utilizing the required standardized format and were completed fully.	

#	Provision	Assessment of Status	Compliance
		New employees were required to sign an acknowledgement form regarding their obligations to report abuse and neglect. Fifty-five of 55 (100%) new employees hired between 8/1/13 and 10/1/13 signed this form when hired. All employees were required to sign an acknowledgement form annually. A random sample of 23 employees at the facility was chosen. Twenty-three of 23 employees (100%) in the sample signed this form annually as required by state policy. The facility was in substantial compliance with the requirements of D2a. The facility should ensure that state office notification is documented in the facility incident report.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The facility 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. The monitoring team was provided with a log of employees who had been reassigned between 4/1/13 and 8/27/13. The log included the applicable investigation case number, date of the incident, any disciplinary actions taken, and the date the employee was returned to work. Based on a review of 13 investigation reports included in Sample D.1, in 11 out of 11 cases (100%) where an alleged perpetrator (AP) was known, it was documented that the AP was placed in no contact status immediately. In 11 out of 11 cases (100%), where there was a known alleged perpetrator, 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 13 investigation files in Sample D.1, 13 (100%) UIRs documented additional protections implemented following the incident. This typically consisted of 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. All allegations were discussed in the daily IMRT meeting and protections were reviewed. Based on the facility's actions to remove staff from duty pending the investigation, and documenting additional actions to protect the alleged victims in all cases, the monitoring team found that the facility was in substantial compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The state policies required all staff to attend competency-based training on preventing and reporting abuse and neglect (ABU0100) and incident reporting procedures (UNU0100) during pre-service and every 12 months thereafter. This was consistent with the requirements of the Settlement Agreement. A random sample of training transcripts for 23 employees was reviewed for compliance with training requirements. This included four employees hired within the past year. • 23 (100%) of these staff had completed competency-based training on abuse and neglect (ABU0100) within the past 12 months. • 16 of the 19 (84%) employees with current training who had been employed over one year had completed the ABU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. • 23 (100%) employees had completed competency based training on unusual incidents (UNU0100) refresher training within the past 12 months. • 13 of the 19 (68%) employees with current training who had been employed over one year had completed the UNU0100 refresher training within 12 months of the previous training unless documentation indicated that the employee was on leave. Based on this review, the facility was not in substantial compliance with the requirement for annual training. The facility needs to ensure that employees complete required training annually.	Noncompliance
	(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	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 (100%) of 23 employees in the sample had a current signed acknowledgement form. Additionally, the facility provided the signed statement regarding the obligations for reporting any suspected abuse, neglect, or exploitation to DFPS for employees hired August 2013-September 2013. Of 55 new employees, 55 (100%) had signed the 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.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	neglect.	The facility reported that two cases where staff failed to report abuse or neglect as required. Action was pending the completion of the DFPS investigations.	
	(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 was reviewed for compliance with this provision. The sample ISPs were for Individual #198, Individual #225, Individual #35, Individual #188, Individual #340, Individual #151, Individual #164, Individual #75, Individual #47, and Individual #203. • Ten (100%) documented that this information was shared with individuals and/or their LARs at the annual IDT meetings. 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.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	A review was completed of the posting the facility used. It included a brief and easily understood statement of: • Individuals' rights, • Information about how to exercise such rights, and • Information about how to report violations of such rights. Observations by the monitoring team of living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. There was a human rights officer at the facility. Information was posted around campus identifying the human rights officer with his name, picture, and contact information. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		HRO was actively involved in educating individuals about their rights through the facility's self-advocacy group.	
	(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 13 allegation investigations completed by DFPS (Sample #D.1), DFPS notified law enforcement and/or OIG of the allegation in 13 (100%), when appropriate. OIG investigated eight cases in the sample and criminal activity was substantiated in none of the cases (0%).	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: • SASSLC Policy addressed this mandate by stating that any employee or individual who in good faith reports abuse, neglect, or exploitation shall not be subjected to retaliatory action by any employee of SASSLC. • Both initial and annual refresher trainer stressed that retaliation for reporting would not be tolerated by the facility and disciplinary action would be taken if this occurred. • "No Tolerance" posters were displayed in all living and day areas throughout the facility. The facility was asked for a list of staff who alleged that they had been retaliated against for in good faith had reported an allegation of abuse/neglect/exploitation. No names were submitted. Based on a review of investigation records (Sample #D.1), there were no concerns related to potential retaliation for reporting.	Substantial Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Metric 2.i.1: The facility policy and/or procedures defined sufficient procedures to audit whether significant injuries are reported for investigation. Metric 2.i.2: The facility conducted audits at least semi-annually, during the preceding 13 months. Metric 2.i.3: The audits conducted were sufficient to determine whether significant resident injuries had been reported for investigation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 #D2 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 facility had implemented an injury audit process to determine if all injuries that should have been reported for investigation were investigated. This included those injuries defined in DADS policy as "serious injuries" as well as non-serious injuries on parts of the body that might indicate potential abuse or neglect, or patterns of minor injuries both witnessed and discovered. Metric 2.i.4: In _____ of _____ (n/a) cases in sample #D.2, significant injuries identified by the audit that had not previously been investigated were reported to the Facility Director, and/or DFPS, as appropriate and immediately investigated. (none found)	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		

#	Provision	Assessment of Status	Compliance
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	DFPS reported its investigators were to have completed APS Facility BSD 1 & 2, or MH & MR Investigations ILSD and ILASD depending on their date of hire. According to an overview of training provided by DFPS, this included training on conducting investigations and working with people with developmental disabilities. Nine DFPS investigators were assigned to complete investigations at SASSLC. Nine DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. SASSLC had six employees designated to complete investigations. The training records for those designated to complete investigations were requested. Six (100%) investigators had completed training on: • Abuse, Neglect, and Exploitation, • Unusual Incidents, and • Comprehensive Investigator Training. Four of six (67%) of the investigators were late in completing annual refresher courses on Abuse, Neglect, and Exploitation. 33% were late in completing the annual refresher course on Unusual Incidents. Facility investigators did not have supervisory duties, therefore, they would not be within the direct line of supervision of the alleged perpetrator. The facility was in substantial compliance with training requirements for investigators, however, the facility should focus on ensuring that all investigators complete annual retraining in a timely manner.	Substantial Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Sample D.1 was reviewed for indication of cooperation by the facility with outside investigators. There was no indication that staff did not cooperate with any outside agency conducting investigations. The facility incident management coordinator reported good cooperation between the facility incident management staff and DFPS. Quarterly meetings were held with OIG and DFPS to discuss any issues between agencies.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such	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	Substantial Compliance

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	investigations.	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 13 investigations completed by DFPS (Sample #D.1), OIG investigated eight 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.	
	(d) Provide for the safeguarding of evidence.	The SASSLC policy on Abuse and Neglect mandated staff to take appropriate steps to preserve and/or secure physical evidence related to an allegation. Documentary evidence was to be secured to prevent alteration until the investigator collected it. Based on a review of the investigations completed by DFPS (Sample #D.1) and the facility (Sample #D.2): • There was no indication that evidence was not safeguarded during any of the investigations. Video surveillance was in place throughout SASSLC, and investigators were regularly using video footage as part of their investigation.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation,	<u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Investigations included in sample #D.1 noted the date and time of initial contact with the alleged victim. o Contact with the alleged victim occurred within 24 hours in six of 13 (46%) investigations. Exceptions were DFPS cases #42836634, #42827304, #4280439, #42796270, #42771982, and #42823945 (UIR #13-247 and UIR #13-066). o 13 (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. • For all investigation in sample #D.1, 11 of 13 (85%) were completed within 10 calendar days of the incident. The investigations not completed within 10 days: o Case #42839556 was submitted on the 17th day (extension filed due to	Substantial Compliance

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	findings and, as appropriate, recommendations for corrective action.	additional interviews needed). o Case #42836634 was submitted on the 17th day (extension filed due to additional interview needed). • All 13 (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 five of 13 (38%) DFPS investigations reviewed in Sample #D.1, concerns or recommendations for corrective action were included. Three of those cases resulted in a referral back to the facility for further investigation. <u>Facility Investigations</u> The following summarizes the results of the review of investigations completed by the facility from sample #D.2: • The investigation began within 24 hours of being reported in seven of seven cases (100%). • Seven of seven (100%) indicated that the investigator completed a report within 10 days of notification of the incident. • Six of seven (86%) included recommendations for follow-up action to address the incident. The facility was in substantial compliance with the requirement of D3e.	
	(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	Metric 3.f.1: Based on the Monitoring Teams' review of DADS revised Policy #021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. Metric 3.f.2: The facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations in #D.1: • Metric 3.f.3: In 13 out of 13 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. • The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.4: In 13 (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.5: In 13 (100%), the name(s) of all witnesses; o Metric 3.f.6: In 13 (100%), the name(s) of all alleged victims and perpetrators;	Noncompliance

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	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.	o Metric 3.f.7: In 13 (100%), the names of all persons interviewed during the investigation; o Metric 3.f.8: In 13 (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 Metric 3.f.9: In 13 (100%), all documents reviewed during the investigation; o Metric 3.f.10: In 13 (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o Metric 3.f.11: In 13 (100%), the investigator's findings; and o Metric 3.f.12: In 13 (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 3.f.13: In three out of seven investigations reviewed (43%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. o UIRs #13-068, #13-065, and #13-078 did not include a summary of the incident and findings. The investigator summarized the resulting IDT meeting in the section of the UIR designated for the conclusion/findings of the investigation. o UIR #13-073 did not include a summary of the incident and findings. • The report utilized a standardized format that set forth explicitly and separately: o Metric 3.f.14: In seven (100%), each unusual/serious incident or allegations of wrongdoing; o Metric 3.f.15: In seven (100%), the name(s) of all witnesses; o Metric 3.f.16: In seven (100%), the name(s) of all alleged victims and perpetrators; o Metric 3.f.17: In seven (100%), the names of all persons interviewed during the investigation; o Metric 3.f.18: In seven (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 Metric 3.f.19: In seven (100%), all documents reviewed during the investigation; o Metric 3.f.20: In seven (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating	

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		agency; ▪ It was not possible to determine how/if findings from previous investigations were used. The facility listed previous investigations but did not comment on the relevancy of those investigations. o Metric 3.f.21: In four (43%), the investigator's findings; and ▪ UIR #13-068, #13-065, #13-078, and #13-073 did not include s summary of findings from the investigation. o Metric 3.f.22: In four (57%), the investigator's reasons for his/her conclusions. (see 3.f.21) To gain compliance with D.3.f, investigations will need to: 1. The investigator should include a statement regarding whether or not findings from prior investigations/incidents were considered relevant to the current investigation. 2. Summarize findings of each investigation and document the investigator's conclusions based on evidence reviewed during the investigation.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Metric 2.g.1: The facility policy and procedures required that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete, and coherent. Metric 2.g.2: The facility policy required that any further inquiries or deficiencies be addressed promptly. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • Metric 2.g.3: The DFPS investigations in Sample D.1 met at least 90% compliance with the requirements of D.3.e (excluding timeliness requirements) <u>and</u> D.3.f, • Metric 2.g.4: The facility Incident Review Team (IRT) accepted 100% percent of the investigations over the six months prior to the onsite review. • Metric 2.g.5: For _____ of the DFPS investigation files the Monitoring Team noted problems with regard to Sections D.3.e, and/or D.3.f. Based on a review of the facility's IRT data, for _____ (_____%), the facility IRT correctly noted the problems with the investigation and/or report, and returned the investigation to DFPS for reconsideration. (none found) • Metric 2.g.6: In _____ investigation reports the facility returned to DFPS for reconsideration, for _____ (_____%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. (none found)	Noncompliance

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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, • 13 (100%) DFPS investigations were reviewed by both the facility director and IMC following completion. • 13 (100%) were reviewed by the facility director and/or the Incident Management Coordinator within five working days of receipt of the completed investigation. Additional investigations were reviewed for this requirement below in regards to investigations completed by the facility. <u>Facility Investigations</u> The following summarizes the results of the review of facility investigations: • Metric 2.g.7: In six out of seven investigation files reviewed (86%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. o There was no documentation of supervisory review for UIR #13-076. • Metric 2.g.8: The supervisor did not identify concerns in any of the cases. For these investigations, for ___ (n/a), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. • Metric 2.g.9: For the four investigation noted above for which the monitoring team identified deficiencies, the supervisory review did not appear to address these deficiencies. The facility was not in substantial compliance with the requirement for review of all facility investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent as evidenced by metric 2.g.7 and metric 2.g.9.	
	(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 13 out of 13 (100%) unusual incidents reviewed. A statement regarding review, recommendations, and follow-up was included on the review form. Metric 3.h.1: The facility-only investigations did not meet the requirements outlined in Section D.3.f.	Noncompliance

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	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Metric 3.i.1: The facility policy and procedures required disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence to be taken promptly and thoroughly. Metric 3.i.2: The policy and procedures did not specify the facility system for tracking and documenting such actions and the corresponding outcomes. The facility continued to track follow-up to recommendations in the daily IMRT meeting minutes. The meeting minutes included a date that recommended action was completed, but no evidence that a review was completed to ensure protections were effective and/or continued to be implemented. A subsample of investigations was reviewed to confirm that appropriate disciplinary and/or programmatic action was taken following the investigation when warranted. This sample included a total of seven cases: • Five DFPS cases: #42839556, #42836634, #42808439, #42771982, and #42716386; and • Two facility investigations: UIR #13-068 and #13-073 Metric 3.i.3: For three out of three of the DFPS investigations reviewed in which disciplinary action was warranted (100%), prompt and adequate disciplinary action had been taken and documented. Based on a review of a subsample of investigations (listed above) for which recommendations for programmatic action were made, the following was found: Metric 3.i.4: For six out of seven of the investigations reviewed (86%), prompt and thorough programmatic action had been taken and documented when recommended by DFPS or the facility investigator. • The facility failed to address concerns regarding inadequate supervision resulting in a confirmed neglect finding in DFPS case #42836634. Metric 3.i.5: For zero out of seven investigations (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action, or when the outcome was not achieved, the plan was modified. The facility did not have a system to track outcomes from investigations. Based on identified issues with the documentation and tracking of recommendations and desired outcomes, the facility remained out of compliance with this provision.	Noncompliance

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	(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.	Metric 4.1: For all categories of unusual incident categories and investigations, the facility had a system that allowed tracking and trending by: • Type of incident; • Staff alleged to have caused the incident; • Individuals directly involved; • Location of incident; • Date and time of incident; • Cause(s) of incident; and • Outcome of investigation. Over the past two quarters, the facility's trend analyses: • Metric 4.2: Were conducted at least quarterly; • Metric 4.3: Did address the minimum data elements; • Metric 4.4: Did use appropriate trend analysis procedures; • Metric 4.5: Did provide a narrative description/explanation of the results and conclusions; and • Metric 4.6: Did contain recommendations for corrective actions. Metric 4.7: Based on a review of trend reports, IMRT minutes, and QAQI Council minutes, when a negative pattern or trend was identified, corrective action plans were developed. Metric 4.8: As appropriate, corrective action plans were developed both for specific individuals and at a systemic level. Metric 4.9: The trend reports and minutes showed that corrective action plans were implemented and tracked to completion. When trends were identified, the incident management department made general recommendations to investigate the trend further at the unit or IDT level. A status update was included the following quarter in the trend analysis. Metric 4.10: The report/minutes reviewed, as appropriate, the effectiveness of previous corrective actions.	Noncompliance

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		Based on a review of resulting action plans included in quarterly trend reports and documentation related to implementation: Quarterly trend reports did not include action plans with specific outcomes related to trends identified. General recommendations for action by the residential unit or IDT were included in the quarterly QA/QI council presentations. • Metric 4.11: Zero action plans included in the quarterly trend report (0%) described actions to be implemented that could reasonably be expected to result in the necessary changes, and identified the person(s) responsible, timelines for completion, and the method to assess effectiveness. • Metric 4.12: For zero of the action plans reviewed (0%), the plan had been timely and thoroughly implemented. • Metric 4.13: For zero action plans (0%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the plan, or when the outcome was not achieved, the plan was modified. To move forward, the facility will need to ensure that as trends are identified, 1. Measurable outcomes and action steps are developed; 2. Specific staff are assigned to monitor and document implementation; and 3. A date is set to review efficacy of the plan and make revisions when needed.	
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	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.	Substantial Compliance

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	volunteer would pose a risk of harm to individuals at the Facility.	Background checks were conducted on new employees prior to orientation and completed annually for all employees. Current employees were subject to fingerprint checks annually. Once the fingerprints were entered into the system, the facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. According to information provided to the monitoring team, for FY13, criminal background checks were submitted for 2055 applicants. 116 applicants failed the background check in the hiring process and therefore were not hired. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Employees were required to sign a form acknowledging the requirement to self report all criminal offenses. The facility remained in substantial compliance with provision D.5.	

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, updated 5/22/13 with new DADS administrative staff names o SASSLC facility-specific policies: • Quality Assurance, #E1, 9/19/13 (the quality assurance plan narrative) • Clinical Services Continuous Quality Improvement, 4/3/13 • Six other policies in the list of facility policies, all the same as last review: 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 September 2013 o SASSLC policy lists, 4/1/13 o List of typical meetings that occurred at SASSLC, undated but likely September 2013 o SASSLC Self-Assessment, 10/8/13 o SASSLC Action Plans, 10/8/13 o SASSLC Provision Action Information, 10/4/13 o SASSLC Quality Assurance Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/21/13 o SASSLC DADS regulatory review reports, June 2013-September 2013 o List of all QA department staff and their responsibilities, 10/7/13 o SASSLC QA department meeting notes, monthly 5/8/13-9/23/13 (7 meetings) o SASSLC data listing/inventory, hard copy, 9/13/13 o SASSLC QA plan narrative, undated o SASSLC QA plan matrix, October 2013 o SASSLC key indictors, undated, likely October 2013 o QAQI Council presentation schedule o Set of blank tools used by QA department staff (3) o Sets of completed tools used by QA department staff (none) o Trend analysis report, for three of four components, last two quarters, ending 8/31/13 o Quarterly meeting between QA director and facility director, 10/9/13 (1) o QAQI Facility and unit processes, one page flowsheet, October 2013 o Monthly QAD-SAC-1:1 meetings, various summaries, once per month, June 2013-September 2013 o Unit QA monthly meetings, minutes and attachments • Unit 1: May, June, August (3) • Unit 2: August, September, October (3) • Unit 3: (0) o Some follow-up material to April 2013 injury reduction activities in Unit 3 o SASSLC QA Reports, monthly, April 2013 through September 2013 (6)

	o QAQI Council minutes, monthly May 2013 to September 2013 (5 months, 19 meetings) • May (4), June (2), July (5), August (4), September (4) • Handouts and agenda for meeting during onsite review, 10/22/13 o PIT, PET, work group reports (none provided) o SASSLC Corrective Action Plan documents • Open/pending CAPs, 22 pages • Closed CAPs, 6 pages • Various other tracking documents and evidence o DADS SSLC family satisfaction survey o Individuals satisfaction survey o Community/business satisfaction survey o Staff satisfaction survey o List of self-advocacy leadership 2013 o Self-advocacy monthly meeting minutes/notes, monthly May 2013 to September 2013, two meetings per month o Home meetings with individuals (two) o Facility newsletters, The Bridge (2) <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 Juan Villalobos, David Ptomey, Annette Longoria, Residential Unit Directors o Ralph Henry, Facility Director <u>Observations Conducted</u>: o QAQI Council meeting, 10/22/13 o QAD-SAC 1:1 sample meeting for F, 10/22/13 o Medical CQI meeting, 10/22/13 o Unit 2 QAQI meeting, 10/23/13 o P&T meeting, 10/23/13 o QA staff meeting Monday 10/21/13 o Self-advocacy meeting
	Facility Self-Assessment The facility self-assessment remained identical to the previous report's, except for provision E3. Therefore, comments from the previous report apply to this self-assessment, except for this one provision. The self-assessment for E3 now lined up with what the monitoring team looks for. The self-assessment, however, rated some of the components in E3 as being in place whereas the monitoring team did not, such as explicitly stating how, when, and to whom the CAPs were disseminated.

	One of the items that the self-assessment did not look at was whether the data being collected and assessed adequately met the requirements specified in the wording of E1 regarding tracking and trending of data across program areas, etc. This is clearly noted in the monitoring team's report.
	Summary of Monitor's Assessment: The QA program at SASSLC made good continued progress. There was not yet a complete and adequate data list inventory, though good progress was made, such as by including more provisions and adding additional items to many of the provisions. The QA director worked with each section lead (usually during the QAD-SAC 1:1 meetings). The QA plan matrix was nine pages long. It was not well organized; items were not grouped by section, and the items did not line up with the data listing inventory, the QA reports, and presentation content to the QAQI Council (based upon the minutes). The QA department embarked on a new activity to create a list of key indicators for each of the 20 sections. This was a very good activity, setting the occasion for section leaders to think about the important indicators for their areas. But as a result, the QA department was now managing three disparate lists: the data list inventory, the list of key indicators, and the QA matrix. The QA director should describe, for each section, possibly in the notes from the QAD-SAC 1:1 meetings, how data were being collected and presented to identify trends across the variables described in the wording of E1. There were frequent references to root cause analyses, intense case analyses, continuous quality improvement, etc. This was great to see and showed that across SASSLC there was a desire to use quality assurance and quality improvement processes to make SASSLC a better place for those who lived and worked there. It was apparent that the facility was only at the beginning stages of thoroughly, adequately, and appropriately applying these QA analysis procedures. The QA department and the section leaders will need training, guidance, and mentoring in order to implement root cause analyses that meet the generally accepted professional standard. Data from 17 of the 20 (85%) sections of the Settlement Agreement were summarized and graphed showing trends over time (all but sections G, H, and J), but few (3 of 20 [15%], C, D, S) analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. Since the last onsite review, a QAD-SAC 1:1 meeting occurred at least twice for 20 of the 20 (100%) sampled sections of the Settlement Agreement. The monitoring team was impressed with the improvements in organization of these meetings. They were held each month, a spreadsheet of items was kept, and sign sheets were maintained. The facility director attended most of these meetings, too. In

	addition, they were being held with each unit director each month. This was another good improvement. The QAD and SAC need to ensure that the meetings and their content and items are meaningful and thoroughly addressed. Unit level QAQI Council meetings continued. This was good to see. In the last six months, 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, 15 (75%) appeared in a QA report at least once each quarter in the last six months (all except for G, H, J, N, and Q). N and Q, however, appeared in one of the two quarters. There was no narrative analysis in the QA report. Some sections included suggestions for improvement (e.g., D, S). There was some narrative description of the data, but little analysis of data. Since the last onsite review, the QAQI Council met at least once each month. The QAQI Council at SASSLC met almost every week, allowing for the meetings to be relatively short and to be a regular part of each manager's weekly schedule. All (100%) CAPs appeared to have been chosen following the written description, policy, or procedure. As of 9/16/13, there were open CAPs for 8 of the 20 sections. 13 of the 20 had closed CAPs, though the time period was not specified. Of the 15 CAPs reviewed by the monitoring team (36% of the total), 10 (67%) appeared to appropriately address the specific problem for which they were created. The facility needs to ensure that CAPs outcomes look at whether the problem for which the CAP was created had improved.

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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, and a stable set of QA staff program auditors. <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. The monitoring team's comments on the state policy are in the previous monitoring report and are not repeated here. Also, given that the statewide policy was disseminated almost two years ago, edits may be needed. State office should consider this. There were SASSLC facility policies that adequately supported the state policy for quality assurance. Since the last review, the QA director created a new facility-specific policy	Noncompliance

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		that adequately described QA processes at SASSLC. The QA director used the QA plan narrative as the base for this policy; this was an appropriate thing to do. Although corrective actions were described in this policy, a more detailed CAP policy was to be developed by the QA director. Curiously though, the list of facility policies for all of SASSLC continued to include a set of six QA-related policies, many of which were no longer applicable. This was mentioned in the previous monitoring report and should be corrected. QA department staff and executive committee staff were trained in the current policies. There were no data reporting on whether all facility staff were at all trained on the QA policies and practices at the facility. <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. The QA department staff 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. <u>Quality Assurance Data List/Inventory</u> There was not yet a complete and adequate data list inventory at the facility though good progress was made, such as by including more provisions and adding additional items to many of the provisions. There was a data list inventory for 18 of the 20 provisions (90%), all except for G and H. The QA department's section E data list inventory continued to include many items that were really part of other sections (e.g., active engagement, guardianship), this this was improved since the last review. This list should report on QA-related activities. The item for CAPs was a good example. The QA director reported that he worked with each section lead (usually during the QAD-SAC 1:1 meetings) to ensure the inventory was comprehensive and correct. This was evident in a review of the meeting minutes for these meetings for 20 of the 20 sections. The data list inventory was, however, current. That is, even though more work was needed on the content, a review and update date within the last six months was included	

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		for each section. The QA director, however, should indicate if this was the date when last reviewed by the QA department or by the QAQI Council. The QA director reported that the data list inventories were periodically presented to QAQI Council. This was evident in the review of the QAQI Council meeting minutes for the data list inventories. Usually, however, the minutes indicated that data listing were to be reviewed, but the minutes rarely indicated what discussion occurred. <u>Quality Assurance Plan Narrative</u> The QA plan narrative at the facility was current, complete, and adequate. The QA director updated the narrative based upon recent changes to some of the QA processes at the facility (e.g., 1:1 meetings, unit QA meetings), and he also incorporated the narrative into the facility-specific policies for quality assurance. The QA plan narrative could be improved by describing how the most important key indicators for each discipline are determined. <u>QA Plan Matrix</u> The QA plan matrix should contain the data from the data list inventory that are to be submitted to the QA department; these data are then included in the QA reports and presented to the QAQI Council. SASSLC had a QA plan matrix. The monitoring team reviewed the October 2013 QA matrix. The SASSLC QA plan matrix was nine pages long. It was not well organized; items were not grouped by section, and the items did not line up with the data listing inventory, the QA reports, and presentation content to the QAQI Council (based upon the minutes). For the 20 sections of the Settlement Agreement, a set of key indicators was included for N/A of the 20 (N/A%). The monitoring team decided to not provide a scoring for this metric because of the following: • Since the last review, the QA department embarked on a new activity to create a list of key indicators for each of the 20 sections. To do so, the QA director, his staff, and the SAC met with each section leader to develop a list of about a half-dozen most important items. This was a very good activity, setting the occasion for section leaders to think about the important indicators for their areas. As a result, the QA department was now managing three disparate lists: the data list inventory, the list of key indicators, and the QA matrix. More work needs to be done to tie these together. For instance, the key indicator list should be part of the data list inventory. Then, key indicators would be selected and put into the QA matrix.	

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		At this time, the QA matrix contained items for 15 of the 20 sections (75%), and the key indicator packet contained items for 18 of the 20 (90%). Of the 20, both process and outcome indicators were identified for N/A of the 20 (N/A%) in the QA matrix. The contents of the data listing inventories and key indicator lists contained both process and outcome indicators, however, due to the disparity across the data listing, key indicator list, and QA matrix, the monitoring team did not score this metric. Similarly, of the 20, in N/A (N/A%), the indicators provided 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 director should describe, for each section, possibly in the notes from the QAD-SAC 1:1 meetings, how data were being collected and presented to identify trends across the variables described in the wording of E1. The QA matrix should also include the self-monitoring tools used for each of the 20 sections of the Settlement Agreement (or indicate that a self-monitoring tool was not necessary along with a rationale). The QA matrix listed self-monitoring tools for 15 of the 20 sections (75%). The data listing inventory, however, for 5 of these 15 (33%) did not include an item labeled as a self-monitoring or self-assessment tool, thus, calling into question the validity of what was on the QA matrix (and as evidenced by the information presented in the QA report and to QAQI Council). Further, the QA director reported that some self-monitoring tools were not being used (e.g., K) and others were being updated (e.g., T). All data that QA staff members collected were not listed in the matrix. The interobserver agreement data that QA staff were to collect was included, but not the other data sets that they collected. It seemed that this aspect of the QA matrix needed to be updated. All satisfaction surveys were not included in the QA matrix. • An individual satisfaction survey was developed with the self-advocacy committee and implemented with about 40 individuals between June 2013 and August 2013. The results were very positive. The no responses, however, were deserving of some follow-up. • The community business satisfaction survey was again completed. Ten local restaurants, stores, and businesses were surveyed between April 2013 and August 2013. The results were overwhelmingly positive.	

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		• 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 developed, however, it was not clear to the monitoring team if it was implemented. The employee council meetings continued to be held. Results were not submitted to the monitoring team. • 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, continued to be an organized activity for the two dozen or so members. The monitoring team was impressed with the work of Ms. Hicks. The QA matrix is really a subset of the larger data list/inventory. Therefore, all items in the QA matrix should also be in the data list inventory. As noted above, the QA matrix, data listing inventory, and key indicator list were not yet lined up properly. This may be a good task for the QAD and SAC to work on together. <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 (e.g., at least once each quarter). 2. Reviewed or analyzed by the QA department and/or the department section leader. 3. Conducted as per the schedule. All three items can be determined during the facility's monthly QAD-SAC 1:1 meetings. Given that the QA matrix was not yet a functional/useable tool, this metric could not be scored by the monitoring team. <u>Self-Monitoring Tools</u> As the QA director and the department section leaders work towards improving their self-monitoring tools, the monitoring team recommends that they review the comments made in previous monitoring reports regarding these tools. Further, for the next onsite review, the QAD should be prepared to present to the monitoring team information regarding the following aspects of the self-monitoring tools at the facility: 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.	

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		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. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The QAD and SAC need to ensure that the content of the data inventories are comprehensive and do not omit any important indicators. A plan to do so should be created, implemented, and reported on at the next onsite review. This will require incorporation of the key indicator lists into the data listing inventories. 2. Ensure the items in the QA matrix represent those process and outcome indicators that are most relevant to the section, and that they track data to identify trends as per the wording of this provision E1.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Continued progress was seen at SASSLC regarding the gathering, organization, and analysis of data. Of note were the frequent references to root cause analyses, intense case analyses, continuous quality improvement, etc. This was great to see and showed that across SASSLC there was a desire to use quality assurance and quality improvement processes to make SASSLC a better place for those who lived and worked there. However, based on documentation reviews and observations by the monitoring at the QAQI Council, QAD-SAC 1:1 meeting, unit QA meeting, medical CQI meeting, P&T meeting, and community transition review, it was apparent that the facility was only at the beginning stages of thoroughly, adequately, and appropriately applying these QA analysis procedures. In an SSLC, the QA department usually takes the lead in helping section leaders to conduct these types of analyses. The QA department at SASSLC, however, lacked the experience and expertise in being able to do so. They (and section leaders) will need training, guidance, and mentoring in order to implement root cause analyses that meet the generally accepted professional standard. Data from 17 of the 20 (85%) sections of the Settlement Agreement were summarized and graphed showing trends over time (all but sections G, H, and J), but few (3 of 20 [15%], C, D, S) analyzed data across program areas, living units, work shifts, protections supports and services, areas of care, individual staff, and/or individuals. To make this	Noncompliance

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		determination, the monitoring team reviewed the QAD-SAC 1:1 meeting notes and attachments, QA reports, and QAQI Council minutes and attachments. <u>Monthly QAD-SAC meeting with discipline departments</u> 1. Since the last onsite review, a meeting occurred at least twice for 20 of the 20 (100%) sampled sections of the Settlement Agreement. The monitoring team counted one meeting per quarter in its data calculations for this report even though more than one meeting may have occurred. The following four metrics were not scored because of the way information from the 1:1 meets were reported. The monitoring team recommends that the QAD-SAC define what is expected for each of the 15 and 8 items (i.e., what it takes to get a yes score), that a short comment be put under each of the items, and/or that they also include a short paragraph regarding the meeting. In the current set of notes, most only contained a yes/no score. Some were marked n/a and some noted that an activity was not done. For some of these, it was not clear if the activity was not done because there was no need for any activity (i.e., there was nothing to update in the inventory) or if the activity should have been completed, but wasn't. 1a. All five topics below were conducted during xx of the xx (xx%) 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 xx of the xx (xx%) meetings, data were available to facilitate department/discipline analysis of data. 3. Since the last onsite review, during xx of the xx (xx%) meetings, data were reviewed and analyzed. 4. Since the last onsite review, during xx of the xx (100%) meetings, action plans and/or CAPs were created for systemic problems and for individual problems, as identified; or an indication was noted that a corrective action plan was not needed.	

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		The monitoring team has a number of comments regarding the QAD-SAC 1:1 meetings: • The monitoring team was impressed with the improvements in organization of these meetings. They were held each month, a spreadsheet of items was kept, and sign sheets were maintained. The facility director attended most of these meetings, too. • In addition to holding these for each of the Settlement Agreement section leaders, they were being held with each unit director each month. This was another good improvement. • A checklist of 15 "scored" items and 8 "non-scored" items was created. This was good to see. o The criterion to score a check mark needs to be made specified in writing for each of these items. o The checklist can be used to create a metric of facility performance on these QA activities. This could then be included in the section E QA report and QAQI Council presentation. • The QAD and SAC need to ensure that the meetings and their content and items are meaningful and thoroughly addressed. The monitoring team observed a 1:1 meeting with the section F leader. Overall, the monitoring team's impression was this was more of a question-answer session (with the QA director and SAC asking questions and the section leader responding) than a conversational, instructional session. If the section leaders experience these meetings as an interrogation, it will become nothing more than a bureaucratic task, with the goal of getting in and out as quickly as possible. This is not the intention of these meetings and, moreover, will not help the facility move towards its goal of conducting thorough analyses of data and root cause analyses. Other sections of this report point to areas where more support for department directors was needed. For example, in Q1 regarding oral hygiene, the monitoring team explored how dental data and information were used by the QA department, if analysis was conducted, and if problem areas were identified. It appeared it had not occurred and that the efforts of the dental clinic were not resulting in any evidence of a facility level plan to address poor oral hygiene scores. On the other hand, in O4, the monitoring team noted that errors in physical and nutritional management were analyzed across the facility, and within each home, and trends were identified related to specific staff. Action steps were identified with a due date for each. An update was completed and reported as to the status of completion of any identified corrective actions from a previous period.	

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		Other QA-Related Meetings • Unit level QAQI monthly meetings: Each of the three unit directors continued to hold a monthly QAQI meeting with the unit's home managers, QIDPs, behavioral health, and nursing staff. These meetings continued to develop and improve. They were also now tied into the facility's overall QA program in three ways. First, the unit directors had a monthly QAD-SAC 1:1 meeting. Second, the unit directors provided updates to the QAQI Council and they responded to recommendations from the QAQI Council. Third, the QA director reviewed the agenda and handouts from each unit's monthly meeting. o The monitoring team observed the unit 2 QAQI meeting. Overall, it was a very good meeting. Staff from each of the home made presentations regarding the topics of interest (e.g., injuries, ANE). Staff were very energetic and appeared to enjoy the opportunity to make a professional presentation with data, graphs, and bulleted items highlighted. The monitoring team believes that the participants would benefit from, and welcome, more training on how to determine the most important pieces of data to present, how to show trending and progress in a way that is easy for the reader to follow, and how to further analysis of the data. o At the last review, the monitoring team highlighted the interesting unit 3 project to assess, analyze, and improve (i.e., reduce) injuries. The intervention was initiated right at the time of the last review. Data through September 2013, however, did not indicate if it was effective (i.e., data were variable from month to month). The monitoring team could not determine if any further work, follow-up, or changes were made. There were no meeting agendas or minutes submitted to the monitoring team for unit 3, perhaps due to the retirement of the unit director who had been the leader of the unit's QAQI activities. • QA director-facility director meetings: These meetings continued and were now quarterly. Given that the facility director was attending most of the QAD-SAC 1:1 meetings, quarterly meetings seemed reasonable. Once the QA director begins to chart the QA-related activities of each section, these data might be reviewed during this meeting. • Medical CQI meetings: This QA-related activity continued to occur monthly and was led by the facility medical director. It is discussed in section L3 of this report.	

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		QA Report In the last six months, 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%). SASSLC built its QA report throughout the month, that is, there was a weekly QAQI Council meeting during which section leaders made presentations. Their presentation materials were then put into the QA report. Thus, the QA report was completed at the end of the calendar month and was comprised of the material and discussion that occurred during that calendar month's QAQI Council meetings. Of the 20 sections of the Settlement Agreement, 15 (75%) appeared in a QA report at least once each quarter in the last six months (all except for G, H, J, N, and Q). N and Q, however, appeared in one of the two quarters. Of the 32 sections of the Settlement Agreement that were presented quarterly, (0%) contained all of the components listed below. Many did not include any self-monitoring tool data (it may be that the department did not use a self-monitoring tool, per se). Many of the sections did regularly occurring and consistent presentations. For example, sections C, D, M, N, O, P, R, and S presented similar data from report to report, allowing the reader to see trends in data. • 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 appropriate • Narrative analysis Some additional comments regarding the QA reports are below: • There was no narrative analysis in the QA report. Some sections included suggestions for improvement (e.g., D, S). There was some narrative description of the data, but little analysis of data. This appeared to be improving at the last review, but was not evident at this time. • SASSLC assembles its monthly QA reports at the end of the month, after all of the presentations are completed. Sometimes, however, the data and charts presented in the QAQI Council meetings did not make it into the QA report. • The section E report should eventually include data on QA activities (e.g., from the QAD-SAC 1:1 meetings). Inclusion of data regarding CAPs was one example.	

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		QAQI Council This meeting plays an important role in the QA program. The monitoring team attended a meeting during the onsite review and read the minutes of the monthly QAQI Council meetings from the end of April 2013 through the end of September 2013 (19 meetings). 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. The QAQI Council at SASSLC met almost every week, allowing for the meetings to be relatively short and to be a regular part of each manager's weekly schedule. Minutes from all (100%) QAQI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, including presentation of Settlement Agreement sections in an organized, scheduled manner. 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. Minutes from 0 (0%) QAQI Council meetings since the last review reflected if recommendations and/or action plans were discussed, suggested, or agreed to during each portion of the meeting. Because so much importance is placed upon the QAQI Council and QA report, the QAQI Council minutes should more accurately reflect discussion, concerns, actions to be taken, etc. There were many problems with the minutes that could be relatively easily corrected: • Agenda and minutes were kept as two separate documents. One document of the minutes would suffice. • The minutes served as the repository for ongoing discussions from work groups, PITs, and unit QAQI meetings. There were many comments from more than a year ago and these comments were repeated week after week. This was very confusing to the reader. Working notes and historical information should be kept elsewhere, not in the minutes. Or, old information versus new information should be clearly delineated for the reader.	

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		• More detail needs to be recorded as to discussion, issues, problems, recommendations, etc. More recent minutes included more wording in the paragraphs about data listing presentations and quarterly presentations. The content, however, was primarily a summation of the data presented by the section leader. That information was available in the attachments. The minutes should reflect discussion. If there was no discussion, questioning, participation, etc., that should be reflected in the minutes, too. During one QAQI Council meeting observed by the monitoring team, there was active participation of participants other than the presenter for all (100%) of the reports/data presented during the meeting. <u>Work Groups/Performance Improvement Teams</u> SASSLC had two performance improvement teams (consents, SAP data). These groups were active and reported to QAQI Council. As noted above and in the previous report, some thought should be given to how their activities are documented in the QAQI Council meeting minutes. <u>Corrective Actions</u> Further work was done to improve the corrective action system. Corrective action plans were tracked by the QA director in two documents. One was for current open CAPs in a 8-page document that contained 42 CAPs as of 9/16/13. The QA director reported that the number had grown to 60 as of 10/14/13. At the time of the last review, there were 59 CAPS. The other was for completed closed CAPs in a six-page document. This was continued since the last onsite review. The number of closed CAPs was 112 as of 9/16/13, and 142 as of 10/14/13. For this review, the set of CAPs from 9/16/13 was used. 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. CAPs were generated from QAQI Council, section leaders, at 1:1 meetings (this was new and still somewhat rare), and from PIT workgroups. Different than at the time of the last review, the facility was no longer counting each component of a larger CAP as a separate CAP, but rather considered all of the steps required to complete a CAP. When considering the full set of CAPs, they all (100%) appeared to have been chosen following the written description, policy, or procedure. As of 9/16/13, there were open CAPs for 8 of the 20 sections. 13 of the 20 had closed CAPs, though the time period was not specified.	

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		Of the 15 CAPs reviewed by the monitoring team (36% of the total), 10 (67%) appeared to appropriately address the specific problem for which they were created. Based on these 15 CAPs: • 13 (87%) included the actions to be taken to remedy and/or prevent the reoccurrence, all but the N CAP and the 5th OP CAP. • 4 (27%) included the anticipated outcome of each action step. o However, there were no specific criteria to determine if the CAP was met, or if progress had occurred (0%). This was a serious problem in the CAPs program. Because the criterion was never specified, the reader cannot determine if the actions met the problem for which they were designed. • 15 (100%) included the job title of the person(s) responsible, however, only the 2 CAPs (13%) included the name of the person responsible. • 11 (73%) included the time frame in which each action step must occur (i.e., a due date). At SASSLC, the entire CAPs management documentation is via the spreadsheet. Thus, the wording of the issue/reason, actions, outcomes, responsible persons, and target dates must be held to a very high standard by the QA department. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • Define and measure what is expected to occur during each QAD-SAC 1:1 meeting. • Analyze data as per the wording of provision E1 when appropriate to do so; or if not, provide a rationale. • Ensure that QAQI Council meeting minutes are accurate and adequately thorough. • Actions for CAPs should directly relate to the purpose/issue for which the CAP was created. • Ensure CAPs outcomes look at whether the problem for which the CAP was created had improved. • Include criteria for a CAP being met.	

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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 • 0 (0%) included documentation of to whom it was disseminated, including the names of the specific persons responsible. o At the last review, the QA department obtained signatures to indicate receipt of the CAP; this was discontinued at this time, however, the QA director and his staff planned to re-implement immediately.	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.	Beginning in mid-August 2013, the QA department began a new system of monitoring CAPs. To do so, one of the program auditors was assigned the weekly task of printing out the set of open CAPs and then meeting with each responsible person to review the status. Some weeks, the program auditor even had the responsible person sign on each and every CAP (e.g., 9/16/13). Overall, this system was a good idea and ensured that every CAP would receive some monitoring of its status every week. The sample of 15 CAPs appeared to have been implemented (100%). This was based upon review of the spreadsheet, it had handwritten notations by the program auditor. The monitoring team, however, could not determine that all aspects of CAPs were implemented fully and in a timely manner. To address this, the QAD and program auditor might indicate status on the spreadsheet and include as one of the items in the QAD-SAC meeting minutes. That is, for each CAP, indicate whether it was implemented in a timely manner, done fully, and modified if needed (this last variable is for section E5). When a CAP, and all of its actions, were completed within the target due date, the reader can infer that it was implemented fully and timely. For those not yet completed, however, the reader cannot determine whether it was implemented fully and timely. There was not yet an adequate system for tracking the status of CAPs. The new system of weekly monitoring should set the occasion for the facility to meet the requirements of this provision by the time of the next review. The facility QA director did maintain summary information/data regarding CAPs and their status (regarding pending/open or closed) that was updated within the month prior to the onsite review. The QA director or section leader did present this information to QAQI Council at least quarterly.	Noncompliance

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		The monitoring team has recommended that the QA director maintain and graph some simple data on CAPs/action plans. These data can be part of the section E data list inventory and possibly the QA matrix, too.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The QA director reviewed CAPs each month with the responsible person/section leader and the program auditor reviewed CAPs each week with the responsible person. There was not, however, a way or place to document if the CAPs were effective, especially for CAPs that were completed/closed. That is, whether the CAP successfully addressed the problem for which it was created, not only that the action steps were implemented. The monitoring team will be looking for: • Evaluation of the effectiveness of CAPs, including outcomes • CAPs are modified when needed. • Modifications/results are discussed at QAQI Council. • Modifications are implemented as written fully and timely.	Noncompliance

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 DADS Policy #051: High Risk Determinations o Curriculum used to train staff on the ISP process o SASSLC Section F Presentation Book o SASSLC Self-Assessment o Corrective action plans to address audit findings o Monitoring tool used to assess the quality of the ISP and the ISP meeting o List of all QIDPs and assigned caseload o A list of QIDPs deemed competent in meeting facilitation o Data summary report on assessments submitted prior to annual ISP meetings o Data summary report on team member participation at annual meetings. 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 Draft ISPs and Assessments for Individual #241 and Individual #55 o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #198, Individual #225, Individual #35, Individual #188, Individual #340, Individual #151, Individual #164, Individual #75, Individual #47, Individual #203, Individual #142, Individual #292, Individual #330, and Individual #137 <u>Interviews and Meetings Held</u>: o Informal interviews with various direct support professionals, program supervisors, and QIDPs in homes and day programs o Charlotte Fisher, Director of Behavioral Services o Megan Lynch, Incident Management Coordinator o Jessica Rodriguez, Facility Investigator o Leticia Jaloma, Facility Investigator o Gevona Hicks, Human Rights Officer o Joan O'Connor, ADOP o Rhonda Sloan, QIDP Coordinator <u>Observations Conducted</u>: o Observations at residences and day programs o Incident Management Review Team Meeting 10/21/13 o Morning Unit Meeting 10/22/13 o QA/QI Meeting 10/22/13

	o Morning Clinical Review Team Meeting 10/21/13 o Annual IDT Meeting for Individual #241 and Individual #55 o Rights Assessment Meeting for Individual #111 o Pre-ISP Meeting for Individual #282 o ISPA regarding falls for Individual #47
	Facility Self-Assessment: SASSLC continued to use the self-assessment format it developed for the last review. It had been updated on 10/7/13 with recent activities and assessment outcomes. The QIDP Director was responsible for the section F self-assessment. SASSLC continued to use the statewide section F monitoring tool to assess compliance with section F. 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. The ISP monitoring checklist had been revised and was being used to monitor annual ISP meetings for inclusion of all required elements. These are the same type of activities that the monitoring team looks at to assess compliance. The facility had not self-assessed all section F provision items. The QIDP coordinator was concentrating on the F1 provisions. The facility self-rated itself as being out of compliance with all provision items in section F. Findings for the provisions that were audited by the facility were similar to findings of the monitoring team.
	Summary of Monitor's Assessment There was progress evident with the ISP process. At two ISP meetings, one pre-ISP meeting, and one ISPA meeting observed by the monitoring team, it was noted that significant progress had been made towards: • Integrating the risk identification process into the ISP process. At the ISPs observed, the risk discussion was woven into the discussion regarding the individual's preferences, daily schedule, and support needs. • Engaging in adequate discussions regarding community living options. IDTs were holding a much more integrated discussion with input from all team members. IDTs observed were moving in a positive direction. It was not evident, however, that meetings were resulting in the development of a comprehensive ISP that incorporated all recommendations and needed supports. To move forward towards compliance with the many provisions in section F, the monitoring team recommends a focus on the following activities during the next six months: • All departments need to ensure that assessments are completed at least 10 days prior to the annual IDT meeting and are available to all team members for review. • When new assessments are recommended, IDTs need to meet to review recommendations and incorporate any recommended changes in supports into the ISP.

	• IDTs need to develop measurable outcomes and implementation strategies that will allow for consistent implementation and data collection. • Outcomes should be developed based on each individual's known preferences that encourage greater exposure to a variety of activities (particularly in the community) and lead towards the acquisition of new skills based on known preferences and needs. • 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. Likewise, data collected regarding incidents, injuries, and illnesses should be used to alert the IDT that supports are either not being implemented or are not effective and should be revised.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	During the week of the review, the monitoring team observed two ISP meetings, one pre-ISP meetings, and one ISPA. The QIDP facilitated each meeting. IDT meetings observed were good examples of facilitation that ensured that team members participated in the meeting. All four QIDPs had excellent facilitation skills that kept the meeting focused and moving. The QIDP Educator attended each meeting and prompted the teams when needed. Participation by all team members present was encouraged. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PSIs, Rights Assessments, Integrated Risk Rating Forms, Integrated Health Care Plans and/or risk action plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last six QIDP monthly reviews, individual's daily schedule, Special Considerations list, and ISP Preparation Meeting documentation as available. A sample was requested of the most recently developed ISPs from each residence on campus, and the eight most recently developed plans were selected for review. Therefore, a variety of QIDPs and interdisciplinary teams (IDTs) responsible for the development of the plans were sampled. The facility used the statewide Q Construction Facilitation Training in conjunction with a competency tool used to assess competency in facilitation skills. Thirteen of 21 QIDPs had been deemed competent in regards to facilitation skills via this tool.	Noncompliance

#	Provision	Assessment of Status	Compliance
		A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was used to assist the QIDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QIDPs used this template to draft portions of the ISP prior to the meeting. The QIDPs 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. A sample of IDT attendance sheets was reviewed for presence of the QIDP at the annual IDT meeting. QIDPs were in attendance at all annual meetings in the sample reviewed. QIDPs remained responsible for monitoring and revision of the ISP. As noted throughout this report, the monitoring team found the QIDPs did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed. While the facility was in substantial compliance with the requirement that one person on the IDT facilitate development of an ISP, 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. To move forward, the facility needs to focus on monitoring progress/regression and revising supports and services when needed. The facility will need to demonstrate that QIDPs were taking action when the monthly review process or other data note a lack of implementation, change in status, or a lack of progress.	
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 #004.1 described the Interdisciplinary Team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QIDP, 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 identify the individual's preferences, strengths, and needs. This information should assist the IDT in determining key team members. SASSLC was using the pre-ISP process to identify assessments to be completed prior to the annual ISP meeting and team members that should be present at the annual ISP meeting. The facility had begun using the ISP Preparation Meeting to identify team members for participation in the ISP meetings, and had a working system to track and trend the resulting data.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The facility was tracking data on attendance at IDT meetings. Attendance by day programming staff, dieticians, occupational therapists, and dental staff, when deemed relevant by the IDT remained low, as did participation by family members or LARs. The table below is a summary of data gathered by the facility in regards to attendance at annual ISP meetings for the past year.	

Team member	Attendance by relevant team members
Individual	80%
Family/Advocate	56%
LAR	74%
Active treatment	89%
Dental services	60%
Dietician	70%
Direct Support Professionals	87%
Home Manager	92%
ISD	100%
Local Authority	89%
Occupational Therapist	70%
Pharmacy Services	No data
Physical Therapist	83%
Primary Care Provider	97%
Psychiatrist	85%
Psychologist/Behavior Analyst	99%
Nursing Services	99%
Speech Therapist	89%
Vocational Services	94%

Four individuals in the sample had a pre-ISP that identified relevant IDT members for the ISP meeting. Review of a sample of ISP attendance sheets confirmed that there were key staff missing who were identified at the pre-ISP as relevant participants in four of four (100%) of the annual meetings in the sample. The sample included Individual #164, Individual #151, Individual #340, and Individual #35.

- At the annual ISP meeting for Individual #164, there was no participation by the LAR, PCP, dental staff, or vocational staff.
- The LA, DSP, and vocational staff did not attend the annual ISP meeting for Individual #151.
- At the annual ISP meeting for Individual #340, there was no participation by the individual and his DSP.
- Individual #35 and his family were not present at his annual ISP meeting. The

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>speech therapist, vocational staff, and home manager were also absent.

Given the number of individuals participating in psychiatry clinic (163), the current allotment of psychiatry resources made it unlikely that psychiatrists could attend all additional meetings required.

Attendance at the ISPs by therapy clinicians was inconsistent with the designations for required attendance in some cases. Only 50% of the individuals with both ISP attendance records and pre-ISPs reviewed in sections O, P, and R of this report had documented attendance by the required therapy clinicians.

The facility was not yet in compliance with requirements for the IDT to ensure input from all team members into the ISP process.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td>DADS Policy #004.1 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 3/1/13 through 8/31/13 indicated that assessments were not routinely submitted prior to ISP planning meetings. The chart below shows assessment submission rates for that time period.

<table>
<tr><th>Assessment</th><th>Submission Rate</th></tr>
<tr><td>Medical</td><td>67%</td></tr>
<tr><td>Audiology</td><td>92%</td></tr>
<tr><td>Dental</td><td>90%</td></tr>
<tr><td>Nutritional</td><td>61%</td></tr>
<tr><td>OT/PT</td><td>58%</td></tr>
<tr><td>Speech</td><td>58%</td></tr>
<tr><td>Nursing</td><td>79%</td></tr>
<tr><td>Pharmacy</td><td>94%</td></tr>
<tr><td>Day Programming</td><td>71%</td></tr>
<tr><td>Psychiatry</td><td>48%</td></tr>
<tr><td>Psychology</td><td>49%</td></tr>
<tr><td>Recreation</td><td>38%</td></tr>
<tr><td>Vocational</td><td>75%</td></tr>
<tr><td>Functional Assessment</td><td>69%</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Zero (0%) of four individuals had all assessment recommended at the pre-ISP meeting completed at least 10 days prior to the annual IDT meeting. • Individual #164 did not have a psychological update, psychiatric assessment, annual physical, nursing assessment, functional skills assessment, OT/PT assessment, nutritional assessment, or vocational assessment prior to his annual meeting. • Individual #151 did not have a psychological update, dental assessment, functional skills assessment, communication assessment, or vocational assessment prior to his annual ISP meeting. • Individual #340 did not have a functional skills assessment, communication assessment, OT/PT evaluation, or vocational assessment completed 10 days prior to his annual ISP meeting. The facility continued to utilize the Functional Skill Assessment (FSA) to identify priority training. As noted above, the assessment was not always completed prior to the annual ISP meeting. As noted in previous reports and in section S of this report, the FSA was, by itself, not adequate for capturing this information. The facility needs to continue to expand opportunities for individuals 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. Although the list of preferences for each individual was fairly comprehensive, the list of strengths included in ISPs in the sample usually offered little information to build on. The list of strengths typically included general statements, such as can feed himself, has a good appetite, can ambulate, and can toilet independently. The IDT should consider strengths that contribute to relationship building, independent living, and competitive employment. Traits, such as enjoys helping others, compassionate, completes tasks, stays focused, and detail oriented are strengths that can be used to build additional skills in these areas. The facility was not yet in compliance with this item based on the data available. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months 1. 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. 2. Assessments should result in recommendations for support needs when applicable.	

#	Provision	Assessment of Status	Compliance
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	As described in F1c, assessments required to develop an appropriate ISP meeting were not consistently done in time for IDT members to review each other's assessments prior to the ISP meeting. There had, however, been considerable progress made in integrating assessment recommendations into support plans when available to the team. QIDPs 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. There was no evidence that the team met when assessments were completed after the ISP meeting to integrate recommendations into the ISP. Plans were not always updated to include changes in supports that occurred after the annual ISP. For example, • Individual #47 had a number of falls since her annual ISP meeting. At least two resulted in serious injuries. Her QIDP monthly reviews noted a change in status in both June 2013 and July 2013. An updated OT/PT assessment was recommended. There was no evidence that supports in her ISP/ IHCP were updated to include any change in supports recommended by the IDT. A review of assessments and ISPs indicated that IDTs were doing a better job of incorporating recommendations from assessments into the ISP. Examples from the sample of ISPs reviewed where assessment results were not incorporated into the supports and services developed by the IDT included: • Recommendations from Individual #35's communication assessment were not integrated into teaching strategies in her SAPs. • Individual #340's psychological assessment recommended additional activities to provide sensory stimulation. This recommendation was not included as an action step in his ISP. Recommendations in his communication assessment were not integrated into his SAPs. • The OT/PT assessment for Individual #151 included recommendations for a wheelchair assessment and assessment by the SLP to consider a change to oral food intake. Action plans were not developed to ensure that the assessments occurred. There was no evidence that the assessment were obtained or if obtained, that the team met to discuss recommendations from the assessments and updated supports if recommended. • Individual #164's IHCP included action steps for habilitation therapy to re-assess her head of bed elevation to address her risk for choking and aspiration and consult with the physician regarding dental care. Recommendations from those assessments were not included in the IHCP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Many of the recommendations made by therapy clinicians were addressed in the ISP, however, recommended SAPs (direct and indirect) were only consistently integrated for communication rather than OT/PT. 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. The facility was not yet in compliance with this provision. To move forward, QIDPs will need to ensure that assessments are completed prior to the annual ISP meeting and all recommendations from assessments are used to develop and revise supports as needed.	
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. As part of the 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 annual ISPs observed for Individual #241 and Individual #55, team members discussed providing supports in a less restrictive environment. • Both teams engaged in discussion regarding what supports would be needed in a community setting and any barriers to living in the community. • Both QIDPs asked for recommendations from all team members regarding optimal placement. Good discussion was observed at both meetings. • The LA was at both ISP meetings and was able to address any questions or concerns regarding community living options. There was little focus on providing additional opportunities for individuals to participate in day programming in the community. The facility did not have options for individuals to receive day habilitation in the community. Minimal formal training was occurring in the community. Ten ISPs were reviewed for the inclusion of training in the community. These were the ISPs for Individual #164, Individual #330, Individual #137, Individual #151, Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		#198, Individual #188, Individual #225, Individual #35, Individual #203, and Individual #47. Three (30%) of the ISPs included meaningful training opportunities in the community. Community based outcomes for most individuals in the sample consisted of generic opportunities to visit in the community with little or no opportunity for training or meaningful integration. For example: • Individual #164 had one community based outcome to go on a community outing twice per year. The outcome did not describe specific training to be provided in the community. • Individual #330 had a community based outcome to increase exposure to the community. He was to be given the opportunity to visit community group homes twice in the next year. • Individual #151, Individual #35, and Individual #198 had a community based outcome to attend off campus outings once per quarter. • Individual #188 had outcomes to visit a community group home and attend off-campus activities. • Individual #47 had an outcome to participate in community leisure activities once per month. The ISP did not describe types of leisure activities that she might enjoy in the community. ISPs that included specific measurable training objectives to be implemented in the community: • Individual #137 and #203 had outcomes to make purchases in the community. • Individual #225 had an outcome to exercise for 30 minutes in the community one to two times per month. 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. There was no focus on providing supported employment or volunteer opportunities for individuals at the facility. The sheltered workshop should be a job training site with a goal to support individuals to work in the community. Meaningful job training was not observed in the vocational program. None of the ISPs in the sample included outcomes developed to increase opportunities to explore job opportunities in integrated work environments.	

#	Provision	Assessment of Status	Compliance
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;	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. It will be necessary for all assessments to be completed prior to the annual ISP meeting to ensure the team will have information necessary to determine prioritized needs, preferences, strengths, and barriers. In the ISP meetings observed, IDTs engaged much better discussion of support needs in relation to preferences. The teams reviewed the list of preferences developed during the pre-ISP meeting, and developed plans to include the individual's preferences throughout the day. Risks were discussed in relation to the individual's preferences and interests. Lists of preferences included a much broader range of activities and were individual specific, which was good to see. IDTs, however, were still not developing action plans that would expand on those preferences by providing opportunities to explore new activities, particularly in the community. As noted in F1e, additional opportunities to try new things should lead to the identification of additional preferences. ISPs in the sample provided few opportunities 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. In a review of 10 recent ISPs, three (30%) offered specific training to be provided in the community. While the community was often listed as a possible training site for outcomes, training was not designed specifically for functional training in the	Noncompliance

#	Provision	Assessment of Status	Compliance
		community. As noted in F1e, outcomes for training offered opportunities for visits in the community, but few were focused on gaining specific skills. For many of these individuals, community awareness had been identified as an obstacle 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. To move in the direction of substantial compliance, the monitoring team recommends that the facility focuses on developing outcomes to address barriers to service and supports being provided in a less restrictive setting.	
	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;	A sample of ISPs, IHCPs, and skill acquisition plans (SAP) 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 very few outcomes written in a way that staff could measure progress towards completion or that provided enough information to ensure consistent implementation. None (0%) of the plans in the sample included a full array of measurable outcomes. There were very few outcomes developed to address learning new skills. Outcomes to address health and risk included general instructions (e.g., follow PNMP, weigh weekly), but did not include specific indicators to be measured. For example: • Individual #142 had action steps in his IHCP to address his high risk for cardiac disease. His action steps included routine lab analysis, routine diagnostic testing, and cardiology consults. There were no specific guidelines to determine what routine testing he might need. Similarly, an action step to address his risk for falls stated "referrals as needed with hab therapy." • Individual #225 had an outcome to address her risk for obesity and diabetes. An action step was written to monitor her weight. An acceptable weight range and instructions for reporting weight fluctuations were not included in her IHCP. • Individual #47 only had one outcome for skill acquisition. She had an outcome to attend work. Her action step stated that she would remain in the work room when she attended work. It was not clear what behavior on her part would demonstrate successful completion of this outcome. • Individual #75 has action steps to address his risk for cardiac disease. One action step instructed staff to assess and record his blood pressure. The action step did not include information on what would be an acceptable range for him or when the PCP should be notified. Communication strategies were not included in staff instructions in his skill acquisition plans.	Noncompliance

#	Provision	Assessment of Status	Compliance
		As noted in F1d, recommendations from assessments were not always used to develop training strategies. Further detail on the adequacy of skill acquisition plans (SAPs) can be found in section S. Sections M and 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.	
	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 struggled. 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. Assessments and recommendations will need to be available for review by the IDT prior to annual meetings. As noted in F1d, the facility did not have an adequate system in place for ensuring that assessment information was integrated into the ISP. The revised ISP meeting guide prompted the teams to discuss, revise, and approve plans that previously had been viewed as separate plans, such as the PNMP, PBSP, crisis intervention plan, psychiatric treatment plan, and IHCP. The facility had made progress in developing comprehensive ISPs that integrated all supports and services. However, as noted throughout section F, assessment information was often not available prior to the ISP meeting. Further, it was not evident that recommendations from assessments obtained after the annual ISP meeting were integrated into the ISP. 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		for providing support to that individual. Observation at the annual ISP meeting for Individual #241 indicated that this IDT was making considerable progress towards integrating protections, services, and supports into one comprehensive plan. For example, this IDT held an in-depth discussion regarding her risk for weight fluctuations. The SLP, psychologist, QIDP, direct support staff, day training staff, nurse, and family member all contributed information on her preferences and needs in an attempt to develop adequate protections and supports. It is expected that progress will continue to be made in developing comprehensive plans as IDTs become more adept at developing both functional and measurable outcomes.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	<u>Method for implementation</u> As discussed in F2a2, action steps in the sample of ISPs reviewed did not include clear methodology for implementation in some cases. 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. IHCP action steps were generally brief statements of action to address the risk. Most did not include methodology or criteria for monitoring effectiveness of intervention. <u>Time frame for completion</u> A sample of seven ISPs were reviewed to verify that outcomes included a time frame for completion. Only two of seven (29%) included projected completion dates. For the two that included dates, the date was an annual date rather than a date based on the individual's expected rate of learning or projected need for specific supports. • All outcomes in Individual #151 and Individual #35's ISPs had completion dates for 12 months from when the ISP was developed. • Individual #330, Individual #225, Individual #188, Individual #198, and Individual #47's outcomes were not assigned completion dates. <u>Staff responsible</u> All SAPs and IHCPs in the sample included designation of which staff would be responsible for implementation of the outcome and which staff would monitor the plan. The facility was not in compliance with the requirement for identifying methods for implementation and time frames for completion.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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. Many of the outcomes in the ISPs reviewed were functional at the facility, but often were not practical or functional in the community and did not allow for individuals to gain independence. None of the ISPs in the sample included adequate outcomes for functional participation or integration in the community. For example, there were no outcomes to shop in the community for food to prepare a meal, complete transactions at a community bank, pick up prescriptions at the pharmacy, seek membership at a gym or library, or take a community art or fitness class. As noted throughout section F, there was very little measurable training occurring in the day habilitation programs. Vocational outcomes were not found that would develop vocational skills needed for community employment. Vocational skills were often taught in relation to jobs at the facility, but would not necessarily translate well in a community work environment. For example, individuals at the facility had part-time schedules for work or day activities. Lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch to eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. To move forward, IDTs will need to accurately identify needed supports and services needed to gain independence and function in a less restrictive setting through an adequate assessment process and then include those needed supports in a comprehensive plan that is functional across settings.	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	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 Health Care Plans included similar information. The type of data to be collected and the frequency of implementation were to be in the SAP, IHCP, or on the ISP outcome summary. As noted throughout F2a, IDTs were still struggling with developing measurable outcomes with methods that would allow for	Noncompliance

#	Provision	Assessment of Status	Compliance
	data collection, and the person(s) responsible for the data review.	consistent data collection to permit the objective analysis of progress. SAPs, ISP outcome summaries, and IHCPs now included the person responsible for data collection and the person responsible for review of that data. As noted in other sections of this report, IDTs were still developing general action steps such as "monitor weight" without including criteria that would trigger a review of supports or change in status. Outcomes will need to be measurable in order to permit objective analysis of the individual's progress.	
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. When assessments were recommended by the team, it was not evident that the ISP was revised to include recommendations once the assessment was completed. To move forward, the facility will need to ensure that recommendations from various assessments are available to all members of the IDT prior to the annual ISP meeting, and then are integrated throughout 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 16 out of 18 (89%) records reviewed, however, none of these included a current IHCP, which should be considered an integral part of the ISP. The facility reported that 41 (24%) of 171 ISPs were filed within 30 days of development over the past year. The facility needs to ensure that all plans are accessible and comprehensible to staff assigned to implement the plan and staff can clearly communicate what supports should be provided and what data should be gathered. As noted above, outcomes and action steps were not always written clearly enough to ensure consistent implementation and data collection. 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

#	Provision	Assessment of Status	Compliance
		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. All outcomes should be written in clear, measurable terms. 2. ISPs should be accessible to staff within 30 days of the development of the plan.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	Teams were required to meet to review any incidents, significant injuries, or changes in status immediately when determined necessary. Each discipline was assigned responsibility for reviewing specific services and supports in the ISP. QIDPs were responsible for reviewing the overall plan. The facility had a QIDP monthly review process to review all supports and services. It was not evident that an adequate review process was in place to ensure that the review of supports and services led to timely implementation of assessments or changes in supports when necessary. An adequate review process was not in place for any of the ISPs in the sample. For example, • The QIDP monthly review of services for August 2013 for Individual #198 did not summarize data collected or progress made on outcomes. There was no indication that the QIDP had reviewed her IPN or any other relevant information during the review. • The QIDP monthly review of services for July 2013 for Individual #151 indicated that a number of his outcome were not implemented throughout the month. For example, his sensory goal was to be implemented four times per month. Data showed that it was implemented once during July. His outcome for swimming was to be implemented during the summer months. The QIDP note indicated that he did not go swimming in July. There was no documentation that the QIDP followed up on lack of implementation. The QIDP review of his PNMP and IHCP only noted that he had plans in place. There were no comments regarding the effectiveness of the supports. As the facility continues to progress toward developing person-centered plans for all individuals at the facility, QIDPs need to keep in mind that ISPs should be a working document that will guide staff in providing supports to individuals with changing needs. To move forward towards compliance, 1. Plans should be updated and modified as individuals gain skills or experience regression in any area. 2. QIDPs should note specific progress or regression occurring through the month and make appropriate recommendations when team members need to follow-up on issues.	Noncompliance

#	Provision	Assessment of Status	Compliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised	In order to meet the Settlement Agreement requirements with regard to competency based training, QIDPs will be required to demonstrate competency in meeting provisions addressing the development of a comprehensive ISP document. The facility had been trained by the state office on developing and implementing the ISP. QIDPs were still learning to use the new statewide ISP format. As noted throughout section F, adequate plans had not yet been developed for a majority of the individuals at SASSLC. Plans that had been developed were often not accessible to staff, particularly IHCPs. Staff instructions for many plans did not offer enough information to ensure consistent implementation or did not include recommended support strategies from assessments. Informal interviews throughout the facility indicated that staff were generally able to describe supports and services developed through the ISP process. A review of data collected regarding implementation indicated that data were often missing or the status of outcomes could not be determined. See comments regarding the monthly review process in F2d. To move forward, the facility will need to ensure that plans are available and training on new or revised supports occurs within 30 days of development.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP 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 16 (89%) of 18 individual notebooks in the sample, however, IHCPs were not available to staff. The monitoring team requested a list of ISP dates with the date the ISP was due, the date the meeting was held, and the date the ISP was filed (document V.10). Data provided by the facility indicated that while all ISP meetings were held within 365 days of the previous ISP meeting, only 41 of 171 (24%) ISPs developed in the past year were filed within 30 days after the annual ISP was held.	Noncompliance

#	Provision	Assessment of Status	Compliance
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. As noted in regards to the facility's self-assessment process, it was not clear that accurate data were being gathered and analyzed. Little progress had been made towards developing an effective quality assurance system to identify problems with the ISP and implementation.	Noncompliance

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 Interviews and Meetings Held: o David Espino, MD, Medical Director o Sharon Tramonte, Pharm D, Clinical Pharmacist o Libby Tolle, RN, Medical Compliance Nurse 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 Meeting
	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 13 items listed, most of which revolved around meeting attendance. These were all reasonable activities, but they were all process oriented. As noted in previous reports, 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.

	For provision G2, the self-assessment indicated that there was no monitoring done for this provision item. 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 evidence of integration of clinical services. No true progress was appreciated. There were no new major initiatives specifically related to the integration of clinical services. However, some meetings were expanded or included more discussions that had the potential to improve integration of clinical services. The monitoring team had the opportunity to meet with the medical director to discuss integration activities at the facility. He reported on integration activities, but the discussion was limited to the meetings of the disciplines. The monitoring team has stressed that meetings do not guarantee that services are delivered in an integrated manner and the monitoring team expects to learn of the outcomes of the meetings Throughout the week of the review, the monitoring team encountered several good examples of integrated clinical services. Areas where integration was needed, but failed to be evident were also noted. Continued work in this area is needed. The monitoring team expects that as additional guidance is provided from state office in the form of a finalized policy, the facility will have greater clarity on how to proceed.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The 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. Additionally, the monitoring team met with the medical director, who served as lead for sections G and H, medical compliance nurse, and lead pharmacist to discuss the status of sections G and H. The medical director discussed the example of the ISP which he believed promoted integration through the attendance of the clinicians. There were a total of 88 ISPs conducted from April 2013 through August 2013. Attendance for the clinical disciplines	Noncompliance

#	Provision	Assessment of Status	Compliance
		is presented in the chart below. ISP Attendance April - August 2013 Discipline: No. ISP/(%) Communication: 41 (46) Dietary: 15 (17) Habilitation Services: 47 (53) Nursing: 77 (87) Medical: 21 (24) Psychiatry: 9 (10) Psychology: 55 (62) Participation by the primary medical providers in the ISPs was very low with an average attendance of 24%. It was reported that this was for the annual ISPs. There were no data submitted for ISPA attendance. Adequate participation in the ISPAs is particularly important following hospitalization for clinical staff and these data should be tracked. As noted in the table, attendance by dietary was also very low. The exact significance of the data reported for psychiatry was not clear. • The monitoring team attended Individual #55's ISP meeting, which was held to complete his integrated risk rating form and integrated health care plan. The individual, his direct support professional (DSP), and relevant clinical team services members were present. The individual's attendance was brief because of his engaged activities of placing objects in a canister, which team members expressed was overpowering the meeting productivity. The DSP did an excellent job of supporting the individual by providing choices of other activities. The individual indicated the choice was to return to a designated work area. The ISP meeting held in-depth discussions related to risk factors and risk. The RN Case Manager presented detailed information that was pertinent in making determinations about the level of risk for falls, the developmental diagnosis, and the causal relationship of the risk. An Annual Comprehensive Nursing Assessment, completed by the RN Case Manager, however, did not sufficiently address changes in weight and had omissions of the individual's BMI and waist circumference. This exemplified the importance of complete nursing assessments, which contribute to the team process for the determination of risk and development of an individualized IHP. The medical director also discussed the Daily Clinical Services Meeting as evidence of integration of clinical services. Attendance for a 10% random sample of the Clinical Services Morning meetings was reviewed each month. Scores for four meetings were	

#	Provision	Assessment of Status	Compliance
		submitted in the self-assessment. The overall average scores for the data provided is presented in the table below. August - September 2013 Discipline: % Meetings Attended Dietary: 50 Habilitation Services: 100 Nursing: 100 Medical: 74 Psychiatry: 62 Psychology: 25 Hospital Liaison: 100 Daily Clinical Services Meeting - The monitoring team attended several of these meetings and found that they were well attended during the week of the review. This level of attendance was higher than what was found in the random sample data represented above. The events of the past 24 hours were discussed, including hospital admissions, transfers, use of emergency drugs, clinic consults, and restraints. At times, however, the medical department staff was overly argumentative among themselves. The tone of the discussions was distracting and nearly disruptive in some meetings. This did not cultivate an environment for robust integrated discussions of clinical services. In other instances, some members of the medical department staff were very dismissive of the concerns that other facility staff had regarding the health of some individuals. This meeting had the potential to be an excellent forum for monitoring the health status of targeted individuals, sharing information and providing educational opportunities and would be more productive with implementation of some basic meeting ground rules. While it was useful to hear about the various committees, the monitoring team was also interested is learning more about the actual integrated delivery of services. The monitoring team offers the following comments based on observations, interviews, document and data review: • The PNMT worked well together for assessment and follow-up with IDT members and medical staff consistently attending meetings as needed. The PNMT RN consistently attended morning medical meetings and PNMT members routinely attended IDT meetings as needed. Most of the referrals to the PNMT were self-generated and the initiation and completion of assessments was not completed in a timely manner. There were very clear referral guidelines in place to assist the IDTs in recognizing when referral was indicated. Once a referral was generated, the IDT participated routinely during PNMT and ISPA meetings	

#	Provision	Assessment of Status	Compliance
		to integrate recommendations into the ISP, IRRF, and IHCP. Another area of strong integration was between psychology and speech services. There was clear collaboration during the assessment process and in the development of supports to address behavioral issues with a communication component. A SLP routinely attended the BSC meetings to promote consistency between the communication plan and the PBSP, though work was still needed to ensure that these plans were well integrated. • Integration of psychology and psychiatry had improved. Psychologists and psychiatrists appeared to have improved interactions during psychiatric clinic meetings observed. • The clinical pharmacists participated in psychiatry and neurology clinics providing updated information related to medications and laboratory monitoring to the consultants and facility staff. During those clinics, individuals were evaluated and treatment decisions were made. They provided recommendations related to medication choices, dosages, and monitoring for clinical effectiveness for the individual. This was not a meeting, but an example of multiple disciplines coming together to deliver an actual clinical service. • When quarterly psychiatry clinics or other psychiatric clinical consultation occurs, there were generally members of the IDT present for integration including psychology, nursing, pharmacy, and therapy services. • Projects related to the development of strategies to overcome barriers to dental treatment were abandoned over the course of time. Although there were few individuals with documented refusals, there remained a need for the relevant disciplines to effectively collaborate to develop and implement as needed, plans to overcome identified barriers to dental treatment. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility should review the participation of the various disciplines in the ISP process and take appropriate corrective actions to increase participation in the fundamental planning meeting. 2. Clinical disciplines should track attendance at ISPAs. Medical should particularly track post-hospitalization ISPA attendance since health plans likely change. 3. The facility should address the issues noted above. 4. The state should provide additional guidance in the form of a policy.'	

#	Provision	Assessment of Status	Compliance
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The facility reported that no monitoring was conducted with regards to this provision item since the last compliance review. The monitoring team found significant problems relative to consultations. The facility appeared to be unable to implement the state issued consult tracking database, therefore, essentially no data were available. The reliability of the scant amount of data that was submitted was questionable. The etiology of the problems was undetermined. However, the facility problems relative to consultation were far more expansive than tracking. There were significant problem relative to the provision of services as well. The monitoring team is concerned that this problem, which was reported during the last compliance review, remains unresolved and with no specific plan of correction. The consults and IPNs for 10 individuals whose records were reviewed as part of the record sample were requested. A total of 45 consults completed after July 2012 (including those from the record sample) were reviewed: • 30 of 45 (66%) 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. The Settlement Agreement required that medical providers review and document whether or not to adopt the recommendations and whether to refer the recommendations to the IDT for integration with existing supports. State policy required that an entry be made in the IPN explaining the reason for the consultation and the significance of the results within five working days. There was evidence that the primary providers reviewed most consults. However, there was inadequate documentation of the consult findings in the IPNs. The requirements for consultation review and documentation were discussed with the medical director. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The monitoring team recommends that IPN documentation include (a) the required summary statement regarding the reason for the consult and significance of the findings, (b) agreement or disagreement with the recommendations, and (c) the need for IDT referral. Clinically justifiable rationales should be provided when the recommendations are not implemented. It is further recommended that that the PCPs always notify the IDT when there is a disagreement with the recommendations of the consultant. 2. The facility must address the lack of a non-functional database. Facility administration should consider this a priority issue because the ability to track	Noncompliance

#	Provision	Assessment of Status	Compliance
		consults in the database is linked to the overall requirement to provide specialty services. There should be a facility level plan of correction to address this issue due to the fact that the medical department was not have a corrective action plan. 3. 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, 1/1/13). 4. The medical director should ensure that the state database has been appropriately implemented. 5. DADS should develop and implement policy for Provision 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: Minimum Common Elements of Care 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, 20 Interviews and Meetings Held: o David Espino, MD, Medical Director o Elizabeth Tolle, RN, Medical Compliance Nurse o Sharon Tramonte, Pharm D, Clinical Pharmacist 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. The self-assessment presented a series of activities that were conducted for each item along with the results of activities and a self-rating; however, the activities of the self-assessment did not align with the key items presented in the facility's section H policy. 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. It is also recommended that the medical director review the proposed state guidelines and local policy since they both include metrics for assessing compliance with this provision. The facility found itself in substantial compliance with provision H2 and H7 and in noncompliance with all other provision items. The monitoring team found the facility in substantial compliance with H2. The monitoring team found the facility in noncompliance with provisions H1, H3, H4, H5, H6, and H7.
	Summary of Monitor's Assessment: The medical director continued to serve as facility lead for this provision. There was minimal progress observed in this provision. The facility implemented a local policy. The policy, which was unsigned, provided no date of adoption or implementation. It was the same policy drafted and implemented at a sister SSLC, however, SASSLC really did not appear to fully implement the policy based on a lack of the various data sets required in the policy. As usual, during the week of the compliance review the monitoring team conducted a meeting with facility staff to discuss to status of provisions G and H. The medical director, medical compliance nurse, and lead pharmacist participated in the discussions. The facility continued to track assessments centrally. Each department also tracked assessments. There was no information available on the quality of assessment and tools had not been developed. Interval assessments were not addressed. The facility continued its Medical Quality Improvement Committee and much of section H was linked to data derived from that committee. This was a logical approach because section H, for the most part, addresses issues related to quality. The quality program, however, was rudimentary and required a great deal of revision. Thus, section H will also require a great deal of work in order to move towards substantial compliance. The state medical services coordinator provided the monitoring team with a copy of a comprehensive set of proposed draft guidelines that addressed each provision item with an operational definition, a method of assessing compliance, action steps for assessing compliance and compliance targets. Overall, this was a reasonable approach and should serve as a valuable source of information for the medical director as the facility moves forward with this provision.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>H1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.</td><td>The state office policy, which remained in draft, required each department to have procedures for performing and documenting assessments and evaluations. Furthermore, assessments were to be completed on a scheduled basis, in response to changes in the individual's status, and in accordance with commonly accepted standards of practice.

During the discussions with the medical director, he reported that a centralized database, maintained by QA, tracked all assessments. The self-assessment documented compliance rates, as reported by the data analyst, for a number of clinical disciplines. The data submitted in the self-assessment are summarized in the table below.

<table>
<tr><td colspan="6">Annual ISP Assessments 2013</td></tr>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td></tr>
<tr><td>No. of ISPs</td><td>14</td><td>27</td><td>20</td><td>27</td><td>19</td></tr>
<tr><td>Discipline</td><td colspan="5">Number (%) Submitted</td></tr>
<tr><td>Audiology</td><td>5 (35)</td><td>16 (59)</td><td>12 (60)</td><td>19 (70)</td><td>12 (63)</td></tr>
<tr><td>Speech</td><td>6 (43)</td><td>12 (44)</td><td>8 (40)</td><td>16 (59)</td><td>14 (74)</td></tr>
<tr><td>Dental</td><td>12 (86)</td><td>22 (81)</td><td>20 (100)</td><td>22 (81)</td><td>17 (89)</td></tr>
<tr><td>Dietary</td><td>2 (14)</td><td>5 (18)</td><td>7 (35)</td><td>25 (92)</td><td>14 (74)</td></tr>
<tr><td>OT/PT</td><td>11(78)</td><td>13(48)</td><td>11 (55)</td><td>9 (33)</td><td>15(79)</td></tr>
<tr><td>Nursing</td><td>10 (71)</td><td>18 (66)</td><td>18 (90)</td><td>17 (63)</td><td>17 (89)</td></tr>
<tr><td>Medical</td><td>10 (71)</td><td>14 (52)</td><td>13 (65)</td><td>13 (48)</td><td>15 (79)</td></tr>
<tr><td>Pharmacy</td><td>12 (86)</td><td>24 (89)</td><td>20 (100)</td><td>27 (100)</td><td>17 (89)</td></tr>
<tr><td>Psychiatry</td><td>3 (21)</td><td>3 (11)</td><td>5 (5)</td><td>10 (37)</td><td>7 (37)</td></tr>
<tr><td>Psychology</td><td>7 (50)</td><td>13 (48)</td><td>8 (40)</td><td>11 (41)</td><td>7 (37)</td></tr>
</table>

Based on these data, many areas demonstrated significant improvement. Notwithstanding these improvements, there were several disciplines with unacceptable compliance rates. Yet, the monitoring team did not learn of any facility plan or the role of section H in addressing the facility's management of assessments. Departmental data were also maintained, but were not submitted from all departments. It was also noted that the number of annual ISPs documented in the table differed from the number of ISPs</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		submitted in other documents. While the facility was tracking the timeliness of scheduled assessments, the quality of these assessments was not evaluated. Moreover, the facility had yet to evaluate timeliness or quality of interval assessments. 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: • For a sample of 15 AMAs, compliance with timely completion was 40%. Assessments were current based on the 365 day requirement. • The facility's requirement to complete Quarterly Medical Summaries was reinstated. However, completion was inconsistent. This is 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 for completion of Annual Dental Assessments/Examinations was 94%. This was a significant improvement for the dental department. • Of the 12 records selected for review, minimal improvement was found in the initial and ongoing assessments to developments, changes, or monitoring of individual's health conditions. A majority of the records reviewed did not have a corresponding nursing entry correlated to the observation note that was documented by the direct support professional regarding a complaint or observation of an acute illness or injury. • The PNMT conducted assessments for individuals referred to the team. For this review period, three assessments were complete as submitted for review and none of these was completed in 30 days or less. Continued work was indicated to ensure that both referrals and evaluations reflect the sense of urgency required for individuals with high risk needs. These assessments resulted in a series of recommendations for the IDT and the PNMT to address collaboratively. Follow-up was also collaborative, as PNMT members attended IDT meetings when the individual they supported was scheduled for review. • Therapy assessments (OT/PT/SLP completed a single assessment) were completed annually for individuals provided direct and indirect supports and services or in the format of a Comprehensive Assessment. These were also completed when a change in status was identified by the IDT, post-hospitalization or by referral for an identified need. A consult assessment was documented as a stand-alone assessment, and in the IPNs.	

#	Provision	Assessment of Status	Compliance
		• The timeliness of OT/PT and communication assessments continued to be problematic, though improvement was noted in the last couple of months. There had been significant improvements in the content aspect of the OT/PT and communication assessments, attributable to routine audits and clearly outlined guidelines for clinicians. • Psychiatry clinic was timely with regard to completion of quarterly medication reviews. There were issues in that a low percentage (35%) of comprehensive psychiatric evaluations per Appendix B had been completed. During the current monitoring period, two individuals were admitted to the facility, both of these individuals were receiving treatment via psychiatry clinic. Only one had a comprehensive psychiatric evaluation completed. • 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. <u>Compliance Rating and Recommendations</u> The monitoring team agreed with the facility's self-rating of noncompliance. To move in the direction of substantial compliance the facility must monitor all three elements that this provision item addresses: 1. The timelines for completion of scheduled assessments 2. The appropriateness of interval assessments in response to changes in status 3. The quality of all assessments (compliance with accepted standards of practice).	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The medical director reported that medical and psychiatric diagnoses were formulated in accordance with ICD/DSM nomenclature. According to the self-assessment, audits revealed 100% compliance. However, the self-assessment indicated this was compliance with the use of ICD nomenclature. There was no documentation of the appropriateness of the diagnosis. That is, did the diagnoses 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 and the diagnoses fit the signs, symptoms, and presentation of the individuals. • Over the course of the visit, the monitoring team observed the psychiatrist relying upon the diagnostic criteria in an effort to appropriately diagnose individuals. Additionally, records reviewed revealed some examples of documentation of specific criteria exhibited by an individual indicating a particular diagnosis.	Substantial compliance

#	Provision	Assessment of Status	Compliance
		o There were challenges as data points collected did not routinely correspond with diagnoses or target symptoms identified for treatment with a particular psychotropic medication. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of substantial compliance.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	The self-assessment reported that assessment of this provision involved review of the Quarterly Medical Summaries. This activity was similar to the activity conducted for the last compliance review. The monitoring team indicated that review of the QMSs alone was not an adequate means of assessing compliance with the requirements of this provision. The self-assessment did not indicate who completed the audits nor did it provide information for any other disciplines. This process was not consistent with the local policy, which required evaluation by all clinical disciplines. The H1 state draft guidelines indicated that facility staff would utilize the clinical pathways, guidelines, and protocols to govern treatments and interventions as appropriate. Additionally, the draft guidelines stated that the facility was responsible for providing education and development of the clinical staff with regards to the guidelines and protocols. Determining compliance with a given protocol will require that a measurable standard or metric – clinical indicators be developed. The minimum common elements of clinical care could be applied to many conditions, such as diabetes mellitus. Medical, nursing, physical therapy and dietary all contribute to the planning and treatment for individuals diagnosed with diabetes mellitus. Clinical indicators are helpful in objectively determining if treatments and interventions are timely and clinically appropriate. They also provide a quantitative basis for quality improvement, or identifying incidents of care that trigger further investigation. The facility's diabetes audit is discussed in sections H4 and L1. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance the facility must monitor a full range of treatments and interventions. Indicators should be developed based on the state protocols and other common medical conditions. The development of clinical guidelines can be an infinite process. Therefore, the facility will need to develop protocols and monitor those conditions determined to have the greatest impact on health status. Conditions that affect many individuals or those that have presented medical management challenges should be considered. Medical audits, hospital and emergency	Noncompliance

#	Provision	Assessment of Status	Compliance
		department data as well as the sick call roster have the potential to provide insight on how prioritization should occur.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	The proposed section H guidelines stated that the facility would ensure that identified clinical indicators measure the response to treatment and interventions and data would be monitored to determine the appropriateness of the interventions. The actions steps to achieve this centered on development of clinical indicators by the clinical disciplines for seven acute and chronic health care conditions. The facility had established a list of clinical indicators that were reviewed through the Continuous Medical Quality Committee, however, this list did not include indicators for all clinical disciplines. Conditions reviewed included diabetes, emesis, hospitalization, seizures, and injurious falls. The medical director will need to be mindful of the selection of indicators and reporting of data. It was widely reported that there was 100% compliance with HbA1c>9%. This was reported in numerous documents and touted as an accomplishment. The metric was extracted from a specific journal article provided which was submitted with the documents request. • However, it was not an appropriate metric for SASSLC. • The facility later reported that the correct metric was HbA1c@7%. This is a more appropriate metric. The development of indicators for the seven conditions, proposed by the state, was a good starting point. As discussed in section H3, additional indicators are needed. Once guidelines are established and indicators are identified, the facility will have a more objective means of assessing treatment. Many of these processes should occur within the medical department. The determination of the appropriateness and efficacy of medical care must be made by a physician through the development of audit tools. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Continue the ongoing efforts related to development of clinical indicators 2. Ensure that the data reported is thoroughly reviewed and analyzed	Noncompliance
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively	The facility assessed compliance with this provision by looking at timely completion of quarterly medical assessments, quarterly drug regimen reviews, and annual medical assessment. Audits of compliance with diabetes standards and with breast cancer screenings were also done to assess compliance with this provision.	Noncompliance

#	Provision	Assessment of Status	Compliance
	monitor the health status of individuals.	The proposed section H guidelines indicated that the health status was discussed in the annual ISP and ISPA as identified by the IDT and a plan was developed to address the needs of the individual. Additionally, the facility tracked data in development of the identified health plan. The monitoring team was concerned about the lack of medical involvement in the development of the health plans given the lack of participation in annual ISPs. The facility must monitor both acute changes and chronic long-term disease by linking the current monitoring systems. Monitoring health status requires a number of processes, reviews, and evaluations due to the need to monitor both acute changes and chronic long-term disease. The monitoring team noted several components that would contribute to monitoring health status: • Risk assessment • Periodic assessments (medical, nursing, therapies, psychiatry, and pharmacy), • Acute assessments via sick call • Reports of acute changes via the daily clinical meetings and other status change meetings • ISPA Process • Medical databases (preventive care, cancer screenings, seizure management) • A medical quality program would be the designated quality program and would report certain data elements to the QA/QI council. With appropriate execution of these systems, an individual's care and monitoring could be assessed across this continuum of activities. However, the monitoring team identified a number of concerns related to current processes and systems: • Risk identification and mitigation continued to present challenges for most disciplines. Medical assessments did not include any documentation of risk assessment. • There were multiple deficiencies identified related to the provision of preventive care services. • Appropriate plan of care were lacking in the annual medical assessments. • Participation in the annual ISPs by primary medical provider and other clinicians was poor. • The facility had not established an appropriate databank of key clinical data. 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 effective monitoring of health status requires proper oversight of risk assessment and provision of medical care. This will require a robust	

#	Provision	Assessment of Status	Compliance
		medical quality program. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. Ensure risk is appropriately addressed by primary medical providers 2. Improve the provision of preventive care and tracking of preventive care 3. Address attendance at ISPs and ISPAs 4. Resolve issues related to data collection and data integrity	
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 self-assessment focused on the diabetes and the morning meetings to describe how treatments and interventions were modified in response to clinical indicators. In order to assess this compliance with this provision there must be some metric The facility must identify clinical indicators that will be used to determine when therapeutic outcomes are reached. Many of those will be based on clinical guidelines developed. These indicators will help determine when treatment plans must be altered. At the time of the compliance review, there was the potential to track some changes via the daily patient care meetings, unit meetings, ISPAs, and other meetings discussed above. Clinical indicators would provide the objective means of assessing the adequacy of the treatments and intervention. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance.	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.	The facility implemented a local policy on 9/5/13. The self-assessment reported that training occurred. However, there was no documentary evidence of the training such as a training roster. Moreover, substantial compliance for this provision item will ultimately require a state policy. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, a state policy related to Provision H should be developed. SASSLC will need to revise its local policy once a state policy is issued.	Noncompliance

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #006.1: At Risk Individuals dated 12/29/10 o 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 individuals 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 who received enteral feeding o List of individuals with chronic and acute 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 Data reports regarding the submission of assessments for IDT review prior to annual ISP meetings o Draft ISPs and IRRF for Individual #241 and Individual #55. o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans, Monthly Reviews (for a subsample): • Individual #198, Individual #225, Individual #35, Individual #188, Individual #340, Individual #151, Individual #164, Individual #75, Individual #47, Individual #203, Individual #142, Individual #292, Individual #330, and Individual #137

	Interviews and Meetings Held: o Informal interviews with various direct support professionals, program supervisors, and QIDPs in homes and day programs o Charlotte Fisher, Director of Behavioral Services o Megan Lynch, Incident Management Coordinator o Jessica Rodriguez, Facility Investigator o Leticia Jaloma, Facility Investigator o Gevona Hicks, Human Rights Officer o Joan O'Connor, ADOP o Rhonda Sloan, QIDP Coordinator Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 10/21/13 o Morning Unit Meeting 10/22/13 o QA/QI Meeting 10/22/13 o Morning Clinical Review Team Meeting 10/21/13 o Annual IDT Meeting for Individual #241 and Individual #55 o Rights Assessment Meeting for Individual #111 o Pre-ISP Meeting for Individual #282 o ISPA regarding falls for Individual #47
	Facility Self-Assessment: SASSLC submitted its self-assessment updated 10/1/13. 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, however, did not complete the self-assessment for provisions I1 and I2. For provision I3, the facility looked at the high risk rating list to determine if risk action plans had been implemented within 14 days of ISP implementation. The facility found that while there were more plans in place, plans were still not in place to address high risk factors for all individuals. The facility self-rated each of the three provision items in section I in noncompliance. The monitoring team agreed.

	Summary of Monitor's Assessment: The statewide risk assessment procedure, with guidelines for rating risk, was in use at the facility. While good progress had been made on meeting substantial compliance, through an improved understanding of the risk process by IDTs, the facility was not in compliance with the three provisions in section I. The monitoring team saw some progress in section I in each of the three provision areas, and observed the risk identification process at two ISP meetings. • The facility was taking a more integrated approach to looking at risk. This was particularly evident at the two ISP meetings observed and at the morning clinical review meetings. • At both annual IDT meetings observed, the IDT held an integrated discussion regarding risk levels and supports needed to address risks identified. • The ISP/Risk identification process was much less fragmented. The IDTs observed discussed supports to address risks in terms of individual's preferences, strengths, and support needs. It was still evident that some important assessment information was not being collected and shared prior to the meeting that could contribute to team's ability to make informed decisions regarding appropriate interventions. Without adequate assessments completed prior to the meeting, it was difficult to make clinical determinations in regards to risks. Teams were not using the IHCP to track the completion of assessments and document resulting recommendations. 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 reviewing supports following a change in status, but failing to document when assessments were completed and recommendations were implemented. IHCPs were not found in individual notebooks, so staff working directly with individuals did not have access to action plans developed through the ISP process. 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. To move forward with section I: • The facility needs to continue to focus on ensuring that all relevant team members are present for meetings and that assessments are completed prior to the discussion of risks. • 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. • Plans should be implemented immediately when individuals are at risk for harm, and then monitored and tracked for efficacy. When plans are not effective for mitigating risk, IDTs should meet immediately and action plans should be revised.

#	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 (IHCP) 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. IHCPs were designed to provide a comprehensive plan to be completed annually and updated as needed. The monitoring team observed two IDT meetings using the new style ISP format and new risk rating forms. Significant progress towards developing an effective process to identify risks was observed in both meetings. IDTs were utilizing the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP). In both meetings, team members appropriately added information to the discussion regarding rationale for each risk rating. Overall, both teams engaged in good discussion and assigned appropriate risk ratings. Action plans were developed to address all medium and high risks. Progress was particularly evident in integrating the risk discussion into the overall discussion of each individual's preferences, strengths, and other support needs. 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. The submission of assessments and attendance at IDT meetings was a barrier to accurately identifying risks and support needs for individuals. A review of a sample of ISPs developed in the last six months supported the facility's own finding that assessments were not being submitted prior to annual ISP meetings in some cases. Zero (0%) of four individuals in the sample had all assessment recommended in the PSI completed at least 10 days prior to the annual IDT meeting. Without current assessment data available, IDTs cannot accurately assess risks. While progress had been made in the risk process, it will be imperative that relevant assessments are submitted prior to the annual IDT meeting and that all recommendations are integrated into the IHCP.	Noncompliance

#	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.	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 implemented, monitored, and revised when significant changes in individuals' health status and needs occurred. As noted in section F, data were often not consistently reviewed. This raised the question of whether or not IDTs were using data to identify when individuals might have a change of status that would require a change in supports to mitigate risk factors. At the ISP meeting for Individual #241, the IDT had identified that she was at risk for seizures. The team had referred her to the neurologist resulting in an adjustment to her medications and VNS settings. The team was unsure of the impact of those changes on the frequency of her seizures. Without having that information readily available, the team was unable to determine if further assessments were needed or if current supports were adequate. The monitoring team also attended the ISP meeting for Individual #55. His team had previously determined that he was at risk for weight loss when he fell under his ideal weight range. Supports were put into place to encourage weight gain. At the time of this annual ISP meeting, he was significantly overweight. The team failed to monitor and revise supports when his weight status changed. A careful review of data should be completed following changes in supports to evaluate the effectiveness of supports. IDTs should meet and revise supports immediately when the desired outcomes is not achieved. A sample of records was reviewed to determine if a determination of risk 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. Due to the lack of revisions made to the IRRFs when individuals experienced a change in status or hospitalization, the monitoring team was unable to determine what additional assessments were needed and/or conducted in response to the change of status. IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. Thus, it was not possible to determine if assessments were completed or if recommendations from assessments were incorporated into supports and tracked for efficacy. The monitoring team reviewed a sample of assessments from each discipline to determine whether or not an adequate assessment process was in place to address	Noncompliance

#	Provision	Assessment of Status	Compliance
		identified risk. Findings by discipline are summarized below, <u>Nursing</u> Based on a review of 12 records of which 11 had completed nursing assessments, IRRFs, and IHCPS. Seven of 11 (63%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individuals health care needs. <u>Medical</u> A total of 24 Annual Medical Assessments was reviewed. For that sample, 0 of 24 (0%) included any discussion related to medical risk factors. It was also clear that staff needed additional training on shifting the focus of management when risks transitioned into an actual diagnosis. This is discussed in further detail in section L1 and section N3. <u>Psychology</u> Based on a review of functional assessments, the functional assessments and PBSPs, although improved, have more work to be consistently comprehensive. Treatment integrity was collected for some, but not all individuals with PBSPs. <u>OT/PT</u> Based on a review of individual records (26) for whom assessments had been completed to address the individuals at risk conditions, 26 (100%) included an adequate PNMT and/or OT/PT assessment to assist the team in developing an appropriate plan. Although these assessments were adequate for identifying risks, it was not evident that assessments were completed prior to the development of IHCPs to address risks or that IDTs met following assessments to incorporate recommendations into the ISP/IHCP. It was not evident that assessments, particularly nursing and medical assessments, were adequate for identifying risk factors. IDTs were still not consistently documenting the completion of assessments and implementation of recommendations.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions	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. According to data provided to the monitoring team, plans were not in place to address risks for all individuals designated as high risk in specific areas. Data were not presented regarding plans to address medium risk categories. The following data were taken from the facility's self-assessment regarding individuals at high risk.	Noncompliance

#	Provision	Assessment of Status	Compliance

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.

Risk Category	# Rated High	# with Risk Action Plans in place	Previous Review Findings
Seizures	22	21/96%	88%
Dehydration	8	3/38%	63%
Aspiration	44	37/84%	89%
Polypharmacy	79	26/40%	19%
Diabetes	3	2/75%	80%
Circulatory	10	8/80%	78%
Hypothermia	2	1/50%	50%
Urinary Tract Infs.	7	87%	87%
Dental	120	97/81%	86%
Osteoporosis	33	21/64%	66%
Fractures	10	8/80%	50%

All ISPs in the sample included general strategies to address identified risks, but again, not all assessments were submitted prior to the determination of risk ratings, thus, it was unlikely that risk ratings were based on current data.

As noted in I2, IDTs were not yet using the IHCP to track the completion of assessments and document resulting recommendations. IDTs were not documenting when plans were implemented. Thus, it was not always possible to determine if IDTs implemented all recommendations from assessments within 14 days. For example,

- Individual #142's IHCP dated 2/7/13 included a recommendation for consultation with a cardiologist. His QIDP monthly reviews from April 2013 through July 2013 did not indicate that the consultation had been obtained. If the consultation was indeed obtained, the IHCP was not updated to reflect resulting recommendations. Additionally, the IDT had identified his risks for falls. He had an action statement to follow-up with habilitation therapy as needed. In March 2013, he sustained a serious injury due to a fall. The team did not document further assessment by habilitation therapy. In May 2013, after a series of falls, the IDT recommended a behavioral assessment to rule out falls as a result of behavior. There was no documentation to indicate that he obtained a behavioral assessment related to falls. In June 2013, following another series of falls resulting in another serious injury, the team recommended consultation with an orthopedists. There was no documentation that the team met to review recommendations from that consultation. In July 2013, the IDT recommended a consultation with his PCP regarding physical therapy. Again, there was no documentation that the team discussed resulting recommendations or implemented recommended changes in supports.

#	Provision	Assessment of Status	Compliance
		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. Many of the risk action plans in the sample reviewed did not include specific risk indicators to be monitored for all areas of risk. Risk action plans often referred to an ancillary plan in place or instructions were too general (e.g., monitor weights weekly, follow PNMP). Not all ancillary plans were integrated into the ISP, so staff did not have a comprehensive plan to monitor all supports. It was not evident that clinical data were gathered and reviewed at least monthly for all risk areas. A review was completed of individual notebooks in the homes and day sites to determine if staff had information needed to provide consistent supports to address risks. IHCP were not found in any (0 of 18) of the records reviewed. This concern was identified at the last review, as well. IHCPs should be considered an integral part of the ISP. Direct support staff will need to have access to current plans to ensure consistent implementation of the plan. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following: 1. Develop action plans with measurable criteria for assessing outcomes. 2. Ensure staff have access to the IHCP. 3. Document the implementation of action plans. 4. Document that clinical data is gathered and reviewed at least monthly. 5. Document action taken to revise supports when data indicates that current supports are not effective.	

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 inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations o Examples of MOSES and DISCUS examination for 10 different individuals, including the psychiatrist's progress note for the psychiatry clinic following completion of the MOSES and DISCUS examinations o A separate list of individuals being prescribed each of the following: anti-epileptic medication being used as a psychotropic medication in the absence of a seizure disorder; Lithium; tricyclic antidepressants; Trazodone; beta blockers being used as a psychotropic medication; Clozaril/Clozapine; Mellaril; Reglan o List of new facility admissions for the previous six months and whether a REISS screen was

	completed o Spreadsheet of all individuals (both new admissions and existing residents) who had a REISS screen completed in the previous 12 months o For five individuals enrolled in psychiatric clinic who were most recently admitted to the facility: 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 inservice training provided by psychiatrists and medical doctors to facility staff o Schedule of consulting neurologist o A list of individuals participating in psychiatry clinic who had a diagnosis of seizure disorder o Any quality assurance documentation regarding facility polypharmacy o Spreadsheet of all individuals designated as meeting criteria for intra-class polypharmacy, including medications in process of active tapering; and justification for polypharmacy o Facility-wide data regarding polypharmacy, including intra-class polypharmacy o For the last 10 <u>newly prescribed</u> psychotropic medications: Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication; signed consent form; PBSP; HRC documentation o For the last six months, a list of any individuals for whom the psychiatric diagnoses were revised,

	including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s) o List of all individuals age 18 or younger receiving psychotropic medication o Name of every individual assigned to psychiatry clinic who had a psychiatric assessment per Appendix B, with the name of the psychiatrist who performed the assessment, date of assessment, and the date of facility admission o Appendix B style evaluations for the following 10 individuals: • Individual #114, Individual #64, Individual #286, Individual #222, Individual #166, Individual #130, Individual #225, Individual #274, Individual #53, and Individual #147 o Documentation of psychiatry attendance at ISP, ISPA, BSP, or IDT meetings o A list of individuals requiring chemical restraint and/or protective supports in the last six months o Section J presentation book <u>Documents requested onsite:</u> o Five examples of nursing post sedation monitoring o For the last six months, any quality assurance results regarding nursing post sedation monitoring o For the last six months, sign in sheets and curriculum from nursing training regarding MOSES/DISCUS. o Proposed schedule of new neurologist. o PBSP regarding Individual #3. o For the last six months, psychiatry clinic documentation regarding psychotropic medication changes. o Data regarding the number of ISP meetings attended by psychiatry vs. the number of meetings held for the previous six months. o Data regarding the number of PBSP documents signed by psychiatry o All data presented, doctor's orders, and Dr. Luna's documentation for psychiatry clinic conducted 10/21/13 regarding the following individuals: • Individual #263, Individual #296, Individual #161 Individual #48, and Individual #17. o All data presented, doctor's orders, and Dr. Luna's documentation for psychiatry clinic conducted 10/22/13 regarding the following individuals: • Individual #87, Individual #264, and Individual #95 o Minutes from the ISP meeting held 10/24/133 regarding Individual #138 o These documents: o Demographic Data Sheet o Consent Section (last six months) o Individual Support Plan, ISPAs, and signature sheets (last six months) o Social History (most current) o Positive Behavior Support Plan and addendums o Psychological Evaluation and update o Human Rights Committee review of consent for psychotropic medication, pretreatment sedation, and BSP (most current) for the last six months o Restraint Checklists for the past six months

	o Suicide Risk Assessment for the last six months o Pretreatment Sedation Assessment-most current o Annual Physician's Summary, Evaluation, Physical Exam o Quarterly Medical Review o Active Medical Problem List o Hospital section for the previous six months o Electrocardiogram, laboratory, and X-ray results for the previous six months o Comprehensive Psychiatric Evaluation o Psychiatry clinic notes for the previous six months o MOSES/DISCUS examinations for the previous six months o Pharmacy Quarterly Drug Regimen Review for the previous six months o Consult section/Neurology Consults for the past year o Pharmacy Annual Evaluation o Physician's orders for the previous six months o Comprehensive Annual (most current) o Quarterly Nursing Assessment (most current) o Integrated progress notes for the previous six months o Annual weight graph o Seizure graph/Record (Active) last six months o Vital Sign Records for the past six months o Health Management Plan (most current) o Current list of all medications (MAR) o Safety Plan/Crises Plan o For the following individuals: • Individual #304, Individual #122, Individual #138, Individual #205, Individual #254, Individual #348, Individual #47, Individual #160, Individual #144, and Individual #57 <u>Interviews and Meetings Held</u>: o David V. Espino, M.D., Medical Director o Sharon M. Tramonte, Pharm. D., Lead Pharmacist and Nicole Cupples, Pharm. D. o Roseann Boyd, R.N., Nursing Operations Officer o Linda Fortmeier, D.N.P., F.N.P and Eileen Farber, M.D. o Charlotte Fisher, M.A., LPC-S, BCBA, Director of Behavioral Services o Sergio H Luna, M.D., facility psychiatrist; Samantha Denise Duran, R.N, psychiatric nurse; and Teresa Ann Valdez, psychiatry assistant o Alvydas Kukleris, DDS, facility dentist and Amy Jo Hush R.D.H. o Eileen Farber, M.D., facility psychiatrist <u>Observations Conducted</u>: o Dr. Luna's psychiatry clinic conducted 10/21/13 regarding the following individuals: Individual #263, Individual #296, Individual #161, Individual #48, and Individual #17. o Behavior Therapy Committee (10/21/13)

	o Morning Medical Meeting (10/22/13) o Pharmacy and Therapeutics Committee (10/23/13) o Dr. Luna's psychiatry clinic 10/22/13 regarding: Individual #87, Individual #264, Individual #95 o ISP regarding Individual #138 (10/24/13) o Polypharmacy Oversight Committee (POC) meeting (10/22/13) o Medical Staff Meeting (10/24/13) o Observation of individuals in various homes throughout visit
	Facility Self-Assessment: SASSLC continued to use the self-assessment format it developed for the last review. The facility rated itself as being in substantial compliance with six provision items: J1, J2, J11, 12, J13, and J15. The monitoring team agreed with three of these J1, J2, and J12. The monitoring team did not agree with the facility self-assessment regarding J11 because 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, however, given the ongoing challenges (e.g., lack of a monthly meeting, review of regimens as opposed to critical review) this provision was rated in noncompliance. The facility must ensure a thorough facility level review of polypharmacy regimens and appropriately justify polypharmacy for each individual meeting criterion in order to reach substantial compliance. The monitoring team did not agree with the facility self-assessment regarding J13 because, although 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, improvements were necessary with regard to the identification target symptoms and behavioral characteristics that would be monitored to assess the treatment's efficacy. There were noted issues with regard to making medication regimen adjustments in the absence of data reflecting the need for such. The monitoring team did not agree with the facility self-assessment regarding J15 because issues remained with regard to the referral of individuals to neurology clinic and with clinic follow-up, as well as adequacy of resources as evidenced by delays. In order to move toward substantial compliance, the facility must ensure adequate neurological resources, appropriate referral of individuals to neurology clinic, and ensure timely/annual clinic follow-up.
	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, there had been challenges due to a turnover in psychiatric clinic staff. The facility lead psychiatrist had left the facility and current 1 FTE was being provided via a temporary locum tenens physician. Currently, 65% of the facility population, 163 individuals, were receiving services via psychiatry clinic.

	The monitoring team observed two psychiatric clinics. Per interviews with psychiatrists and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QIDP, direct care staff, and the individual). A review of psychiatric documentation revealed improvements with timeliness of quarterly psychiatric medication reviews. During both clinics, there were reports that some individuals were experiencing increased behavioral challenges. These were 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 as evidenced by the fact that only 35% of comprehensive psychiatric evaluations per Appendix B had been completed. 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. 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 prior 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, provision J5 remained in noncompliance. The paucity of psychiatric resources was also reportedly the determining factor in other areas, specifically related to completion of comprehensive psychiatric evaluations (J6) and the implementation of informed consent practices via the prescribing practitioner (J14). There were several areas where the facility was able to achieve substantial compliance ratings (e.g., J1, J2, and J12).

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Qualifications and Experience The psychiatrists providing services at the facility were either board eligible or board certified in psychiatry by the American Board of Psychiatry and Neurology. One provider, board certified in general psychiatry was also board eligible in Child and Adolescent psychiatry. He had numerous years of experience providing assessment and treatment for individuals with developmental disabilities and had previously provided services at another SSLC. He was employed at SASSLC since 4/16/12. Since the last visit, the board certified psychiatrist, designated as lead psychiatrist, had terminated services as of 7/31/13. As such, the facility had engaged the services of a board eligible psychiatrist who began providing services as of 8/28/13. This provider planned to continue providing services through 12/15/13. This provider had years of experience in providing assessment and treatment to individuals with developmental disabilities, and had provided services at other SSLCs. Although the two psychiatrists were making advances with regard to 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 stability with regard to psychiatric physicians, additional psychiatry resources, as well as administrative and interdisciplinary support in order to move forward. Monitoring Team's Compliance Rating Based on the qualifications of the current psychiatric staff, this item was rated in substantial compliance. Psychiatry staffing, administrative support, and the determination of required FTEs will be reviewed in section J5.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible	Number of Individuals Evaluated At SASSLC, 163 of the 248 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 two 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	Substantial Compliance

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	psychiatrist.	discussion and documentation of the individual's history and presenting symptoms. The reviews observed during the visit were not geared toward a revision of diagnostic criteria and identification of the specific indications for the psychotropic medications. This would have been challenging in some cases, specifically due to deficits in data production. For example, in one clinic, the data presented for five individuals reviewed was seven weeks old, impeding the psychiatrist's ability to make data driven decisions. <u>Clinical Justification</u> The facility self-assessment noted there were 60/60 (100%) Quarterly Clinic Addendum-Treatment Plan Reviews done during 4/1/13 to 9/30/13 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. Per a review of 15 records, 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 the assigned DSM-IV diagnosis (reviewed in J11). <u>Tracking Diagnoses and Updates</u> 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. There were concerns regarding these data as of a total of 14 diagnosis changes, 11 justifications were designated as pending. • A good example was regarding Individual #114, for whom a diagnosis of psychotic disorder, not otherwise specified, was changed to schizophrenia, paranoid type, chronic. Per the written justification for this diagnostic change, "…appears to have symptoms consistent with this diagnosis including paranoid delusions, hallucinations, disorganized thinking and behavior…resulting in social dysfunction and persisting for more than six months." <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 for the next monitoring period. The completion of a Comprehensive Psychiatric Evaluation may actually be utilized in lieu of a quarterly evaluation if completed during the time frame 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 and turnover in providers.	

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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.	Treatment Program/Psychiatric Diagnosis 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 15 records, all had a psychiatric diagnosis noted in the record. 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 pharmacological interventions. As discussed in J2 above, observations did not include reviews of specific diagnoses, however, documentation in the "Quarterly Clinic Addendum-Treatment Plan Review" did review the documented diagnoses. An expansion of this review should include a routine review of non-pharmacological 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-IV 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. During this monitoring review issues related to data were noted. Specifically, during one clinic, the psychiatrist was provided with data that were approximately seven weeks old, making data driven decision-making impossible. In addition, it was noted that in many cases, the behaviors tracked via psychology did not relate to the determined diagnosis, again, making response to prescribed medication impossible to determine. 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 4/1/13 to 9/30/13 to confirm that justification was provided when single-agent chemical restraint was ineffective. This self-assessment practice was good to see and highlighted that no incidents required the use of multiple agents. 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.	Noncompliance

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		Emergency use of Psychotropic Medications The facility use of emergency psychotropic medication for individuals during periods of agitation/aggression/SIB (i.e., chemical restraint) had remained stable. During the prior monitoring period, there were a total of five incidents involving five different individuals. During this monitoring period, there were a total of five incidents involving three different individuals: Individual #304, Individual #95, and Individual #225. A review of the documentation regarding the five instances of chemical restraint revealed that in 60% of the examples provided by the facility, a psychiatrist's progress note regarding the incident was not included. During previous monitoring reviews, 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. Monitoring Team's Compliance Rating 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	Extent of Pretreatment Sedation There was a listing of individuals who received pretreatment sedation for either medical or dental clinic. 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. This listing from April 2013 through August 2013 indicated there were 47 instances of pretreatment sedation for dental clinic. The summary also included when TIVA was administered (TIVA is reviewed in section Q).	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.	Of the 47 administrations of pretreatment sedation, 31 were TIVA. Of all 47 administrations, 34 were for individuals currently participating in psychiatry clinic who were also administered a daily regimen of psychotropic medication and, therefore, were at risk for potential drug-drug interactions. No data were included regarding individuals receiving pretreatment sedation or TIVA for medical reasons. In the previous monitoring report, concerns regarding individuals receiving multiple pretreatment sedations were documented. Data reviewed for this monitoring period did not reveal individuals receiving numerous pretreatment sedations. For dental clinic, there were five individuals who received sedation twice during this period. Four of these individuals were participating in psychiatry clinic. It was not possible to determine if pretreatment sedation for medical interventions would have increased the incidence. <u>Interdisciplinary Coordination</u> 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. The 10 examples provided revealed consultative recommendations from primary care, psychiatry, and pharmacy. Give the information on the form itself, it was not possible to determine what the consensus recommendation was. Per staff report, the consensus recommendation was obtained during a review of the consultation during the morning medical meeting. This was not observed during this monitoring visit, as there were no pending consultations during this time. <u>Desensitization Protocols and Other Strategies</u> A list of all individuals with medical/dental desensitization plans and date of implementation were requested. Information provided indicated that there were six individuals with pending desensitization plans. This was echoed by the facility self-assessment, which indicated that six of 163 individuals (3%) receiving psychiatric services who required pretreatment sedation had a pending desensitization plan. Discussions with facility staff indicated that there had been no progress with regard to the development of desensitization plans outside of basic assessments performed by the dental clinic staff. 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.	

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		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. <u>Monitoring After Pretreatment Sedation</u> 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. <u>Monitoring Team's Compliance Rating</u> This item remains in noncompliance, in agreement with the facility self-assessment, as further effort must be made regarding the determination of the extent of pretreatment sedation for medical procedures, in the development of a clinical consultation process for medical pretreatment sedation similar to that utilized for dental clinic, and with regard to documentation of the consensus recommendations in both instances. Further, the facility must develop a continuum of individualized interventions from simple strategies to desensitization plans in an effort to reduce their reliance upon pretreatment sedation.	
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.	<u>Psychiatry Staffing</u> Approximately 65% of the census received psychopharmacologic intervention requiring psychiatric services at SASSLC as of 10/21/13. There were two FTE psychiatrists providing services, one of them via a contract with a locum tenens company. The two facility psychiatrists were scheduled to work 40 hours per week and were available after hours via telephone consultation. One psychiatrist currently employed at the facility was board eligible, the other was board certified in psychiatry. <u>Administrative Support</u> There was a full time psychiatry assistant and a full time psychiatric nurse. These staff, although enthusiastic and energetic, were experiencing difficulties due to the lack of a lead psychiatrist. The facility was reportedly in the process of attempting to recruit a full time psychiatrist for the lead position.	Noncompliance

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		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. Currently, one psychiatrist had a caseload of 102 individuals with the second, temporary psychiatrist, having a caseload of 61 individuals. Caseloads of this level did not allow for time to address completion of the Comprehensive Psychiatric Evaluations or to allow for regular attendance at ISP meetings. SASSLC should engage in an activity to determine the 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. If additional psychiatric resources are not available, the facility could consider midlevel providers (e.g., nurse practitioners). 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, this provision remained in noncompliance in agreement with the facility self-assessment.	
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 58 comprehensive psychiatric evaluations per Appendix B guidelines that were completed as of 8/29/13. Given that 163 individuals received treatment via psychiatry clinic, the vast majority of the individuals still required a comprehensive psychiatric assessment. It was noted that for individuals newly admitted to the facility (Individual #53 and Individual #254), there was documentation that Individual #53 had a completed comprehensive psychiatric evaluation within 30 days of admission. There was no completed comprehensive psychiatric evaluation located for Individual #254. There was a facility-specific policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" implemented 7/1/13. 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	Noncompliance

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		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 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 #114, Individual #64, Individual #286, Individual #222, Individual #166, Individual #130, Individual #225, Individual #274, Individual #53, and Individual #147. 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 level of functioning. Treatment recommendations inclusive of non-pharmacological interventions were included in the documentation, however, the examples generally did not include any other nonpharmacological interventions outside of the individual's PBSP. <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, in agreement with the facility self-assessment. Per interviews with the psychiatry clinic staff, there were plans to schedule 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 13 months.	
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	<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 two new admissions for the previous six months with both of these individuals being administered a Reiss screen within two weeks of admission. • One of the two newly admitted individuals had yet to receive a comprehensive	Noncompliance

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	each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	psychiatric evaluation (Individual #254). <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 248 with 163 individuals (66%) enrolled in psychiatry clinic. Therefore, 85 individuals were eligible for baseline Reiss screening. A listing of individuals who had received Reiss Screens included the names of all individuals residing at the facility. There were 76 individual's who had results "consistent with a mentally health individual." 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. Regardless, given that all individuals were represented, and there were scores for all individuals, although dates of screenings were not always included, it appeared that baseline screenings had been completed. In addition, data reviewed revealed that in two instances a "repeat" Reiss Screen had been performed due to change in status. Given the manner of presentation of the data, it was not possible to determine the outcome of the repeat" Reiss Screen (i.e., if it led to a comprehensive psychiatric evaluation). <u>Referral for Psychiatric Evaluation Following Reiss Screen</u> The referral and response process for psychiatric consultation following Reiss Screening was included in policy and procedure entitled, "SASSLC Psychiatry Clinical Services Policy." The procedure included a requirement for Reiss Screening of all new facility admissions, for a psychiatry clinic within 10 working days of admission for new admissions that have been identified as in need of psychiatric services, and for completion of a comprehensive psychiatric evaluation in Appendix B format within 30 calendar days of admission. The document does not address the use of the Reiss Screen for change of status, or referral to psychiatry due to a positive Reiss Screen due to a change in status. <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 monitoring review was improved in that it appeared that baseline screens had been completed. There were issues in that individual's newly admitted to the facility did not have a completed comprehensive psychiatric evaluation performed within 30 days as required by policy. In addition, there was no allowance for Reiss Screening or psychiatric referral due to change of status in policy. It was not possible to determine the outcome of the two instances where individuals received Reiss Screening due to changes 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 SSLC statewide policy and procedure dated 8/30/11 for psychiatry services had a title of "Integrated Care" summarizing that each state center must "develop and implement a system to integrate pharmacologic treatments with behavioral and other interventions through combined assessment and case formulation." There were, however, no specific procedural elements denoted for the IDT to follow, therefore, there were no written documents to guide the development and implementation of such a system to address this provision. The facility had a facility specific policy and procedure regarding psychiatry in effect dated 7/1/13, and this document did not specifically address a system to integrate pharmacological treatments with behavioral and other interventions; however, 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 two separate psychiatric clinics. Per interviews with psychiatry and psychology staff, as well as observation during psychiatry clinics, IDT members were attentive to the individual and to one another. There was participation in the discussion and collaboration between the disciplines (psychiatry, psychology, nursing, QIDP, direct care staff, and the individual). There was marked variability in the quality of data provided by psychology. In one clinic, data were current to the date of the clinic and graphed appropriately. In another clinical encounter, data were approximately seven weeks old, making data driven decision making impossible. When current data are provided, psychology must improve the description and analysis of the data and their assessment of what the presented data means, so that all members present have a good understanding. 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. The facility 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. Medication decisions made during clinic observations conducted during this onsite review were based on approximately 20 minute observations/interactions with the individuals, as well as the review of information provided during the time of the clinic. In the two psychiatry clinic observations, the psychiatrist met with the individual and his or her treatment team members during clinic, discussed the individual's progress with them, and discussed the plan, if any, for changes to the medication regimen. As stated repeatedly in this report, there was an IDT process	Noncompliance

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		within the psychiatry clinic with representatives from various disciplines participating in the clinical encounter. While this was a positive development, again, there was a need for improvement in the use of analyzed data with regard to making adjustments to the individual's psychotropic medication regimen. A review of the psychological and psychiatric documentation for 15 individual records did reveal case formulations that tied the information regarding a particular individual's case together, documented in the "Quarterly Clinic Addendum-Treatment Plan Review." There was clear documentation of the IDT process in psychiatry clinic as well as the use of information from other disciplines in the formulation of the individual's diagnosis. What made this process challenging was that in many cases, the "Quarterly Clinic Addendum-Treatment Plan Review" was the only case formulation available. This was due to the paucity of comprehensive psychiatric evaluations completed per Appendix B. Therefore, there were inconsistencies with regard to the implementation of a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. Case formulation should provide information regarding the individual's diagnosis, including the specific symptom clusters that led the writer to make the diagnosis, factors that influenced symptom presentation, and important historical information pertinent to the individual's current level of functioning. There was minimal discussion during the psychiatric clinics regarding results of objective assessment instruments being utilized to track specific symptoms related to a particular diagnosis. The use of objective instruments (i.e., rating scales and screeners) that are normed for this particular population would be useful to psychiatry and psychology in determining the presence of symptoms and in monitoring symptom response to targeted interventions. <u>Integration of Treatment Efforts Between Psychology and Psychiatry</u> The biggest challenges with regard to integration remained as outlined: • The presentation of behavioral data was not helpful in determination of the efficacy of the psychopharmacological regimen. • The deficiency in the completion of the collaborative case formulations for each individual enrolled in psychiatry clinic per Appendix B. • The need for the identification and implementation of non-pharmacological interventions specific to the individual's needs. • The current vacancy in the position of lead psychiatrist.	

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		Coordination of Behavioral and Pharmacological Treatments There was cause for concern with regard to some examples of rapid, multiple medication regimen alterations in the absence of data review to determine the effect of a specific medication change on the individual's symptoms or behaviors. The generally accepted professional standard of care is to change medication dosages slowly, one medication at a time, while simultaneously reviewing the data regarding identified target symptoms. In this manner, the psychiatrist can make data driven decisions with regard to medications, and the team can determine the need to increase or alter behavioral supports to address symptoms. This type of treatment coordination was not evident in the psychiatric clinics observed, or in the clinical documentation reviewed. Additionally, documents reviewed revealed a paucity of nonpharmacological interventions outside of the individual's PBSP. For example, Individual #304 had multiple medication regimen changes over the previous months: • 3/21/13 Propranolol increased to 20 mg three times daily • 3/29/13 Abilify started at 2 mg • 5/3/13 Propranolol increased to 30 mg three times daily • 6/25/13 Six physical restraints and one chemical restraint with Ativan 2 mg intramuscularly • 6/26/13 Clonazepam 0.5 mg in the morning due to anxiety • 7/17/13 Abilify increased to 5 mg • 7/17/13 Two physical restraints • 8/8/13 Risperdal started 0.5 mg twice daily • 8/9/13 Abilify decreased to 2 mg due to lack of effectiveness • 8/12/13 Risperdal increased to 1 mg twice daily • 8/30/13 Two physical restraints and one chemical restraint with Ativan 2 mg intramuscularly • 9/4/13 Lithium started at 300 mg three times daily • 9/4/13 Abilify discontinued • 9/18/13 Chemical restraint with Geodon 20 mg intramuscularly • 9/27/13 Risperdal increased to 1.5 mg twice daily Review of this individual's record revealed target symptoms for the specific medication documented by the psychiatrist, but documentation did not indicate a review of specific graphed data in order to determine benefit or the lack thereof due to a medication change outside of anecdotal information reported. The medication regimen alterations outlined above are concerning specifically given the multiple medications that have been trialed, the risk of side effects with the combination of medications, and the report that this individual experienced bradycardia (low heartbeat) due to propranolol requiring a dosage reduction.	

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		Monitoring Team's Compliance Rating The monitoring team agreed with the facility self-assessment that this provision remained in noncompliance. The monitoring team identified a paucity of combined assessment and case formulation, a lack of identification of non-pharmacologic treatment interventions outside of the PBSP, and a lack of coordination in behavioral and pharmacological 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. The data provided by the self-assessment were confusing in that it was noted that 70/70 (100%) PBSP documents were reviewed during psychiatry clinic. There were 163 individuals participating in psychiatry clinic, therefore, 42% of PBSP documents had been reviewed. 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. Documentation of psychiatric attendance at IDT, ISP, and PBSP meetings was reviewed. There were 47 meetings attended by psychiatry this review period, quite a reduction from 105 meetings attended two review periods prior. From the manner in which the data were presented, it was not possible to determine if these ISP meetings were held in psychiatry clinic or as a separate meeting. There were no 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 data relevant to this provision item.	Noncompliance

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		Treatment via Behavioral, Pharmacology, or other Interventions The example highlighted in J8 above outlined the continued problems of multiple medication regimen adjustments. Record review noted that the psychiatrists better documented the rationale for multiple and rapid medication adjustments, however, concern with regard to this practice remains. Many of the medication changes outlined in the case of Individual #304 were done in close temporal proximity to each other, which did not allow for the review of data to determine the benefit, or lack thereof, as a result of a specific regimen adjustment. 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. Therefore, this provision item was rated as being in noncompliance with the following comments: • The psychiatrists were not able to routinely attend annual ISP meetings because of time constraint, but reportedly focused their attention on individuals deemed high risk with frequent behavioral challenges. • 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.	
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	Policy and Procedure A review of DADS policy and procedure "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." The monitoring team was informed during the previous monitoring visit that	Noncompliance

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	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.	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, however, although facility policy had been updated to reflect changes, the statewide policy had not yet been adopted. Review of "SASSLC Psychiatry Clinical Services Policy" dated 7/1/13 revealed that prior to the initiation of a medication, the "New Psychotropic Medication Justification 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 28 new psychotropic medications were initiated for 17 individuals. The facility reported that 21/28 psychotropic medications were initiated on an emergency basis, therefore, only 25% of these prescriptions were begun with routine orders and procedure. Data provided for these 28 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 28/28 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 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	

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		with regard to the risk/benefit analysis and possible drug-drug interactions. • An example was Individual #147, prescribed Seroquel (Quetiapine) to treat intermittent explosive disorder inclusive of symptoms of "explosive outbursts, erratic behavior, assaultive behavior." The "New Psychotropic Medication Justification Form" mentioned this individual's history of treatment with the antidepressant medication Prozac (Fluoxetine) for similar indications with positive benefit. The form did not mention other medications prescribed for psychiatric indications, including Klonopin (Clonazepam) for aggression and agitation, and Depakote (Divalproex) for aggression and irritability. As discussed in J14, there were examples noted of "Psychiatry Department Consent for Use of Psychoactive Medication for Behavior Support." This document, generated by psychology staff, 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 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 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.	

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		Observation of Psychiatric Clinic 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 during 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 throughout the clinic and at times did not allow for their ongoing conversation with the IDT due to task of completing handwritten notes. Human Rights Committee Activities 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). Interviews with facility staff indicated that there had been some occasions where HRC had declined psychopharmacological interventions due to deficits in data. This was documented in the record of Individual #57. Issues with data are documented elsewhere in this report. Monitoring Team's Compliance Rating There was a need for assessment of whether the harmful effects of the individual's mental illness outweighed the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies were likely to be less effective, or potentially more dangerous, than the medications for all individuals prescribed psychotropic medications. The input of the psychiatrist and various disciplines must occur and be documented in order for the facility to meet the requirements of this provision item. 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 75% 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	

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		the clinical history. The facility should monitor the pattern of initiating emergency psychotropic orders and to ensure that the prescribing practitioner addresses the detailed elements required in the Risk-Benefit Analysis of the consent process. Given the issues outlined above, this provision will remain in noncompliance in agreement with the facility self-assessment.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	<u>Facility-Level Review System</u> The facility held the inaugural Polypharmacy Overview Committee (POC) meeting on 6/22/12. During this monitoring period, three committee meetings were held (5/2/13, 7/9/13, 8/12/13) plus one during the onsite review on 10/22/13. The self-assessment outlined that, as of 3/8/13, 134/175 (76%) individuals who received psychiatric services met criteria for being prescribed polypharmacy. These data were identical to those presented for the previous monitoring report, and had not been recalculated for the current monitoring period. The POC meeting was observed during the monitoring visit and consisted of a review of the pharmaceutical regimens of selected individuals. There was not a critical review of the regimens per se, rather a review of the current treatment and monitoring. Review of previous meeting minutes did not reveal documentation of the results of reviews of individual regimens, however, meeting materials provided during the monitoring visit revealed detailed information for each individual reviewed. During the observed meeting, it was concerning that several individuals treated with Lithium were experiencing issues with renal function. These individuals had not had routine annual 24-hour urine creatinine clearance examinations. Following this meeting, it was reported that this testing would be considered for individuals prescribed Lithium. <u>Review of Polypharmacy Data</u> Documentation presented during the Pharmacy and Therapeutics meeting 10/23/13 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 32. This was a decrease from 37 individuals reported in the previous monitoring period. • The total number of individuals residing at the facility prescribed three or more psychotropic medications was 66. This was a reduction from 81 individuals in the previous monitoring period. • 67% of the individuals prescribed psychotropic medications at SASSLC met criteria for polypharmacy. This percentage is the same as that noted during the previous	Noncompliance

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		monitoring review. • 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 (163) was provided to the monitoring team from the psychiatry department. 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.) 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 substantial 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., lack of a monthly meeting, review of regimens as opposed to critical review), this provision was rated in noncompliance. The facility must ensure a thorough facility level review of polypharmacy regimens and appropriately justify polypharmacy for each individual meeting criterion.	
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	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 April 2013 through September 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	Substantial Compliance

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	on the individual's current status and/or changing needs, but at least quarterly.	completion of the instruments over time and changes in scores requiring further clinical evaluation. The self-assessment indicated that 164/164 (100%) of individuals receiving psychiatric services had a MOSES and DISCUS scale completed on a quarterly basis from 4/1/13 to 9/30/13. In addition, it was reported the nurse from the psychiatry clinic had continued to review MOSES and DISCUS during clinics as defined by the policy for quality of clinical correlation in regards to potential psychotropic medication side effects. <u>Training</u> Per the response to the request for information regarding inservice training for facility nursing staff regarding administration of MOSES and DISCUS examinations, there was "no evidence for file" for both this review and the previous monitoring visit. Additional information requested onsite revealed that in May 2013, 13 nurses attended training regarding MOSES and DISCUS with regard to AVATAR. In a prior monitoring report, it was noted that an inservice training occurred 6/22/11 where 21 nurses attended. 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. <u>Quality of Completion of Side Effect Rating Scales</u> 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 all examples, clinical correlation was documented on the evaluation form inclusive of the conclusion regarding the presence or absence of a diagnosis of Tardive Dyskinesia. In the previous monitoring review, it was noted that the MOSES and DISCUS results historically included on the "Psychiatry Clinic" form, had been removed following a revision. During this monitoring review, it was noted that the previous MOSES/DISCUS scores were included on the "Psychiatry Clinic" form allowing for comparison of data from previous rating periods. Observation of psychiatry clinics performed during this monitoring period revealed the psychiatric physicians review of both the MOSES and DISCUS during the clinic encounter. Twenty-six individuals were noted to have the diagnosis of Tardive Dyskinesia (TD). This was an increase from 22 individuals identified in the previous monitoring report. 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). Twenty-seven individuals were prescribed Reglan and two (Individual #302, Individual #199) were diagnosed with Tardive Dyskinesia.	

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		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>Implementation of Avatar</u> In the intervening period since the last monitoring report, the facility had implemented the Avatar system. This was an electronic database where information including MOSES and DISCUS results could be stored. While this was a good step, there were issues with the Avatar system. Specifically, Avatar only allowed for inclusion of the basic form with ratings for each individual exam. It did not allow for documentation of the clinical review of the examination, nor did it allow for an electronic signature of the reviewer. As such, although the forms are uploaded into Avatar, the facility continued with paper documentation in order to allow for this. <u>Monitoring Team's Compliance Rating</u> Given the documentation of clinical correlation present on the MOSES/DISCUS forms, the ability to compare results from previous rating scales due to the documentation included in the "Psychiatry Clinic" note, the inclusion of MOSES/DISCUS review in the "Quarterly Clinic Addendum-Treatment Plan Review," and the review of these rating scales during psychiatry clinic, this provision will remain in substantial compliance in agreement with the facility self-assessment.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric	<u>Policy and Procedure</u> Per a review of the DADS statewide policy and procedure "Psychiatry Services," dated 8/20/11, "state centers must insure that individuals receive needed integrated clinical services, including psychiatry." Updated policy and procedure, while noted in facility specific policy, had yet to be fully implemented. "SASSLC Psychiatry Clinical Services Policy" dated 7/1/13 outlined the requirements for psychiatric practice consistent with statewide policy and procedure. The facility had implemented the "New Psychotropic Medication Justification Form," which included information, such as the medication dosage, indications, risk/benefit analysis, alternatives to treatment, symptoms/behavioral characteristics to be monitored, and the expected timeline for therapeutic effects to occur. Diagnoses were addressed in the quarterly clinic notes.	Noncompliance

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	symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	<u>Treatment Plan for the Psychotropic Medication</u> Per record reviews for 15 individuals, there were treatment plans for psychotropic medication included in the "Quarterly Clinic-Treatment Plan Review" documents. A review of documentation noted inclusion of the rationale for the psychiatrist choosing the medication (i.e., the current diagnosis or the behavioral-pharmacological treatment hypothesis). Other required elements including the expected timeline for the therapeutic effects of the medication to occur were included. One issue noted in records reviewed was the lack of consistency between diagnosis/medication and data points collected. For example, in the record of Individual #160, diagnoses including PTSD and Bipolar Mood Disorder, Type I were documented. This individual was prescribed medication including Zyprexa (an atypical antipsychotic medication), Lithium (a mood stabilizer), and Wellbutrin (an antidepressant medication). Per the psychiatric documentation, the "IDT does not see symptoms supporting this diagnosis" was noted for each diagnosis. This was concerning because this individual was prescribed three medications to address symptoms associated with these diagnoses. In addition, the presence or absence of symptoms would likely be anecdotally reported as current data collection focused on aggression and tantrum behaviors rather than the specific target symptoms outlined for the prescribed medications, which included "aggression, mood swings, flashbacks, and hallucinations." <u>Psychiatric Participation in ISP Meetings</u> The information for psychiatric participation in ISP meetings was summarized above 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 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, two 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 20-30 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.	

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		During clinic, the psychiatrist made attempts to review behavioral data. This was challenging in some instances, as data presented in one clinic were approximately seven weeks old. On the other hand, in the second clinic encounter, data presented were up to date and appropriately graphed. Review of 15 records revealed that in general, data were presented in a tabular format, which 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. In addition, psychiatry was conducting many clinics on a monthly basis. This was discussed with the providers during the monitoring visit. The facility was not adequately staffed with psychiatric practitioners to allow for regularly reoccurring monthly clinics. It was acknowledged that some individuals do require monthly visits due to the acuity of their illness, however, if medication changes are made, follow-up can wait until the next regularly scheduled quarterly clinic to allow for accumulation of data in order to determine the individual's response to the medication alteration. <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 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.	

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		Monitoring Team's Compliance Rating Per a review of the facility self-assessment, this provision was rated in substantial compliance. The monitoring team rated this provision in noncompliance. 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, however, improvements are necessary with regard to the identification target symptoms and behavioral characteristics that would be monitored to assess the treatment's efficacy. Given these deficiencies, the facility remained in noncompliance for this item.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	Policy and Procedure Per DADS policy and procedure "Psychiatry Services" dated 8/30/11, "State Centers must provide education about medications when appropriate to individuals, their families, and LAR according to accepted guidelines…State Centers must obtain informed consent (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures." In addition, it was reported that DADS was in the process of developing a statewide policy and procedure entitled "Consent for Psychotropic Medications." Per the facility policy and procedure entitled "SASSLC Psychiatry Clinical Services Policy" implemented 7/1/13, the procedure for prescribing psychotropic medication included: "Initiation of a new psychotropic medication on an emergency basis: 'New Psychotropic Medication Justification Form' will be filled out by the psychiatry provider…if there is a LAR the psychiatry provider will make attempts during clinic to reach the LAR for verbal consent. If unable to reach the LAR, the psychiatry provider will continue to make attempts outside of clinic hours…for at least five working days thereafter…attempts to reach the LAR need to be documented in the integrated progress notes…" Current Practices Per the facility self-assessment, 133/163 (82%) 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.	Noncompliance

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		A review of information provided regarding consent information for the last seven newly prescribed psychotropic medications revealed a document entitled "Consent for Use of Psychoactive Medication for Behavior Support." These documents named specific medications; however, it was noted that in some cases, multiple medications were included in a single consent form. In addition, side effects were listed, but per staff interview, psychology staff authored these. Signed consent forms included the signature of the LAR, but did not indicate the name of the individual providing the information regarding the risks, benefits, side effects, or alternatives to treatment with a particular medication. For newly prescribed medications, documentation also 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. This document did not include a listing of potential side effects of the medication, nor did include the names of other medications the individual was prescribed or potential drug-drug interactions. Monitoring Team's Compliance Rating Even though there were improvements, current facility practice was not consistent with generally accepted professional standards of care that require that the prescribing practitioner disclose to the individual (or guardian or party consenting to treatment) the risks, benefits, side effects, alternatives to treatment, and potential consequences for lack of treatment, as well as give the individual or his or her legally authorized representative the opportunity to ask questions in order to ensure their understanding of the information. This process must be documented in the record. This provision remained in noncompliance, in agreement with the facility self-assessment, due to the inadequate informed consent practices.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Policy and Procedure Per DADS policy, Psychiatry Services dated 8/30/11, "the neurologist and psychiatrist must coordinate the use of medications, through the IDT process, when the medications are prescribed to treat both seizures and a mental health disorder." Facility policy and procedure dated 7/1/13 included procedures for requesting a neurology consultation, and 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.	Noncompliance

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		Individuals with Seizure Disorder Enrolled in Psychiatry Clinic A list of individuals participating in the psychiatry clinic who had a diagnosis of seizure disorder included 68 individuals. Data provided via the facility self-assessment indicated eight individuals receiving psychiatric services were diagnosed with seizure disorder and were prescribed medications to treat both seizures and mental health symptoms. These data were confusing, and there were no additional data provided identifying these individuals. Issues regarding referral for neurology consultation remained. For example, Individual #47 was last seen in neurology clinic 10/30/12. This individual had a diagnosis of seizure disorder with a reported history of an abnormal EEG in 1994. There were eight reported seizures in the last year, she was prescribed a total of three anticonvulsants, and she wore a helmet to prevent head injury during seizure activity. At the time of the last neurology consultation, the anticonvulsant medication Keppra was tapered and replaced with the anticonvulsant medication Vimpat. Although Keppra was ultimately discontinued 12/27/12, this individual was not subsequently seen in neurology clinic. It was further concerning that in the intervening period since the last neurology consultation, the psychiatric physician adjusted this individual's Topamax dosage, an anticonvulsant medication utilized in this case for self-injurious behavior, resulting in two seizure episodes. The Topamax dosage was increased to previous levels as a result. Adequacy of Current Neurology Resources The neurologist was scheduled to evaluate individuals at SASSLC the second and last Tuesdays of every month starting at 10:00 am. The schedule from 5/8/13-9/24/13 included 6 neurology clinics (only one clinic in May, June, August, and September 2013, and two clinics in July 2013). Additional information presented revealed that the current consulting neurologist would conduct clinic at the facility once a month alternating with an epileptologist for a total of two neurology clinics monthly. A review of the document "Seizure Disorder Diagnosis Currently Receiving Psychiatric Services" included the date of the last neurology consultation for 68 individuals, but there were no data regarding the most recent neurology clinic evaluation provided for one individual. In other cases, notations such as "free since 1983" indicating that the individual was not currently experiencing seizure activity were present in seven instances. Thirty-four of the individuals [non-inclusive of the seven individuals with notations discussed above] had not been seen in neurology clinic in the previous year. One individual was last seen in 2005, one individual was last seen in 2008, three individuals were last seen in 2009, five individuals were last seen in 2010, seven individuals were last seen in 2011, and 17 individuals were last seen in 2012. Given these data, it was evident that additional	

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		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 68 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. <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. Issues remained with regard to the referral of individuals to neurology clinic and with clinic follow-up, as well as adequacy of resources as evidenced by the delays in review outlined above. Given these issues, this provision will remain in noncompliance, in disagreement with the facility self-assessment. In order to move toward substantial compliance, the facility must ensure adequate neurological resources, appropriate referral of individuals to neurology clinic, and ensure timely/annual clinic follow-up.	

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 #114 (6/25/13), Individual #53 (6/11/13), Individual #183 (6/18/13), Individual #310 (3/13/13), Individual #188 (6/28/13), Individual #259 (3/26/13), Individual #256 (5/22/13), Individual #13 (4/11/13), Individual #333 (5/13/13), Individual #304 (7/8/13) o Positive Behavior Support Plans (PBSPs) for: • Individual #114 (7/1/13), Individual #53 (7/1/13), Individual #183 (7/15/13), Individual #310 (3/13/13), Individual #188 (8/26/13), Individual #259 (5/13/13), Individual #256 (6/17/13), Individual #13 (7/15/13), Individual #333 (7/29/13), Individual #350 (7/15/13), Individual #304 (7/15/13), Individual #314 (5/29/13) o Annual Psychological updates for: • Individual #114 (6/25/13), Individual #53 (6/15/13), Individual #183 (6/18/13), Individual #188 (6/28/13), Individual #259 (3/26/13), Individual #256 (5/20/13), Individual #13 (4/11/13), Individual #333 (5/8/13), Individual #350 (8/12/13), Individual #310 (3/13/13) o Six months of progress notes for: • Individual #114 (7/1/13), Individual #53 (7/1/13), Individual #183 (7/15/13), Individual #310 (3/13/13), Individual #188 (8/26/13), Individual #259 (5/13/13), Individual #256 (6/17/13), Individual #13 (7/15/13), Individual #333 (7/29/13), Individual #350 (7/15/13), Individual #304 (7/15/13), Individual #314 (5/29/13) o Psychological treatment plans and progress notes for: • Individual #304, Individual #83, Individual #140, Individual #209, Individual #285, Individual #16, Individual #350, Individual #39, Individual #142 o Treatment integrity sheets for: • Individual #101, Individual #127, Individual #191, Individual #277, Individual #104, Individual #214, Individual #324, Individual #34 o IOA and data collection reliability sheets for: • Individual #234, Individual #265 o PBSP readability scores (Flesch-Kincaid) for: • Individual #256, Individual #55, Individual #43, Individual #22, Individual #183, Individual #128, Individual #282, Individual #350, Individual #240, Individual #114 o IOA schedule and data collection monitoring schedule, undated o List of individuals with a crisis intervention plan, 9/13 o List of all individuals with a functional assessment and PBSP (including date of most recent revision/plan), undated

	o Status of enrollment in BCBA coursework for each staff member that writes PBSPs, undated o For the past six months, minutes from meetings of the behavioral health department o Internal and external peer review minutes from April 2013 to September 2013 o SASSLC self-assessment, 10/7/13 o SASSLC action plans, 10/7/13 o Section K presentation book, undated o A list of all individuals receiving psychological services other than a PBSP, undated o QA/QI meeting agenda, 10/22/13 o Interobserver agreement and data integrity data sheet o Target behavior documentation from 4/1/13-8/5/13 o List of individuals most recent psychological assessment, undated <u>Interviews and Meetings Held</u>: o Charlotte Fisher, BCBA, Director of Behavioral Health Services o Melanie Rogers, BCBA, Behavior Analyst o Mark Boozer, BCBA, Behavior Analyst o Juan Villalobos, Unit I Director; David Ptomey, Unit II Director; Annette Longoria, Unit III Director <u>Observations Conducted</u>: o Behavior Therapy Committee (BTC) Meeting • Individuals presented: Individual #144, Individual #77, and Individual #160 o Internal Peer review • Individual presented: Individual #130 o Psychiatric Clinic meeting (10/21/13): • Psychiatrist: Dr. Luna • Individuals presented: Individual #296, Individual #161 o Psychiatric Clinic meeting (10/22/13): • Psychiatrist: Dr. Luna • Individual presented: Individual #95 o Observation of IOA and data collection reliability on PBSPs for: • Individual #234, Individual #265 o QA/QI meeting
	Facility Self-Assessment: The self-assessment included relevant activities in the "activities engaged in" sections. The self-assessment appeared to be based 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 behavioral health 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 behavioral health 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, K7, and K11. The monitoring team's review of this provision was congruent with the facility's self-assessment. 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 suggests 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: SASSLC did not achieve substantial compliance for any additional items since the last review. The facility, however, maintained substantial compliance on the four items (K2, K3, K7, and K11) that were in substantial compliance prior to this review. Some improvements since the last review include: • Development of a schedule for collecting data collection reliability, interobserver agreement (IOA) and treatment integrity data based on the severity and frequency of the target behavior (K4/K10) • Establishment of minimum levels of data collection reliability, IOA, and treatment integrity (K4/K10) • Evidence that the individual books containing target and replacement data sheets were more accessible to direct support professionals (DSPs) (K4) • Consistent use of simplified graphs of target behaviors (K4) • Evidence that in those instances when an individual was not making expected progress, the progress note consistently indicated that some activity to address the lack of progress had occurred (K4) • Improvements in the quality of the functional assessments (K5) • Improvements in the comprehensiveness of psychological services other than PBSPs treatment plans (K8) The areas that the monitoring team suggests that SASSLC work on for the next onsite review are: • Ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors (K4) • Consistently collect and graph replacement behavior (K4/K10) • Ensure that the collection of data collection reliability, IOA, and treatment integrity measures are consistent across all staff (K4/K10)

	• Demonstrate that goal frequencies and levels of data collection reliability, IOA, and treatment integrity are achieved (K4, K10) • Ensure that current data are consistently available and graphed at interdisciplinary meetings to ensure that data based decisions are made (K4) • Ensure that all functional assessments contain hypothesized antecedents to target behaviors and hypothesized consequences of target behaviors (K5) • Ensure that all psychological services other than PBSPs treatment plans contain a plan to generalize skills learned, and that all progress notes reflect specific treatment objectives (K8) • Ensure that PBSPs are consistently implemented within 14 days of receiving consent (K9) • Ensure that PBSPs contain replacement behaviors that are functional, or an explanation why functional replacement behaviors are not possible or impractical (K9)

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item was rated as being in noncompliance because, at the time of the onsite review, not all of the staff at SASSLC who wrote Positive Behavior Support Plans (PBSPs) were certified as board certified behavior analysts (BCBAs). At the time of the onsite review, three (38%) of the eight staff that wrote PBSPs were BCBAs. This is the same number of BCBAs reported in the last review. Additionally, seven of eight staff that wrote PBSPs (88%) were either enrolled, or completed coursework, toward attaining a BCBA. This was similar to the last review when 82% of the staff that wrote PBSPs were either enrolled in, or completed, BCBA coursework. The facility should ensure that all psychologists that write PBSPs have BCBAs. The director of behavioral health services was certified as a behavior analyst, and was providing supervision to the psychologists enrolled in BCBA coursework. SASSLC and DADS are to be commended for their efforts to recruit and train staff to meet the requirements of this provision item. The facility developed a spreadsheet to track each psychologist's BCBA training and credentials.	Noncompliance
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 behavioral services had a master's degree in psychology, was a certified applied behavior analyst (BCBA), 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

#	Provision	Assessment of Status	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 continued to be in substantial compliance with this provision item. SASSLC continued its weekly internal, and monthly external, peer review meetings. The internal peer review meetings provided an opportunity for staff to present new cases or those that were not progressing as expected. The internal peer review meeting observed by the monitoring team reviewed Individual #130's functional assessment and PBSP. The peer review meeting included active participation from all of the department's behavior analysts and behavioral health specialists, and appeared to result in some additional strategies to address Individual #130's target behaviors. Review of minutes from internal peer review meetings indicated that the majority of staff that wrote PBSPs regularly attended peer review meetings. Additionally, meeting minutes from the last six months indicated that internal peer review meetings occurred in 22 of the last 24 weeks (92%), and that once in each of the last six months, these meetings included a participant from outside the facility, therefore, achieving the requirement of monthly external peer review meetings. Finally, there was evidence of the implementation of recommendations made in peer review. Operating procedures for both internal and external peer review committees were established, and were consistent with this provision item. In order to maintain substantial compliance, SASSLC needs to provide documentation that internal peer review occurs during at least 80% of the weeks reviewed, external peer review occurs during at least 80% of the months reviewed, and there is evidence of follow-up/implementation of recommendations made in peer review.	Substantial Compliance
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	The monitoring team noted progress in this area. More work, discussed in detail below, is necessary before this provision item can be judged to be in substantial compliance. The facility continued to utilize 30-minute target behavior data collection in all residential and day programming sites. In this data collection system, direct support professionals (DSPs) were required to record a zero in each recording interval if target behavior 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 staff that write PBSPs to review data sheets and determine if DSPs were recording data in a timely manner (e.g., every 30 minutes).	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	SASSLC conducted data collection reliability, and provided performance feedback to DSPs. The facility reported that from April 2013 to August 2013 target data were recorded within the previous interval for 49% of the data sheets sampled. 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 two of 14 data sheets reviewed (14%) were completed within the previous 30 minutes. This was considerably lower than the data collection reliability reported by the facility, and represented a substantial decrease from the last review when 45% of data sheets reviewed by the monitoring team were completed within 30 minutes of the behavior occurring. These observations indicated that DSPs were not consistently recording target behaviors. This is a serious problem because if the DSPs are not accurately recording data, the psychologists cannot evaluate the effects of their interventions. One likely reason that the facility's data collection reliability scores were discrepant from those of the monitoring team is differences in how data collection reliability was measured. The monitoring team simply reviewed data sheets, and noted if data were completed for the previous interval. When the monitoring team observed a SASSLC staff conduct data collection reliability, however, she recorded the data as timely if the DSP recorded the behavior correctly following her request to document the interval. This inconsistent measure of data collection reliability likely contributed to the overall poor data collection reliability because DSPs were receiving inconsistent feedback concerning when data needed to be recorded. It is recommended that the department retrain the staff on the collection of data collection reliability to ensure that all measures are consistent. Another possible explanation of the poor data collection reliability is the inflexibility of the data system. Several of the target behaviors reviewed by the monitoring team were occurring at very low rates, resulting in DSPs needing to record data every 30 minutes that typically only occurred daily or a few times a week. For target behaviors occurring at low rates, intervals longer than every 30 minutes would appear to capture the behavior, and reduce the unnecessary recording requirements on DSPs. 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 for improving the accurately and usefulness of the data. 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.	

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		One improvement in this area is that the individual notebooks, containing the target and replacement behavior data sheets, appeared to be more accessible to DSPs. In the last review, the monitoring team noted that the majority of individual notebooks were kept behind locked doors. During the current review, several homes that had the individual notebooks behind locked doors (e.g., home 668), were now placing the individual notebooks in carts on the unit floor. Some homes (e.g., home 766), however, continued to maintain the individual notebooks behind locked doors. In order to improve data collection reliability, it is recommended that SASSLC ensure that data sheets are consistently accessible to DSPs so that they can record target and replacement behaviors as soon as possible after they occur. The monitoring team found only five of 14 individual records (36%) reviewed contained data sheets (or replacement behavior skill acquisition plans) that included replacement behaviors. Although this represented an improvement from the last review when only 10% of records reviewed contained replacement data sheets or SAPs, it is important that all individuals have replacement data collected. The facility is urged to ensure that replacement behavior data are collected for all individuals with a PBSP. 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 and reported from 4/1/13 to 8/5/13 it averaged 95%. Another improvement since the last review is that SASSLC recently established minimum frequencies for the collection of data collection reliability and IOA (i.e., how often it is collected) based on the severity and frequency of the target behavior. Additionally, the facility identified minimal data collection reliability and IOA levels (i.e., what are acceptable scores) at 90%. The level of IOA reported by the facility is encouraging, however, at the time of the onsite review, IOA was not being assessed at SASSLC's established frequency. At this point, it is recommended that the facility ensure that the established minimal frequencies and levels of data collection reliability and IOA are achieved. All of the graphs of target behaviors observed by the monitoring team were simplified (i.e., reduced number of data paths and addition of phase lines to mark medication changes and/or other potentially important events). This represented another improvement from the last review when the monitoring team encountered some graphs in PBSPs that were very difficult to interpret because they included several target behaviors and/or medication dosages on the same graph. Finally, although the monitoring team encountered a few graphs of replacement behaviors (e.g., Individual #281), none of the PBSPs reviewed included graphs of replacement behaviors. It is recommended that replacement behaviors be graphed for all individuals with PBSPs.	

#	Provision	Assessment of Status	Compliance
		The routine use of data to make treatment decisions was mixed. In a psychiatric clinic for Individual #95, observed by the monitoring team, the psychologist presented graphs that were current, clearly indicated when important environmental events occurred, and were simple to understand. The clear and current graphs contributed to a very productive discussion by Individual #95's team, and to data based decisions concerning her use of medications. In another psychiatric clinic observed (i.e., for Individual #296), simplified graphs of target and replacement behaviors were presented and discussed, however, the graph did not include the last six weeks of data. In order to achieve substantial compliance with this provision item, SASSLC needs to ensure that all treatment decisions are data based. Specifically, the facility needs to demonstrate the value of data by ensuring it is current and reliable, and consistently graphing and presenting data in increments that encourage data based treatment decisions. In reviewing PBSP data in 12 individuals' progress notes, six (50%) indicated a lack of progress in at least one severe target behavior (i.e., Individual #259, Individual #114, Individual #53, Individual #310, Individual #304, and Individual #350). This was the same as the last review when 50% of PBSPs reviewed indicated a lack of progress. An area of improvement for the facility is the documentation of action taken to address the lack of progress. For five of the six individuals (Individual #53 was the exception) for whom there was no obvious progress in severe target behaviors (83%), the progress notes clearly documented specific staff actions to address the absence of target behavior change. Additionally, the monitoring team encountered several PBSPs (e.g., Individual #304, Individual #350) that were modified prior to the annual review due to the absence of progress. It is recommended that in those instances when an individual is not making expected progress, that the progress note consistently indicates that some activity (e.g., retraining of staff, modification of PBSP) had occurred. There is much work needed, discussed in detail above, to ultimately achieve substantial compliance with this provision item. Over the next six months, however, it is recommended that SASSLC focus on improving the practicality and reliability of their data system. Specifically, the facility should ensure that the data system is flexible enough to incorporate the most appropriate measure of an individual's target and replacement/alternative behaviors. The data system should also ensure that replacement behaviors are collected and graphed for all individuals with PBSPs. Additionally, the facility needs to review the data collection reliability and IOA collection procedures to ensure they are consistent across the facility, and that goal frequencies and levels are achieved. Finally, it is recommended that SASSLC ensure that all treatment decisions are data based.	

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K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	This provision item was rated as being in noncompliance due to the absence of full psychological assessments for each individual, and at least 85% of the functional assessments reviewed were not comprehensive. <u>Psychological Assessments</u> The director of behavioral health services 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. <u>Functional Assessments</u> A list of functional assessments and PBSPs indicated that all individuals with a PBSP had a functional assessment. Additionally, 169 of the 176 individuals with a PBSP (96%) had current (i.e., revised/reviewed within one year) functional assessments. This is similar to the last review when 95% of individuals with PBSPs that had current functional assessments. A list of all functional assessments indicated that 100 were completed since the last review. Ten of those functional assessments (10%) were reviewed to assess compliance with this provision item. As found in the last review, 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 appropriate indirect assessment procedures. Nine of the functional assessments reviewed (90%) utilized direct assessment procedures that were rated as complete. This represented an improvement from the last two reviews when 62% and 64% of direct observations were rated as complete. An example of a complete direct assessment procedure was:	Noncompliance

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		• Individual #310's functional assessment described direct observations of her engaging in self-injurious behavior (SIB) that resulted in enhanced supervision and increased staff attention. This direct observation suggested that Individual #310's SIB likely functioned as a way for her to attain staff attention. The one direct functional assessment judged as incomplete (i.e., Individual #333) included direct observations, but none of those observations included an example of the target behaviors (it did include observations of SIB and property destruction, however these were not listed as target behaviors). Therefore, this direct observation procedure did not provide any additional information about relevant antecedent or consequent events affecting the target behaviors. 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 can 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. Eight of the 10 functional assessments reviewed (80%) identified potential antecedents and consequences of the undesired behavior. One of the two remaining functional assessments reviewed (i.e., Individual #114) included antecedents that appeared to be precursors to the target behavior (e.g., squinting his eyes, focusing on things that are present). Additionally, both Individual #114 and Individual #183's functional assessments appeared to include consequences that were interventions from the behavior support plan (e.g., verbal redirection, keep Individual #183 safe and at a distance from others). 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., attaining staff attention, escaping demands, obtaining tangible items).	

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		As discussed in the last report, when comprehensive functional assessments are conducted, there are going to be some variables identified that are determined to not be important in affecting the individual's target behaviors. An effective functional assessment needs to integrate these ideas and observations from various sources (i.e., direct and indirect assessments) into a comprehensive plan (i.e., a conclusion or summary statement) that will guide the development of the PBSP. All 10 of the functional assessments reviewed (100%) included a clear summary statement. This represented an improvement from the last review when 91% of the functional assessments reviewed were judged to have a clear summary statement. Overall, seven (i.e., Individual #13, Individual #256, Individual #259, Individual #188, Individual #53, Individual #310, and Individual #304) of the 10 functional assessments reviewed (70%) were evaluated to be comprehensive and clear. This represented an improvement from the last review when 55% of the functional assessments were determined to be complete. SASSLC made progress in this provision item. It is recommended that, over the next six months, the facility focus on ensuring that all functional assessments contain hypothesized antecedents to target behaviors and hypothesized consequences of target behaviors.	
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 behavioral health services, 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, 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	SASSLC continued to be in substantial compliance with this provision item. In addition to full psychological assessments, SASSLC completed annual psychological updates. A spreadsheet provided the monitoring team indicated that current (i.e., reviewed/revised at least every 12 months) annual psychological updates were completed for 243 of the 248 individuals (98%) currently residing at the facility. A spreadsheet indicated that 135 annual psychological updates were completed in the last six months, and 10 (7%) of these were reviewed by monitoring team to assess their comprehensiveness.	Substantial Compliance

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	standard psychological assessment procedures.	All 10 of the annual psychological updates reviewed (100%) were complete and contained a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status. Additionally, psychological assessments should be conducted within 30 days for newly admitted individuals. A review of recent admissions to the facility indicated that the one individual admitted to the facility in the last six months had a psychological assessment within 30 days of admission. In order to maintain compliance with this item of the Settlement Agreement, at least 90% of the individuals at the facility will need to have an annual psychological update, and at least 85% of those assessments will need to be judged as complete (i.e., contain a standardized assessment of intellectual and adaptive ability, a review of personal history, a review of behavioral/psychiatric status, and a review of medical status). Additionally, at least 85% of individuals admitted to the facility in the last six months will need to have a psychological assessment completed within 30 days of admission.	
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.	Although there were improvements, the monitoring team did not believe this item was in substantial compliance because the treatment plans for psychological services other than PBSPs did not include procedures/plans to generalize skills learned, and the progress notes did not appear to be related to the objectives. Psychological services other than PBSPs were provided for nine individuals at SASSLC. Therapists outside of the facility provided counseling services to all of these individuals. Treatment plans and progress notes were reviewed for all nine individuals (100%) to assess compliance with this provision item. The treatment plans reviewed included the following: • A plan of service • Goals and measurable objectives • Qualified staff (i.e., psychologists with a degree in counseling) providing the services • A "fail criteria" that will trigger a review and revision of interventions to ensure that services do not continue if objective are not achieved This represented an improvement from the last review when measurable objectives and a fail criterion were absent from all plans reviewed.	Noncompliance

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		Over the next six months it is recommended that SASSLC ensure that each treatment plan have procedures/plans to generalize skills learned, and progress notes that are related to the objectives. In order to achieve substantial compliance with this provision, the facility will need to demonstrate that at least 85% of psychological services other than PBSPs contain the following: • A treatment plan that includes an initial analysis of problem or intervention target • Services that are goal directed with measurable objectives and treatment expectations • Services that reflect evidence-based practices • Services that include documentation and review of progress • A service plan that includes a "fail criteria"— that is, a criteria that will trigger review and revision of intervention • A service plan that includes procedures to generalize skills learned or intervention techniques to living, work, leisure, and other settings Additionally, the facility needs to document the need for these services and that individuals that would benefit from these services receive it.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	This provision item was rated as being in noncompliance because PBSPs were not documented to be consistently implemented within 14 days of receiving consent, and at least 85% of the PBSPs were not comprehensive. A list of individuals with PBSPs indicated that 176 individuals at SASSLC had PBSPs, and all of these (100%) were current (i.e., reviewed/revised at least every 12 months). This is similar to the last review when 96% of PBSPs were current. As reported in the last review, all PBSPs had the necessary consent and approvals. There was, however, no documentation that PBSPs were implemented within 14 days of receiving consent. SASSLC should ensure that PBSPs are implemented within 14 days of receiving necessary approvals and consents. One hundred and six PBSPs were completed since the last review, and 12 (11%) of these were reviewed to evaluate compliance with this provision item. As found in the last review, all PBSPs reviewed (100%) included operational descriptions of target and replacement behaviors. Additionally, all 12 of the PBSPs reviewed (100%) described antecedent and consequent interventions to weaken target behaviors that appeared to be consistent with the stated function of the behavior and, therefore, were likely to be useful for weakening undesired behavior. This is an improvement from the last review when 92% of the PBSPs reviewed were judged to be consistent with the	Noncompliance

#	Provision	Assessment of Status	Compliance
		stated function. Replacement behaviors were included in 11 of the 12 (92%) PBSPs reviewed (Individual #188's PBSPs was the exception). This represented a decrease from the last review when 100% of the PBSPs reviewed included replacement behaviors. All PBSPs should include replacement behaviors. Replacement behaviors should be functional (i.e., they should represent desired behaviors that serve the same function as the undesired behavior) when practical and possible. An example of a functional replacement behavior was: • Individual #114's PBSP hypothesized that one function of his physical aggression and SIB was to escape or avoid undesired requests or activities. His PBSP included a replacement behavior of communicating to staff that he wanted to be left alone. The monitoring team found that in two (i.e., Individual #13, and Individual #310) of the 11 PBSPs reviewed with replacement behaviors (18%), replacement behaviors that could be functional were not functional. This is similar to the last report, when 17% of replacement behaviors that could be functional were not functional. An example of a replacement behavior that was not functional was: • Individual #13's PBSP hypothesized that his physical aggression was maintained by negative reinforcement (i.e., escape or avoidance of undesired activities). His replacement behavior was to use sign language to attain a drink or to eat. A replacement behavior to learn to communicate one's desires can be a very effective replacement behavior if it matches the hypothesized function of the target behavior. In Individual #13's PBSP, however, the communication training appeared to be restricted to requesting drinks and edibles, while his PBSP indicated he engaged in aggression to escape undesired requests or activities. In order to be functional, Individual #13's replacement behavior could be extended to reinforcing him for signing that he wanted a break, or to leave the area. In some situations teaching an individual an appropriate way to attain desires may not be practical (e.g., escaping necessary medical demands). In those cases it is important that the PBSP indicate why a functional replacement behavior is not practical. 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.	

#	Provision	Assessment of Status	Compliance
		Finally, in 10 of the 11 PBSPs reviewed (91%), the reinforcement of replacement alternative behaviors was included in the PBSP. In the one exception (i.e., Individual #53's PBSP) her replacement behavior was listed (i.e., asking to postpone a task), but how staff would train or reinforce the replacement behavior was not explained. The reinforcement of functional replacement behaviors should be included in the all PBSPs. Overall, eight (Individual #333, Individual #256, Individual #259, Individual #114, Individual #183, Individual #314, Individual #304, and Individual #350) of the 12 PBSPs reviewed (67%) represented examples of comprehensive 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 decrease from the last review when 83% of the PBSPs reviewed were judged to be acceptable. Over the next six months it is recommended that the facility document that PBSPs are consistently implemented within 14 days of receiving consent. Additionally, SASSLC should ensure that all PBSPs have functional replacement behaviors, or explain why functional replacement behaviors are not practical or possible.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	There were improvements in this provision item, however, it was rated as being in noncompliance because of the reasons discussed below. At the time of the onsite review, SASSLC was the collecting IOA. As discussed in K4, the facility recently established minimum frequencies for the collection of IOA integrity (i.e., how often it is collected) based on the severity and frequency of the target behavior. Additionally, the facility identified minimal IOA levels (i.e., what are acceptable data collection reliability scores) at 90%. The facility reported that from 4/1/13 to 8/5/13 IOA averaged 95%. The director of behavioral services, however, indicated the frequency of IOA collection had not been consistent with the facility's established goal. It is now recommended that the facility demonstrate that their goal frequency of IOA collection is attained. All of the DSPs 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 established minimum frequencies for the collection of treatment integrity (i.e., how often it is collected) based on the severity and frequency of the target behavior. Additionally, the facility identified minimal treatment integrity levels (i.e., what are acceptable data collection reliability scores) at 90%. The facility reported that	Noncompliance

#	Provision	Assessment of Status	Compliance
		from 4/1/13 to 8/5/13 treatment integrity averaged 79%. The director of behavioral health services indicated that, like IOA, the frequency of treatment integrity collection had not been consistent with the facility's established goal. It is now recommended that the facility demonstrate that their goal frequency and level of treatment integrity is achieved. 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 behavioral health services specialist/assistant observed the DSP implementing the plan. A review of eight completed treatment integrity data sheets, however, indicated that four (50%), did not include the direct observation component. It is recommended that the facility ensure that all treatment integrity sessions include an observation of DSPs implementing the PBSP. Target behaviors were consistently graphed. All of the graphs reviewed contained horizontal and vertical axes and labels, condition change lines/indicators, data points, and a data path. The monitoring team, however, only found a few examples of graphed replacement behaviors (see K4). It is recommended that replacement behaviors be graphed for all individuals with PBSPs.	
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. Therefore, SASSLC continued to be in substantial compliance with this provision item. The behavioral health services department reviewed all PBSPs that were presented in peer review and the Behavior Therapy Committee to ensure that they were simple, clear, and written in a style that would promote staff understanding. The monitoring team reviewed 12 PBSPs written in the last six months and concluded that they were written in a manner that DSPs were likely to understand. The PBSPs reviewed were consistently brief and concise, contained a minimal number of target behaviors (the monitoring team's sample averaged 3.8 target behaviors per PBSP reviewed), and technical language appeared to be kept at a minimal. As an objective measure of the readability of PBSPs, SASSLC monitored the reading level (using the Flesch-Kincaid Readability score) of a sample of PBSPs written in the last six months and determined that they averaged a 7.9 reading level. Finally, the monitoring team also asked several DSPs across all treatment sites if they could understand the PBSPs, and all DSPs indicated that the plans were simple, clear, and easy to understand.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
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. Behavioral health specialists and behavior analysts conducted the trainings prior to PBSP implementation and whenever plans changed. No trainings of staff on a PBSP occurred during the onsite visit, therefore, the monitoring team could not observe the training of DSPs on individual PBSPs. During past reviews, however, trainings were found to be thorough and included a review of the PBSP by a member of the behavioral health services department, an opportunity for DSPs to ask questions covering varying aspects of the PBSP, and written questions pertinent to each individual's PBSP. The facility indicated that they maintained inservice logs on all staff training. They reported, however, that float staff were inserviced by the residential staff and they did not know the method used to train these staff. 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 for every 30 individuals, and one psychology assistant for every two BCBAs. At the time of the onsite review, SASSLC had a census of 248 individuals and employed three behavior analysts and five behavioral health specialists responsible for writing PBSPs. Additionally, the facility employed five psychology assistants, and one psychology technician. In order to achieve compliance with this provision item, the facility must have at least nine behavior analysts (i.e., staff with BCBAs).	Noncompliance

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Health Care Guidelines, May 2009 o DADS Policy #009.2: Medical Care, 5/15/13 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, rev 5/13 • Anaphylaxis Protocol, 12/11 • Bowel Management, 10/10, 3/4/13 • Guidelines on management of Antibiotic Associated Diarrhea and Clostridium difficile Infection, rev 2/6/13 • Bone Health Guidelines, 5/10/13 • Seizure Management, 5/301/13 • Urinary Tract Infection Guidelines, 12/11, 8/29/13 • Anticoagulant Therapy Interdisciplinary Protocol, 3/12/12 • Diabetes Mellitus and Healthcare Guidelines, 3/4/13 • IID Guidelines, 7/1/13 • Lab Matrix o SASSLC Facility Medical Services Policy, 12/28/11, revised 3/4/13 o SASSLC Pneumonia Review Committee, 4/10/12 o SASSLC Medical Continuous Quality Improvement Committee, 4/17/12 o Medical Services Departmental Policy on Integration of Clinical Services, 9/1/12 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 External Clinic Tracking Log o Internal Clinic Tracking Log o Listing, Neurology Clinics o Internal and External Medical Reviews o Listing, Individuals with seizure disorder o Listing, Individuals with history of status epilepticus since last compliance review o Listing, Individuals with diagnosis of refractory seizure disorder o Listing, Individuals with VNS 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 AED Polypharmacy Data o Components of the active integrated record - annual physician summary, active problem list, preventive care flow sheet, immunization record, hospital summaries, active x-ray reports, active lab reports, 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 #10, Individual #3, Individual #213, Individual #197, Individual #311, Individual #80, Individual #254, Individual #277, Individual #113, Individual #74, Individual #22 o Annual Medical Assessments the following individuals: • Individual #96, Individual #247, Individual #339, Individual #99 Individual #127, Individual #291 Individual #68, Individual #200, Individual #22, Individual #59, Individual #174, Individual #265, Individual #160, Individual #348, Individual #230 o Neurology Notes for the following individuals: • Individual #163, Individual #336, Individual #228, Individual #30, Individual #136, Individual #190, Individual #348, Individual #124, Individual #115, Individual #208 <u>Interviews and Meetings Held</u>: o David Espino, MD, Medical Director o David Bessman, MD, Primary Care Physician o John Sadberry, MD Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Family Nurse Practitioner o Sharon Tramonte, Pharm D, Clinical Pharmacist o Mandy Pena, RN, QA Nurse o Chip Dunlap, RN, MSN, MHA, Chief Nurse Executive

	o Larry Algueseva, QA Director o Robert Zertuche, RN, Program Compliance Nurse <u>Observations Conducted</u>: o Daily Clinical Services Meetings o Medical Staff Meeting o Observations of homes o Medical Continuous Quality Improvement Meeting o Medication Variance 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. The monitoring team's report has consistently stated that the self-assessment should include the areas that are reviewed by the monitoring team. Nonetheless, the self-assessment did not really reflect the content of the previous report. For each provision item, the self-assessment listed a series of activities that were completed to determine a self-rating. For provision L1, the self-assessment looked at compliance with annual medical assessments, quarterly medical assessments, compliance with colonoscopies, mammogram pap smears, TSH monitoring for individuals diagnosed with Down syndrome, management of diabetes, and DNR status changes. Much of the data were reported to be in progress. Data were reported for diabetes monitoring, colonoscopies, TSH screening, and mammography. The data reported in several instances differed from the findings of the monitoring team. For example, the self-assessment stated that there were no changes in the DNR status. Yet the documents submitted showed three individuals were added to the DNR list. For provision L3, the self-assessment reviewed the quality improvement committee notes to determine data collection and evaluation of outcome related indicators. Issues related to the use of BMI and decubitus data are discussed in the results section below. As has been stated in previous reports, the self-assessment should include a mix of process, outcome, and structural data similar to those used by the monitoring team. The monitoring team assesses structural processes, such as staffing and the provision of adequate medical services. Clinical processes, such as timely provision of vaccinations and screenings are reviewed. Finally, clinical outcomes are assessed as well. A self-assessment that does not evaluate all of the requirements of the Settlement Agreement will result in a faulty self-rating. Ensuring adequate medical staffing and access to specialists are fundamental components of a health care system and, therefore, it would be prudent to develop tools that included assessments of those areas.

	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. 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: There was little progress seen within the medical department. The medical director reported that a lack of staff, specifically the lack of a medical compliance nurse, limited progress. A new compliance nurse was hired in July 2013. The medical director, who functioned primarily in an administrative capacity, had been working at the facility nearly one year. The lead clinical pharmacist provided a great deal of assistance to him over the past year and the medical compliance nurse had been learning her job over the three months prior to the compliance review. While some degree of unsettlement would be expected, the monitoring team was somewhat disconcerted with the level of disorganization within the department and to learn that the status of many projects remained no different than they were six months ago. The databases were still reported works in progress. Additionally, the department was unable to fulfill many of the document requests for this review. Items submitted in the past were no longer available or were in formats that were not usable. The department was not maintaining adequate documentation of training activities even though some activities appeared to be occurring. The monitoring team received statements, such as "CPR training was up to date" with no supporting documentation. It was not clear if this was just due to a lack of understanding of the requirements or a failure of the department to ensure that the appropriate documentation was maintained. These deficiencies, which were documented and discussed in the last compliance report, were even more pronounced during this review. There were changes in staffing, but overall, the medical department was fully staffed and caseloads were lower than seen in the past. A full complement of staff did not result in a harmonious department. In several meetings attended by the monitoring team, the medical staff was argumentative and did not foster a collegial approach to discussions nor model how to achieve integration of clinical services. This was unfortunate because there were times when staff should have surfaced concerns related to patient care, but may have been reluctant to do so because some medical providers made references to other non-medical staff "wasting my time."

	Individuals received basic care consisting of preventive care, vision, and hearing screenings. Compliance with some cancer screenings was quite low based on data submitted and records reviewed. It appeared that some medical providers accepted the word of case managers related to refusals rather than contact family directly to explain the risk and benefits of screenings. As noted in the previous review, the facility suspended PSA screenings based on the USPTF guidelines even though almost all major organizations have supported factoring the preference of the patient into the decision making process. It was difficult to determine if some services were provided as needed because the facility was unable to adequately track clinic appointments. This was a significant deficit because it undercut the basic obligation to provide health care services in a prompt and timely manner. The monitoring team encountered difficulty determining the provision of neurological care because documentation regarding clinics was inadequate. Handwritten contractor invoices were submitted when a list of individuals seen in clinic was requested. There were marked discrepancies in data and the monitoring team did not understand why clinic appointments could not be tracked. Overall, it appeared that the number of neurology appointments was small and services were not adequate to meet the needs of the individuals. There were several examples of individuals who were seen in clinic and did not return for the recommended follow-up. Other individuals did not start drugs due to medication variances. Clinic appointments were cancelled because lab monitoring was not done and seizure logs were not available. One encouraging finding was that the university epileptologist who provided good services started conducting clinic the week of the compliance review. The plan was to conduct clinic for half a day each month. External and internal audits were completed. While the monitoring team received hundred of pages of data, there was no concise summary of findings. That is, for the external audits, the exit narratives for Round 7 and Round 8 were not available. Thus, the monitoring team had no statement regarding the methodology used for the audits or the number of records reviewed. The compliance-by-question graphs, which summarized the overall areas reviewed, were also not provided for the external reviews. Since the facility did not submit these data, it appeared that the data were not generated and utilized, thereby calling into question the utility of the medical audits. There were attempts to enhance the mortality review system by adding additional levels of review. Immediate reviews were completed following deaths and an external physician began conducting death reviews as well. However, none of the mortality reviews identified any issues related to medical care. Facility staff stated they conducted reviews in accordance with state policy and were instructed not to include recommendations in the death reviews that were not causally related. This is unfortunately an outdated approach to conducting mortality reviews. SASSLC had seven deaths at the time of the compliance review with the average age of death having significantly decreased over the past two years. Given these findings, the facility should seize every opportunity to make improvements, related to the health, safety, and well being of the individuals. Mortality reviews conducted by the appropriate professionals offer opportunities for affecting both provider specific and system wide service delivery.

	The efforts to develop a medical quality improvement program were continued and some progress was seen in this area. The work on the development of the clinical indicators continued. There were also efforts to implement other quality initiatives. The major barrier in these efforts was a lack of training. The staff frequently had some, but insufficient, knowledge to complete some of the quality initiatives that were started. Training will be needed to resolve many of these issues. Progress was also seen in the development an implementation of several policies and procedures. This was another example where the complete lack of organization or failure to note requirements of the provision impacted progress. The facility could provide no documentation that the appropriate training was provided relative to the new policies and procedures that were developed. Similar to the April 2013 review, this review was impeded by problems related to the provision of the requested documents. Eleven active records were requested, two of which were for reviews of deaths. One was excluded due to a large segment of information not being included. Other records were also missing selected items. The April 2013 report specifically highlighted that double-sided documents were submitted incomplete, as were data for the medical audits. Once again, there was no attention given to this detail. As a result of this, every active record was submitted with an incomplete MOSES evaluation, which ultimately impacted the random sample.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The process of determining compliance with this provision item included reviews of records, documents, facility reported data, staff interviews, and observations. Records were selected from the various listings included in the above documents reviewed list. Moreover, the facility's census was utilized for random selection of additional records. The findings of the monitoring team are organized in subsections based on the various requirements of the Settlement Agreement and as specified in the Health Care Guidelines. **Staffing** The medical staff was comprised of a medical director, one full time staff primary care physician, one full time advanced practice registered nurse, and one full time locum tenens primary care physician. The locum tenens physician, who began in July 2013, filled the vacancy created by the June 2013 resignation of a full time provider. The medical director carried a caseload of 19 while the APRN's caseload was about 64. The primary care physicians carried an average caseload of 83. A new medical compliance nurse began working at the facility 7/16/13. The collaborative agreement for the APRN was reviewed. It was signed by all members of the primary medical staff, but none of the signatures was dated. This agreement is required by state statute and proper execution requires that all parties sign and date the agreement.	Noncompliance

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		The monitoring team routinely requests documentation of the completion of CPR training for employees of the medical department. This information was not submitted for this review. Rather a statement that everyone "is current" was submitted with the document request. This was not an acceptable submission and did not fulfill the document request. **Physician Participation In Team Process** <u>Daily Clinical Services Meeting</u> 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. The meeting was expanded to include discussions related to admissions, discharges, and clinic consultations. <u>ISP Meetings</u> The monitoring team requested documentation of PCP attendance at the annual ISP meetings. Data for the months of April 2013 through September 2013 were submitted and are summarized in the table below.	

Primary Care Provider ISP Attendance 2013		
	Number of ISPs	Meetings Attended (%)
Apr	10	10%
May	24	12.5%
Jun	17	23.5%
Jul	24	33%
Aug	13	38.5%
Sep	17	23.5%

During interviews, it was reported that PCP attendance at ISPs was approximately 60%. Over the six month period, the primary providers attended a total of 25 of 105 (24%) of annual ISPs. Overall, for a staff of four primary providers, there was very little participation in the annual ISPs by the primary care medical staff. However, attendance did appear to increase in recent months. The primary care provider plays an important role in the planning process and should make every effort to attend ISPs as well as ISPAs.

#	Provision	Assessment of Status	Compliance
		Overview of the Provision of Medical Services The medical staff conducted rounds in the homes of the individuals who received a variety of medical services. They were provided with preventive, routine, specialty, and acute care services. The facility conducted onsite neurology, dental, podiatry, dermatology, gynecology, and psychiatry clinics. Ophthalmology clinic was no longer conducted onsite. Referrals for ophthalmology and other specialty services were provided at the university health sciences center or by community physicians. Problems were encountered in tracking the provision of these services. This is discussed in further detail in this section under access to specialists. The medical director reported that individuals were admitted to Nix Hospital. This was a full service hospital and could address all needs with the exception of neurosurgery. The medical staff had access to the records of individuals hospitalized at the Nix hospital. 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. Stat labs were completed through Baptist Health Systems. A mobile x-ray service provided services 24 hours/day seven days a week. 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 time frames. In recent months, there was improvement in timely completion. 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. The lack of an onsite eye clinic resulted in a poor compliance with the requirements to conduct vision exams, and compliance rates for most cancer screenings remained low. The management of pneumonia continued to be problematic and compliance with aspiration guidelines appeared poor. Documentation of medical follow-up by the primary providers continued to be limited. 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 various subsections and in the end of this section under case examples.	

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		Annual Medical Assessments 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%) records included an AMA • 9 of 9 (100%) AMAs were current • 8 of 9 (89%) AMAs included comments on family history • 9 of 9 (100%) AMAs included information about smoking and/or substance abuse history • 9 of 9 (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: • 6 of 15 (40%) 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 The AMA was considered timely if it was completed within 365 days of the previous summary. Most of the assessments reviewed did an adequate job of presenting historical information, such as immunizations and preventive care. The presentation of consultation data and the interval history, however, were not effective in providing a snapshot of the individual's health status. There was also no discussion of risk or risk mitigation. The monitoring team has recommended in the past and continues to recommend that interval care be presented chronologically, but organized by problems. Organizing an AMA in this manner would encourage a more thorough exploration of each problem by documenting all of the relevant care. This is particularly important for individuals with complicated medical problems, such as pneumonia. For any given individuals with the diagnosis of pneumonia, the AMA would provide information related to all relevant care and events, such as GI evaluation, pulmonary evaluation, hospitalizations, and diagnostics in a cogent manner that allowed for analysis of risk and formulation of an	

#	Provision	Assessment of Status	Compliance
		appropriate medical plan of care. Problem oriented discussion essentially mandates that the medical provider review each problem and ensure that the appropriate care was provided in accordance with clinical guidelines. The assessments and plans will need to improve even for individuals without complex medical problems. Many providers listed plans that were usually inadequate in lieu of an assessment and plan. For example, hypothyroidism - continue Synthroid. A more appropriate assessment and plan might have been hypothyroidism - clinically and biochemically euthyroid; continue current dose of Synthroid. This statement would indicate that the individual is stable (euthyroid) based on diagnostics (the TFTs) and physical exam. <u>Quarterly Medical Summaries</u> Quarterly Medical Summaries were being completed as required by the Health Care Guidelines by some medical providers For the records contained in the record sample: • 6 of 10 (60%) records included current QMSs • 4 of 6 (67%) summaries utilized the state template The QMSs completed were done using a state issued template. The content of these reviews was generally good and included information on recent hospitalizations, medication changes, and recent consults. However, not all providers were utilizing the state issued template. The medical director reported that approximately 50% were completed using the template. The monitoring team observed that records for one provider did not include QMSs. It was also noted that several QMSs reported old data. Vital signs such as blood pressure, heart rate, and temperature were identical over a span of months. <u>Active Problem List</u> For the records contained in the record sample: • 9 of 10 (90%) records included an APL The APLs were found in most records and appeared to have updates added in many instances. <u>Integrated Progress Notes</u> Physicians generally documented in the IPN in SOAP format when the entry involved a clinical encounter. The notes were usually signed and dated. Documentation was infrequent. Post-hospital documentation required improvement. In many cases, IPN	

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		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. Legibility of provider entries was a problem in some instances. <u>Physician Orders</u> 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. <u>Consultation Referrals</u> The medical staff documented consultations in the IPN. Generally, a brief summary was noted along with agreement or disagreement. Referral to the IDT was generally not indicated. SASSLC continued to report problems tracking consults. Thus, they submitted only one month of data related to external consultation since the last compliance review. During the last compliance review, similar issues were reported and apparently were not resolved. The facility was utilizing the same state issued database that had been implemented at other SSLCs, so it was not clear why the facility was unable to resolve the database problems. Consults were recently adding the daily clinical meeting discussion. Consultation referrals are discussed in further detail in section G2. **Routine and Preventive Care** Routine and preventive services were available to all individuals at the facility. Hearing screenings were provided with high rates of compliance. Compliance with vision exams was uncharacteristically decreasing. Documentation indicated that the yearly influenza, pneumococcal, and hepatitis B vaccinations were usually administered to individuals. The data for colorectal cancer screening showed no improvement and cervical cancer screening remained essentially unchanged. The facility removed the requirements to complete PSA testing. There was no documentation of discussions with the individual/LAR regarding the decision to screen. As reported during the last compliance review, 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. Even though the previous medical director retired in October 2012, the current medical director continued to report that the data were being established. However, this comment differed somewhat from the medical compliance nurse who indicated that the preventive care data was established and compliance scores reflected the data retrieved from the records. It did appear that other data elements were continuing to be compiled.	

#	Provision	Assessment of Status	Compliance
		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: • 9 of 10 (90%) records included PCFSs • 7 of 9 (78%) forms included updates for 2013 The Preventive Care Flowsheets were found in most 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. <u>Immunizations</u> • 9 of 10 (90%) individuals received the influenza, hepatitis B, and pneumococcal vaccinations • 9 of 10 (90%) individuals had documentation of varicella status The documentation of varicella status improved. Many individuals now had serologic evidence of immunity. There were also several individuals who had a history reported by a family member and did not have serologic evidence of immunity. <u>Screenings</u> • 7 of 10 (70%) individuals received appropriate vision screening • 10 of 10 (100%) individuals received appropriate hearing testing <u>Prostate Cancer Screening</u> The facility did not conduct routine PSA testing, therefore, no data were presented. The monitoring team noted that while this practice was consistent with the guidelines of the United States Preventive Task Force (USPTSF), the recently revised medical audits included assessment of the provision of preventive care inclusive of PSA screenings. Numerous organizations, such as the American College of Physicians, have issued "guidance statements" based on a rigorous review of guidelines developed by US organizations, including the American College of Preventive Medicine, the American Cancer Society, the American Urological Association, and the US Preventive Services Task Force. Many of the statements indicate that patient preference should be factored into the decision making process. State office should provide further guidance on this issue.	

#	Provision	Assessment of Status	Compliance
		Breast Cancer Screening • 2 of 3 females met criteria for breast cancer screening • 1 of 2 (50%) females had current breast cancer screenings A list of females age 40 and older was provided. The list included the names of 97 females, the date of the last mammogram, and explanations for any lack of testing: • 40 of 97 (41%) females completed breast cancer screening within the past year Cervical Cancer Screening • 4 of 4 females met criteria for cervical cancer screening • 2 of 4 (50%) females completed cervical cancer screening within three years The monitoring team was provided with a one page document that was not related to cervical cancer screening. During interviews, the medical compliance nurse and medical director both indicated they were not aware of the origin of the data. Corrected data was requested, but was not submitted. Colorectal Cancer Screening • 5 of 10 individuals met criteria for colorectal cancer screening • 1 of 5 (20%) individuals completed colonoscopies for colorectal cancer screening A list of individuals age 50 and older was provided. The list contained 124 individuals: • 46 of 124 (37%) individuals had completed colonoscopies • 16 of 124 (13%) individuals were listed as "will not do" secondary to increased risk • 57 of 124 (46%) individuals did not complete colonoscopies and no explanation was provided • 5 of 124 (4%) individuals did not complete colposcopies due to other reasons **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. The management of pneumonia is discussed below. As with many other areas, the facility submitted incomplete data related to pneumonia. The monthly incidence rates or absolute cases of new pneumonia were not submitted. Data related to the types of nutrition received by individuals with a diagnosis of pneumonia was indicated in the document request as "a work in progress."	

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		SASSLC reported that for the past year, nine individuals were diagnosed with pneumonia. The dates were not provided. The facility also entered data into the AVATAR database. Copies of the reporting forms were submitted and reviewed by the monitoring team. The AVATAR pneumonia tracking form information is summarized in the table below.	

AVATAR Pneumonia Data 2013									
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Aspiration	0	0	0	1	0	1	1	--	--
Bacterial	1	0	2	0	0	1	0		
Viral	0	0	0	0	0	0	0		
Total	1	0	2	1	0	2	1	--	--

The monitoring team noted that there were inconsistencies in the data. For example, Individual #198 was listed in the AVATAR database, but was not included in the facility reported pneumonia list. Information for six individuals was provided, one of whom experienced two episodes of aspiration pneumonia.

The AVATAR report forms were incomplete. This was also noted in the April 2013 report. A database tracking information related to pneumonia should include the key information related to diagnostics, such as laboratory information and chest x-rays. It should also track the information related to the individual's form of nutrition (oral/enteral) and presence or absence of dysphagia. The form required this data, but it was not completed for most individuals. Individual #189 received an altered texture diet and thickened liquids, but the MBSS results were not documented in the appropriate section. Thus, the reason for the altered texture was unknown.

The pneumonia review committee conducted two meetings since the last compliance review. The facility submitted notes for meetings held on 9/13/13 and 10/4/13. Seven individuals were reviewed. Checklists were submitted for two individuals. The meeting notes included a very brief synopsis for each individual. The summary provided clinical information, but did not cover all of the key information included in the checklist.

In addition to the review, committee the medical director participated in the PNMT committee, which reviewed pneumonia. The primary care provider was also present for discussion of individuals in their caseload.

The medical director must ensure that all of the criteria are adequately documented. For several individuals, there was no documentation in either the checklists or summary notes of the chest x-ray findings, results of lab studies, clinical symptoms, and risk factors. Based on the committee review, two individuals were diagnosed with

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		pneumonia in August 2013. These data are not reflected in the table above. The external audits continued to show relatively low compliance scores in this area indicating that greater focus on management was needed. **Case Examples** Individual #74 • This individual was involved in a medication error that occurred on 6/13/13. The error involved the receipt of another individual's medications. A review of the active record showed that there was a nursing entry on 6/13/13 and another on 6/14/13. There was no medical evaluation until 6/17/13. At that time, there was an IPN entry that noted the EKG showed a normal sinus rhythm and psychiatry was notified. There was no follow-up evaluation. A review of the physician orders showed that a verbal order was given by the medical provider on 6/13/13 at 8:55 am to hold am meds and perform vital signs every shift, but there was no medical evaluation at that time. The only documented medical evaluation was on 6/17/13. • This adult male also had a documented iron deficiency anemia with a ferritin of 19 on 12/5/12. The medical provider reported that iron studies were normal which they were not. The etiology of the iron loss was unknown. There were no recent CBCs in the record. Individual #213 • This individual was reported to not have a screening colonoscopy because consent was not obtained. The exact issues regarding consent were not clear. Management of the individual's neurology issues is discussed below. **Seizure Management** A listing of all individuals with seizure disorder and their medication regimens was provided to the monitoring team. The list included 130 individuals. The following data regarding AED use were summarized from the list provided: • 17 of 130 (13%) individuals received 0 AEDs • 57 of 130 (43%) individuals received 1 AED • 26 of 130 (20%) individuals received 2 AEDs • 16 of 130 (12%) individuals received 3 AEDs • 10 of 130 (7%) individuals received 4 AEDs • 4 of 130 (3%) individuals received 5 AEDs The facility continued to conduct an onsite neurology clinic. 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. Psychiatrists also attended the neurology	

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		clinic. Individuals with a psychiatric diagnosis in addition to seizure disorder were seen in the neurology clinic by both the neurologist and psychiatrist. Primary providers often attended as well. In the past, this clinic was conducted once or twice a month. Based on the data submitted, a very limited number of clinics occurred since the last compliance review.	

Neurology Clinic Appointments 2013	
Mar	--
Apr	1
May	6
Jun	2
Jul	3
Aug	14
Sep	0
Total	26

The 26 appointments, which included on-campus, off-campus and four EEG appointments were significantly less than the 65 campus clinic appointments documented for the last reporting period. The list represented scheduled appointments. The monitoring team determined through record reviews that some appointments did not actually occur.

Documents submitted separately for the neurology campus clinic tracking indicated a few more individuals were scheduled for on-campus appointments, but there was no definitive evidence that the appointments were completed because the logs submitted were actually the handwritten contract invoices. A contractual agreement was finalized with the epileptologist, who saw some individuals at the health sciences center, to begin conducting an on-campus clinic. The initial clinic was held during the week of the compliance review. This half-day clinic was scheduled to occur once a month.

As documented above, many individuals required multiple drugs for management of their seizure disorder and management was often complicated. For the 130 individuals, the following represents a summary of key data:

- 113 of 130 (87%) individuals with seizure disorder received AEDs
  - 56 of 113 (49%) individuals received two or more drugs
- 14 of 130 (11%) individuals had refractory seizure disorder
- 11 of 130 (8%) individuals had a VNS implanted
- 0 of 14 (0%) refractory individuals was in the process of a VNS workup
- 6 of 130 (5%) individuals had a recent episode of status (within 6 months)

The actual number of individuals with a history of status since the previous compliance review was not clear. The data submitted to the monitoring team indicated that six individuals had experienced status epilepticus. However, the medical director indicated

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		this was incorrect data. The documentation submitted did not provide information sufficient to clarify the diagnosis because the actual documentation of seizure activity was not provided. The monitoring team requested neurology consultation notes for 10 individuals. Notes for nine individuals seen in neurology clinic were submitted. These individuals are listed in the above documents reviewed section. The following is a summary of the review of the records: • 4 of 9 (44%) individuals were seen at least twice over the past 12 months • 5 of 9 (56%) individuals had documentation of the seizure description • 9 of 9 (100%) individuals had documentation of current medications for seizures and dosages • 8 of 9 (89%) individuals had documentation of recent blood levels of antiepileptic medications • 2 of 9 (22%) individuals had documentation of the presence or absence of side effects, including side effects from relevant side effect monitoring forms • 6 of 9 (67%) individuals had documentation of recommendations for medications • 0 of 9 (0%) individuals had documentation of recommendations related to monitoring of bone health, etc. The monitoring team was concerned about many issues related to the provision of care to individuals with seizure disorder: • Consult notes did not always indicate why the individuals required evaluation. • Individuals did not always receive prompt follow-up. • 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. • Documentation of medication side effects and even monitoring were not always adequate. Labs were not always available as required and the notes did not comment on side effects of medications. Some notes utilized the templates with the MOSES/DISCUS scores and some did not. Even when the scores were present, there was no comment related to them. The impact of medications on the quality of life should be taken into consideration. The following are some examples of concerns identified with regards to neurological care provided to the individuals supported by the facility: • Individual #213 was seen in neurology clinic in January 2013. The neurologist recommended that the individual return after a CT of the head and DNA studies were completed. On 6/28/13, the PCP saw the individual and made the decision	

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		to start Sinemet due to cogwheel rigidity. There was no documentation of follow-up to assess response. The QDRR indicated that the medication was not started due to a medication error on 7/8/13. There were no further neurology consultation notes in the record, however, there was a neurology IPN entry on 9/24/13 that was signed by the clinical pharmacist. It stated, "Follow-up on Sinemet initiated in June. Movements didn't appear to be Parkinson movements, but have not improved, stop Sinemet, low dose Prolixin suggested for asterixis. Will need MOSES/DISCUS monitoring." o The monitoring team was very confused by this entry and did not understand who was actually making this recommendation. There was no consult available in the record for review. The recommendation was signed by the clinical pharmacist, but it was not clear that such a recommendation would be within the scope of practice of the clinical pharmacist as defined by the facility. If this were the recommendation of the neurologist, the IPN entry with the recommendation should have been signed by the neurologist. • Individual #124 was followed in the SASSLC clinic due to refractory seizure disorder. The individual received four AEDs, prn Ativan, and also had a VNS, but was not followed by an epileptologist. The seizure frequency was reported to be one per week. The clinic note, dated 7/16/13, did not document any AED levels, lab values, or side effects of the multiple medications that were given. There was no information regarding the MOSES and DISCUS scores included on the consultation form. There was only one clinic note submitted so the level of follow-up was not clear. The VNS was adjusted in clinic, but no time frame was given for a follow-up appointment. • Individual #unknown (ID # in notes extract Visit Id#000006042-3-650) was seen in neurology clinic on 8/20/13. The clinical pharmacist documented in the notes extracts that the neurologist was informed about medications and laboratory. The individual was reviewed for lethargy. It was documented that attempts had been made to obtain a neurosurgical consult and the neurologist advised that a shunt could be tragic even if it was a high pressure shunt due to collapse of the ventricles. The lethargy/decrease in mental status could be due to dementia. This documentation refers to "attempts" to provide services. The monitoring team had no further information regarding the inability to provide services, however, the facility had an obligation to provide the necessary specialty services in a timely manner. • Individual #unknown (ID # in notes extract Visit Id#000006021-2-650) was seen in clinic on 7/16/13. The clinical pharmacist documented in the notes extracts that the individual was reported to be followed by the epileptologist, received a very complex medication regimen, and continued to have seizures. It	

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		was noted that the individual was extremely sedated and slept during the clinic appointment. An ADR was generated. The neurologist recommended consideration of VNS placement. • Individual #22 was seen by the nephrologist on 5/8/13 who noted K+, acid in blood, chronic kidney disease, stage 2; blood pressure on low side. The individual was not seen in neurology clinic on 5/28/13 because labs were not done and seizure records were not available. There was no subsequent neurology follow-up. • Individual #3 was seen in clinic on 2/19/13 for evaluation of possible pseudo-seizures. The individual was to return to clinic following an EEG, but no record of a follow-up consult was found in the records. **Access To Specialists** The medical director and medical compliance nurse reported that there were significant problems utilizing the state issued consultation database. Therefore, there was very little information available about community clinic appointments since the last compliance review. However, there was ample evidence that services in many areas were inadequate. Data showed more than 40% of individuals had outstanding needs for follow-up by an eye provider. Many individuals required neurology follow-up and there was documentation of other attempts to schedule specialty appointments. During the April 2013 review, the monitoring team learned about plans to implement a new consult referral process, which was intended to assign prioritization to consultation requests such that urgent appointments were fast tracked. The medical director explained that the process did not appear successful. This process was stated to be a "work in progress." Additional discussion is found in section L3. The facility will need to address the requirement to provide access to specialists as part of the provision of healthcare services. Monitoring of clinic appointments must track the timely completion of appointments based on the determined need and prioritization of the appointment. Moreover, the facility must have a procedure in place to ensure that follow-up of failed appointments occurs in a timely manner. This is a disturbing finding because the facility must be able to accurately track the needs of the individuals and the response of the facility to those needs in terms of providing access to health care services. **Do Not Resuscitate** The facility did not submit any documentation related to the DNRs other than a facility-generated chart listing the names of the 15 individuals with active DNRs. This number increased by two since the previous compliance review.	

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		Three individuals were added to the list. Two of the individuals were 52 years of age and one individual was 26 years old. The monitoring team was provided no explanation for the implementation of the new DNR orders. During the April 2013 compliance review, the medical director acknowledged that additional attention was needed in better defining the qualifying diagnosis. However, when the monitoring team inquired about the information included in the document request, the medical director did not appear to be familiar with the data submitted. It was reported that the facility had an Ethics Committee, but there had been no recent meetings. The DNR for Individual #268 stated the Ethics Committee review was pending. The monitoring team was unable to conduct any further assessment in this area. The concerns, however, remain. SASSLC continues to have long term DNRs in place with qualifying diagnoses that are not consistent with the definitions found in state policy. Furthermore, for the three new individuals, the qualifying conditions were not submitted for review. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The medical director should ensure that the primary care medical providers are attending the annual ISPs and ISPAs as required. 2. The documentation issues identified should be addressed o Completion of AMA within 365 days of previous AMAs o Compliance with completion of QMSs o Legibility of documentation o Physician orders 3. The facility must develop a plan of correction related to the consultation referral system and clinic tracking as discussed in the body of the report 4. The medical director must address the low compliance rates of cancer screenings 5. The pneumonia review system should be re-evaluated as discussed in the body of the report 6. The numerous deficiencies related to neurology services need to be addressed. 7. The facility should comply with sate policy related to DNRs. There must be an appropriate justification for implementation of a DNR. 8. Training is needed relative to appropriate documentation in the active records. Each discipline should make entries under the appropriate tile. Clinic entries should be noted as such.	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L2</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.</td><td>Medical Reviews - External
An external medical reviewer conducted Round 7 of the medical audits April 4-5, 2013. State guidelines required that a sample of records be examined for compliance with 30 requirements of the Health Care Guidelines. The requirements were divided into essential and nonessential elements. There were essential elements related to the active problem lists, annual medical assessments, documentation of allergies, and the appropriateness of medical testing and treatment. In order to obtain an acceptable rating, all essential items were required to be in place, in addition to receiving a score of 80% on nonessential items. The facility submitted data for the external audits. Those data are summarized in the table below:

<table>
<tr><th colspan="3">Round 7 - General Medical Audits
Compliance (%)</th></tr>
<tr><td></td><td>Essential</td><td>Non-essential</td></tr>
<tr><td>Round 7</td><td>81</td><td>88</td></tr>
</table>

In addition to the general medical audits, medical management audits were also completed. The results for the Round 7 medical management audits are listed below.

<table>
<tr><th colspan="4">Round 7 - Medical Management Audits
Compliance (%)</th></tr>
<tr><td></td><td>Diabetes Mellitus</td><td>Osteoporosis</td><td>Pneumonia</td></tr>
<tr><td>April 2013</td><td>100</td><td>83</td><td>78</td></tr>
</table>

The medical director indicated that the reviewer's exit comments were not available. There was no additional narrative documenting the number of records audited and compliance by question graphs were not submitted for either of the external audits. Therefore, the monitoring team could not easily determine compliance rates for the specific questions/areas reviewed. It was determined that 16 records for four providers were audited.

Corrective action plans continued to be developed by the QA department. The facility provided the status of the corrective action plans for Round 7 of the general audits. Multiple tables were provided, many of which were not dated. It appeared that a corrective action plan was implemented for each identified deficiency. However, the completion dates of the corrective actions could not be determined. The facility will need to address how it documents the status of the corrective actions. No additional information, such as list of inservices or training, that addressed low compliance scores in the areas of pneumonia and osteoporosis, was submitted.

Round 8 of the medical audits was completed on October 11-12, 2013. There were no data or comments from the exit available at the time of the compliance review. It was</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		reported that the audits were conducted in the new expanded format. The revised audit tool included additional questions related to administration of core immunizations, cancer screenings, and preventive care. These revisions helped to ensure that some very essential health care services were being assessed as part of the external reviews. The following concerns were noted by the monitoring team: • Compliance with completion of the external medical audits could not be determined. The sample sizes for each component of the audit were not explicitly stated. • The documentation of the follow-up of the corrective action plan was not adequate. The plans may have been executed in a timely manner, but the documentation did not provide concrete evidence of the timelines. • The facility conducted medical management audits for six conditions on a rotating basis. This was a good starting point, however, there was an obvious need to assess the medical management of a number of disease conditions, such as hypertension and chronic hepatitis. The facility should draft additional management guidelines to ensure that the medical staff provide the appropriate care. These guidelines could then be utilized to develop brief audit tools to ensure that the care provided is in accordance with generally acceptable standards. <u>Mortality Management at SASSLC</u> Seven deaths had occurred in 2013, five of which occurred since the last compliance review. The average age of all deaths for 2013 was 52.5 years. This was a decrease in the average age of death compared to the years of 2011 and 2012. The average age at the time of death for those years was 57 and 58.5 years respectively. The mortality documents for the four deaths that occurred from June 2013 through August 2013 were reviewed. Information for those deaths is summarized below: • The average age of death was 50 years with an age range of 35 to 61 years. • The causes of death were: (1) aspiration pneumonia for two individuals, (2) gall bladder sepsis, and (3) mechanical small bowel obstruction. • No autopsies were performed. • Two individuals died during hospitalization. The other two individuals were receiving hospice services. The monitoring team met with the medical director, CNE, QA director, QA nurse, medical compliance nurse, and program compliance nurse to discuss mortality management at the facility. Specific monitoring team concerns included the dearth of recommendations noted in the clinical death reviews. Facility staff reported that they were to only include	

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		systemic issues in the facility review. None of the reviews cited any concerns or recommendations related to medical care. Given the many deficiencies noted throughout the conduct of this review, the monitoring team is concerned about the lack of opportunities found or taken for improvement. However, the medical director stated no concerns were identified. The monitoring team encourages the facility staff to continue the multilayered reviews, but enhance the process even further by: • Ensuring adequate information is reviewed (no less than one year of the records, and two if possible) • Ensuring that all hospital information is obtained for review • Having external reviews completed by qualified physicians, such as board certified primary care physicians, with experience in treating individuals with developmental disabilities, when possible. It is also important that the culture of the facility shift with regards to the mortality review process. The reviews should go beyond the focus of simply being a death review. Rather, each should be understood to have the potential to improve the quality of care and safety for other individuals through the identification of concerns that may not have directly contributed to the death. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The medical audits must be completed in accordance with state guidelines and provide clear documentation of the methodology. 2. Corrective actions should be tracked in a timely manner and appropriate documentation maintained of the tracking. 3. There should be evidence that data are utilized by the medical department for the purpose of performance improvement. The medical director should address other issues noted above.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>L3</td><td>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.</td><td>The Continuous Medical Quality Improvement Committee
During the April 2013 compliance review, the medical director informed the monitoring team that the CQI committee and process was being revamped and overhauled. While the process was very different from the initial process observed by the monitoring team in 2012, the committee policy, which outlined the process, had not been updated at the time of this review.

The monitoring team attended the meeting held during the week of the compliance review. Discussions included, but were not limited to:
• Reviews of run charts related to emesis episodes, ER visits, hospitalizations, injurious falls, and total number of seizures
• A presentation by a member of the medical staff on a review of hospitalizations
• Revision of the clinical indicator list
• A summary of the RCA for Individual #343

The committee efforts resulted in positive movement in the overall development of a medical quality program. Yet, it was apparent that there was a need for staff to undergo training related to the basic concepts of quality improvement, data collection, and data analysis. The monitoring team noted a specific need for improvement related to the use of appropriate methodologies, such as root cause analysis, as well as proper use of data.

Other Quality Improvement Initiatives
The medical compliance nurse completed an audit on all individuals with diabetes mellitus. Compliance with process and outcome indicators were reported as follows:

<table><tr><th>Process Indicator</th><th>Compliance (%)</th></tr><tr><td>HbA1c</td><td>100</td></tr><tr><td>LDL</td><td>94</td></tr><tr><td>Micro</td><td>64</td></tr><tr><td>Eye exam</td><td>52.9</td></tr><tr><td>Foot Exam</td><td>88.2</td></tr><tr><td>Smoking St</td><td>Not assessed</td></tr><tr><th>Outcome Indicator</th><th>Compliance (%)</th></tr><tr><td>HbA1c >9</td><td>100</td></tr><tr><td>LDL<130</td><td>100</td></tr><tr><td>BP < 140/90</td><td>88.2</td></tr></table>
The criteria for the audit were those identified by the National Diabetes Quality Improvement Alliance, as published in the article Selecting indicators for the quality of diabetes care at the health systems level in OECD countries, International Quality in Health Care, September 2006. The authors utilized a HbA1c >9.0% as one of three outcome measures. This is inarguably one of the key clinical outcomes in the</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		management of diabetes mellitus. The article, however, clearly stated that this metric indicated "poor control." SASSLC reported 100% compliance with the metric of HbA1c >9. Ostensibly, a compliance of 100% with this metric would indicate that every individual at the facility was experiencing very poor outcomes related to glucose control. This compliance rate was found in several documents. Following the onsite review, the facility indicated that the correct metric was HbA1c@7%. The monitoring team agrees that this is a more appropriate metric. During the onsite review, the monitoring team questioned the use of this particular set of indicators for several reasons: • State office issued clinical guidelines and audits should utilize outcome measures that can be linked to the state clinical guidelines. • The facility conducted internal audits for diabetes as part of the state required medical management audits. While those audits require expansion to include clinical outcomes, the fundamental criteria should not differ. • State guidelines and audits were based on the guidelines set by the American Diabetes Association. Facility policy, procedures, and guidelines must be consistent with state issued guidelines. Apart from the selection of the criteria, this was a good initial effort in assessing the quality of diabetes care provided at SASSLC. This exercise was indicative of the need to focus on several concepts related to quality: • Metric selection - The use of the selected HbA1c did not appear to be the best outcome metric and was not consistent with the metrics seen in state guidelines or the facility's guidelines which listed the American Diabetes Association Standards of Medical Care in Diabetes 2011 as a reference. • Methodology - There was no documentation of the methodology. Data should be accompanied by a brief narrative that provides an explanation of the methodology inclusive of the sample size, selection of sample, etc. • Corrective Action Plans - Corrective action plans should be developed for deficiencies. The actual data reported for the HbA1c values, if accurate, should have called for an immediate plan of correction to address poor clinical outcomes. It is possible that consistent reporting of such poor outcomes was due to misinterpretation of the metric. However, if these data were properly reviewed, the discrepancy should have been noted.	

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		Other Quality Initiatives To the credit of the staff and medical director, there were many efforts to apply quality improvement principles and utilize quality tools for the purpose of performance improvement. For example, the facility had problems with the consultation referral process, which resulted in mapping of the process. This frequently employed technique is used to discover gaps in faulty processes. The flow chart reviewed included several steps in addition to a comment that "RNs and the clinic nurse were interviewed to determine where the system was breaking down." This was labeled as completion of a root cause analysis. Mapping out the process was a very good selection in terms of methodology. However, the use of this method requires a great deal more detail than was provided in the chart reviewed by the monitoring team. Learning how to complete this process requires some degree, but not a great deal, of training. Further training in this area would prove to be beneficial for the medical department and the entire facility (also see section E of this report). Internal Medical Reviews The internal medical audits were completed in April 2013 and July 2013. The results are presented in the table below.	

Round 7 - General Medical Audits Compliance (%)			
		Essential	Non-essential
4/4/13	Round 7	99	88
7/18/13	Round 7.x	98	99

The April Round 7 internal audits were completed in tandem with the external audits using the same records. The July audits were also identified as Round 7 internal audits in the documents provided. Compliance by question graphs were submitted for the July audits. As noted in the table, few deficiencies were identified. Thus, 14 corrective action plans were implemented and completed.

The results for the internal medical management audits were presented in an inter-rater reliability graph only. No other data were provided. It was also noted that these data were not included in the self-assessment.

Round 7 - Medical Management Audits Compliance (%)			
	Diabetes Mellitus	Osteoporosis	Pneumonia
Round 7	80	67	100

#	Provision	Assessment of Status	Compliance
		While the facility completed the audits, the monitoring team had concerns related to the process. The concerns were similar to those expressed with the external audits and other quality activities, including the lack of documentation of methodology and lack of corrective action plans. Overall, the monitoring team recognized progress in the development of a medical quality program: • There were continued efforts to develop and revise indicators to assess the quality of medical care. • Data were collected and utilized • Adverse trends in data resulted in more in depth reviews. • Quality improvement initiatives were implemented in areas such as diabetes mellitus. • Internal audits were conducted. While problems were identified within most of these areas, the framework for quality improvement had begun. The facility will need to focus on providing training related to a few more advanced principles of quality improvement. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The clinical disciplines should continue to work on development of the metrics that will be used as part of the CQI program 2. The facility should provide additional training to staff involved in the program on quality related issues.	
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	The medical department developed and/or revised a number of policies, procedures and guidelines related to the provision of medical care and clinical services including: • Diabetes mellitus and metabolic syndrome • Urinary tract infections • Aspiration and pneumonia • Seizure management • Osteoporosis • II D Guidelines for Down Syndrome, Tuberous sclerosis, Prader Willi, Fragile X Syndrome The monitoring team noted that the diabetes protocols indicated that the Standards of Medical Care 2011 was utilized as a source for the diabetes protocols. Two updates have	Noncompliance

#	Provision	Assessment of Status	Compliance
	accepted professional standards of care with regard to this provision in a separate monitoring plan.	been published since that time and were available at the time the facility guidelines were revised. The guidelines should reflect the most current available literature. The revised seizure management procedure included a notation to refer to the medical staff notes for details regarding approval of the policy. This policy should be available facility wide and the typical reader would not have access to such notes. Therefore, the policy should include all relevant information. The medical director reported that the medical staff was inserviced on all new policies and procedures. Yet, there was no documentation available to support this claim. The staff was fully aware that this was necessary. In fact, the monitoring team received correspondence from the Settlement Agreement Coordinator on 5/17/13 addressing this very issue stating: "With the new updates that came out yesterday regarding the state wide medical services policy, the medical director will begin to document these inservices accordingly (with signature sheets and copy of any handouts that were given for such P/P inservicing moving forward)." This should have occurred, but did not. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. In addition to the guidelines issued by state office, the facility should have additional guidelines for other common medical conditions such as hypertension, hyperlipidemia, chronic hepatitis and other identified conditions. 2. Each member of the medical staff should have a medical department policy and procedure manual that includes all relevant policies and procedures and guidelines. 3. The medical department should maintain written documentation of all training and inservices that are provided, consistent with the comments included above from the office of the SAC. 4. The department needs a process to ensure that all policies and procedures are reviewed on a yearly basis and updated as necessary.	

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: 10/7/13 o SASSLC Section M Action Plans, updated: 10/7/13 o SASSLC Section M Presentation Book o SASSLC Nursing Organization Chart o SASSLC Map of Facility o SSLC Nursing Quality Assurance Audit Process, dated 3/21/13 o SASSLC Quality Assessment Operations Meeting dated: 4/16/13 o SASSLC Dietary Meeting Minutes dated: 5/20/13 o SASSLC Continuous Quality Improvement Notes and associated documents, dated: 7/17/13 and 8/14/13 o SASSLC 10/22/13 QA/QI Meeting Agenda and associated documents o SASSLC Section M Nursing Compliance Data, dated: 9/13/13 o SASSLC Nurse Managers Meeting Notes, dated: 4/18/13 o SASSLC Medical Services and Quality Assurance Comprehensive Death Policy, approved and implemented: 8/22/13 o SASSLC Communication/Correspondence for Mortality Nursing Corrective Action Plans, dated: 6/20/13, 6/20/13 and 7/2/13 o SASSLC Corrective Action Plan Tracking Log, Plan of Correction entitled SASSLC Nursing Mortality Recommendations Log, revised dated: 10/24/13 o SASSLC Instructions for Audit of SOAP Documentation, dated: 2/15/12 o SSLC Nursing Protocol: Emergency Response and Equipment, dated: 5/11 o SSLC Emergency Response Policy # 044.2, effective dated: 9/7/11 o SSLC Emergency Equipment Walkthrough Checklist #044, dated: 9/11 o SSLC AED and Emergency Bag Check Off #044B, dated: 9/11 o SSLC Emergency Oxygen Tank and Suction Machine Check list, #044C, dated: 9/11 o SASSLC last six months, all code blue/emergency drill reports, including recommendations and/or corrective actions plans o SSLC Nursing Protocol: Blood Glucose Monitoring, dated: 5/11 o SSLC 9/13 and 10/13 Blood Glucose Quality Control Record for: Individual #6, Individual #324, Individual #247, Individual #34, Individual #36, Individual #200, and Unit #673 o SSLC Medication Administration Guidelines, dated: 8/13 o SSLC Medication Administration Observation Guidelines, dated: 10/12 o SASSLC Medication Administration Observation Form, dated: 10/31/12 o SASSLC Last 10 Medication Administration Observations o SASSLC Last 10 Medication Inter-Rater Reviews and associated analysis o SASSLC Last six months Medication Administration Observations Report o SASSLC Medication Observation Assignments for Due Date 9/30/13

	o SASSLC 9/13 Monthly Medication Inspections for Units#665, #668, #670, #672, #673F, #673M, #674, #766 Pyxis, Dental, and #673-After-Hours Unit o SASSLC 9/13 and 10/13 Refrigeration Temperature Check Sheets for all units o SSLC Medication Variance Policy#053, effective: 9/23/11 o SSLC Medication Variance Report SSLC#053, (no date) o SASSLC Last four months Medication Variances Data Report o SASSLC Last six months Medication Variance Committee Minutes o SASSLC Last six months Pharmacy and Therapeutic Committee Minutes o SASSLC Morning Reports, dated: 10/21/13, 10/22/13, 10/23/13, and 10/24/13 o SASSLC ODRN 24-Hour Reports, dated: 10/21/13, 10/22/13, 10/23/13, and 10/24/13 o SSLC Nursing Protocol: Assessment of Vital Signs, dated: 5/11 o SASSLC Hot Chart Guideline, revised: 7/25/13 o SSLC Nursing Procedure: Skin Management and Wound Prevention, dated: 5/11 o SASSLC Last six months Pressure Ulcer Tracking Log o SSLC Nursing Protocol: Hospitalizations, Transfers and Discharges, dated: 3/13 o SSLC Infection Control Preventions and Practices, dated: 12/23/11 o SASSLC Pandemic Respiratory Infectious Disease Readiness Plan Attachment J (no date) o SASSLC List of individuals ever diagnosed with human immunodeficiency virus (HIV) o SASSLC list of individuals diagnosed with Methicillin-resistant Staphylococcus aurous (MRSA), Hepatitis, A, B, and C, positive Purified Protein Derivative (PPD), convertors, HINI, Clostridium Difficile (C-Diff) and/or sexually transmitted disease (STD's) o SASSLC 10/23 Infection Control Meeting Minutes, and associated documents o SASSLC Infection Control Guidelines dated: 2013 • Real-Time Monitoring of Communicable Disease • Monthly Infection Control Report • Monitoring of Hand Hygiene during Meal Time • Environment of Care o SASSLC Guidelines for the Prevention and Control of an Infectious Disease Outbreak, dated: 6/13 o SASSLC Last six months Safety Committee Meeting Minutes o SASSLC Last six months Environment of Care Audits o SASSLC Last six months Employee Health Data Report o SASSLC Targeted Tuberculosis Surveillance: List of individuals with positive PPD, dated: 9/13 o SASSLC List of Individuals diagnosed with hepatitis, A, B, C o SSLC Seizure Management Guidelines, dated: 2/11 o SSLC Vagal Nerve Stimulator, dated: 2/11 o SSLC Nursing Protocol: Pretreatment and Post-Sedation Monitoring, dated: 2/11 o SASSLC Nursing Competencies Report, (no date) o SASSLC Nursing Dashboard, (no date) o SASSLC Monitoring Tool/Protocol Audit Scores 2013 (no date) o SSLC Case Manager Responsibilities, dated: 12/30/11 o SSLC Direct Care RN Responsibilities, dated: 8/20/10 o SASSLC Nursing Coverage Policy, revised date: 3/21/13

	o SASSLC Transfers to Medically Enhanced Supervision #300-7A, (no date) o SASSLC Line Listing Individuals Transitioned to Community 5/13/13 -8/26/13 o SSLC Physical Nutritional Management Policy # 012.3, effective date: 3/4/13 o SASSLC Seizure Management Guidelines, as approved by the Medical Staff, effective dated: 5/30/13 o SASSLC focused record review, including MARs/TARs for Individual #172 and Individual #74 o SASSLC focused record review onsite, including MARs/TARs, Individual #314 o SASSLC review of Individuals blood Glucose Monitoring Records, Individual #6, Individual #324, Individual #34, Individual, #247, Individual #36, and Individual #200 o SASSLC Focused record review MARs/TARs, Nursing Master Signature Sheet, and associated IPN for conducted Medication Administration Pass Observations and applicable Enteral Flow Sheet across campus: Individual #17, Individual #94, Individual #128, Individual #74, Individual #267, Individual #72, Individual #8, Individual #151, Individual #140, Individual #150, Individual #117, Individual #305, Individual #340, Individual #115, Individual #292, Individual #315, Individual #306, Individual #71, and Individual #288 o SASSLC Review of Community Living Discharges for Individual #85, Individual #316, Individual #83, Individual #97 Individual #155, and Individual #146 o SASSLC Comprehensive record reviews, including MARs/TARs selected from the facility's At Risk for high/medium risk rated individuals across campus: Individual #55, Individual #305, Individual #347, Individual #313, Individual #328, Individual #342, Individual #259, Individual #330, Individual #34, Individual #256, Individual #47, Individual, and Individual #71 <u>People Interviewed</u>: o Chief Nurse Executive, Cleveland "Chip" Dunlap, RN, MSN, MHA o Interim Chief Nurse Executive/Nursing Operations Officer, Roseanne Boyd, RN o Program Compliance Nurse, Robert Zertuche, RN o Hospital Liaison Nurse, Jennifer Costello, RN o Quality Assurance Nurse, Mandy Pena, RN o Infection Control Nurse, Qiuhua "Ellen" Li, RN, Ph.D. o Nurse Educator, Joe Gomez RN o Nurse Manager, Lola Faulkner, RN o Nurse Manager, Gayhindria Collier, RN o Clinical Nurse, Jeff Pittman, LVN o Pharmacy Director, Sharon M. Tramonte, PharmD o Informal interviews with numerous direct care nurses (LVNs and RNs) and direct support professionals (DSPs) <u>Meeting Attended/Observations</u>: o Visited individuals residing on all units o Visited individuals on developmental center work unit and nursing center o Medication Observations on all units o Emergency Equipment Checks all units and developmental center

	o Medication Room Inspections all units and developmental center o Enteral Feedings/Medication Administration on selected units o 10/21/13, 10/22/13, and 10/23/13 Clinical Services Meetings o 10/22/13 QA/QI Meeting o 10/22/13 Polypharmacy Oversight Committee o 10/23/13 Infection Control and Skin Committee Meeting o 10/23/13 Nursing Operations Meeting o 10/23/13 Medication Variance Meeting o 10/24/13 Mortality Review Meeting o 10/24/13 ISP Meeting for Individual #55 o 10/24/13 Nursing M Compliance Meeting
	Facility Self-Assessment: The facility submitted its self-assessment for section M, updated 10/7/13, and provided comments/status for section M provision M1 through M6 of the Settlement Agreement. The facility indicated noncompliance with M1, M3, M4, M5, and M6, of which the monitoring team was in agreement. The facility indicated compliance for M2 with which the monitoring team disagreed. The format for both facility self-assessment and action plan provided activities associated with each provision. The action plan, updated 10/7/13, provided the monitoring team with a status of action steps taken for each provision, and included steps that were completed and/or were ongoing and the projected date of completion. The facility documented its self-assessment through the use of eight monitoring/audit tools. Medication monitoring was included in the eight tools. The self-assessment as noted in monitoring team's last report did not include results from audits that had a corresponding inter-rater reliability and did not include the population for which the sample was drawn. The CNE should ensure that the facility's self-assessment includes, for those areas in need of improvement, an in-depth analysis of the problems, and actions referenced in response to negative findings, are referenced in the facility action plan.
	Summary of Monitor's Assessment: Provision M1: This provision was not found in compliance. Since the last monitoring visit, the nursing department had turnover in three nursing leadership positions, the Chief Nurse Executive (CNE), Nursing Operations Officer (NOO) position, and the RN Case Manager Supervisor. The RN Case Manager Supervisor transferred to the Nursing Operations Officer. She was also appointed to the interim CNE/NOO position, and continued the functions of supervising the RN Case Managers. The vacated Hospital Nursing Liaison position noted in the last monitoring had been filled by one of the nursing staff at the facility. The facility filled the vacant CNE position on 10/21/13. Over the past six months, the significant turnover in the

	nursing leadership, with the exception of the Nurse Educator and Nursing Compliance Officer, directly affected the Nursing Department's progress in all of the provisions of Section M. Currently, the facility had 10 nursing vacancies. The nursing leadership's team efforts in working together and in setting unified goals was evident, such as improving upon timelines for the completion of nursing assessments. During the onsite week, the new CNE accompanied the monitoring team on rounds, and was present at meetings and interviews with the nursing staff. Provision M2: This provision was not found in compliance. Compliance in this provision requires an understanding of health risk and risk factors when implementing timely and quality nursing assessments and their associated health care plans. The facility made improvements in the submission of timely nursing assessments. A review by the monitoring team, however, did not find that assessments sufficiently summarized the individuals' health status regarding whether their conditions were improving or regressing. Health care plans were not representative of the individuals' current health status. Provision M3: This provision was not found in compliance. The facility oversight focused on supervision in monitoring nursing assessments for individualization, and appropriateness to the health care needs of the individual. The facility made little improvement in the development of individualized IHCPs derived from the nursing assessments. . Provision M4: This provision was not found in compliance. The Nurse Educator had made significant progress in organizing the nurse education program to include the development of a tracking log for documenting compliance of nursing education. The Nurse Educator had begun to conduct inter-rater reliability on medication observation passes. Compliance in this provision requires the facility must put in place state nursing policies, procedures, and protocols, and ensure training is implemented and demonstrated in actual clinical practice. Provision M5: This provision was not found in compliance. There was little improvement. This provision requires the integration and collaboration of all relevant disciplines to accurately identify risk assessments and to develop and implement plans of care to sufficiently meet the individual's needs. Provision M6: This provision was not found in compliance. The monitoring team's review found that the facility was not following its own Medication Variance Policy in documenting, monitoring, and providing corrective actions sufficiently for its medication variances. The monitoring team was also concerned with the discrepancy between the number of un-reconciled medications and medication variances. Much continued work is needed to ensure sufficient systems are in place to ensure individuals received their prescribed medications.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	The monitoring team validated information though an independent review of the facility's self-assessment, action plans and information, meetings/interviews with the CNE and interim CNE/NOO, Nurse Educator, Compliance Officer, Clinical Nurse, Infection Control Nurse, Hospital Liaison Nurse, Nurse Managers, direct care nurses, developmental center nurse, review of individuals' records, interviews and observations on the units, and attendance at the Morning Clinical Meetings, Continuous Quality Improvement Meeting, and Section M Compliance Meeting. The facility self-assessment stated noncompliance with provision M1, and the monitoring team agreed. <u>Staffing, Structure and Supervision</u> At the time of the review, the facility census was 248. There were a total of 108 budgeted positions of which 98 were filled. There were six unfilled RN positions and four unfilled LVN positions. The Nursing Department did not use agency staff and relied on its own staff to volunteer for shift-to-shift coverage. The monitoring team review of staffing records indicated an increase in overtime from July 2013 through August 2013. For the past six months, the facility's documentation of staffing patterns showed they had maintained staffing ratios, most likely via the use of overtime. . The Nursing Department maintained the leadership positions of the Nurse Educator and Compliance Officer, however, there was turnover in the CNE, RN Case Manager Supervisor, and Nursing Operations Officer. Although there was an interim appointment for the CNE position, the appointee was also performing the functions of the Nursing Operations Officer and RN Case Manager Supervisor. This interim appointee was previously the RN Case Manager Supervisor, and she accepted the position of the Nursing Operations Officer. The Nurse Managers also shared in the additional responsibilities due to an extended absence of a Nurse Manager Supervisor. Thus, staffing continued impact the nursing department in making significant progress toward compliance. The Nursing Department recruitment and retention activities included participation in health fairs, collaboration with nursing schools, and the availability of a preceptor program. During rounds with the interim CNE/NOO, Nurse Educator, and Compliance Nurse, it was positive to observe nursing leadership engaged with the nursing staff, direct support professionals, and the individuals. The current leadership staff were in need of a more structured leadership to model and guide standards of nursing care. The recently hired CNE should be able to work towards this, given his masters degree in nursing, and health care management experience. Although it was his first week at the facility, the CNE was observed to quickly gather his team and provide guidance in the development of corrective action plans. More positively,	Noncompliance

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		the nursing team was responsive to his leadership guidance. The nursing department acknowledged the monitoring team's recommendations in the last report regarding the development a process for accountability for all nurses. Specifically, nursing leadership had revised the Nursing Coverage Policy, implemented functional job descriptions, performance evaluations, and developed Direct Care Responsibilities for RNs. <u>Availability of Pertinent Records</u> • Acute Care Plans were not always present in the active record. • Nursing notes, signatures, titles were not always legible. • Frequently, notes were prefaced with "late entry." • Acute Care Plans were not consistently instituted, revised, or discontinued when the acute care problem was resolved. • Regardless of the individual's acute illness or injury, nursing notes predominately contained statements such as "continue to monitor," and "continue plan of care." • Acute illness and injury involving wounds were not consistently described as to appearance of size, color, presence or character of drainage, depth, width, and smell. • Integrated Progress Notes (IPN) did not contain instructions that were verbalized/told to the individual or the individual's direct support professional. <u>Hospitalizations and Hospital Liaison Activities</u> The Hospital Liaison Nurse had been in her new position for five months, and established working relationships with hospitals and long term care facilities utilized by the facility. The Hospital Liaison nurse followed up on all hospitalizations, transfers, and admissions to long term care facilities. The monitoring team interviewed the Hospital Liaison Nurse and found: • The nursing department had a designated Nurse Manager for back-up coverage. • The Hospital Nurse Liaison attended the Clinical Morning Meetings and provided an updated status on individuals who were hospitalized or in long term care facilities to team members. • The Hospital Liaison reported that she ensured continuity of care between the facilities by conducting onsite visits, reviewing medical records, and obtained day-to-day information related to current health status, lab, x-rays, reports, pending procedures, and discharges; and planning for any specialized equipment or supplies. • Hospital Liaison reports were provided to the individual's Primary Care Provider (PCP), direct care nurses, Nurse Managers, RN Case Managers, and other team members, and placed in the active record.	

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		The monitoring team attended the Clinical Morning Meetings on 10/21/13 and 10/22/13, and there observed the Hospital Liaison provide an in-depth review of Individual #167's current health status, response to treatment, enteral feedings, and supports that will be needed upon discharge back to the facility. Team members asked questions and requested follow-up regarding pertinent information related to the enteral feedings. The Hospital Liaison reported her findings regarding the eternal feedings. The information was used to make IDT decisions regarding needed supports upon discharge. The monitoring team reviewed 11 Hospital liaison reports for the period of 7/19/13 through 8/28/13 for individual #259 and Individual #313. The monitoring team found: • All of the Hospital Liaison reports contained the same repetitive typed statements. For example: "He was positioned properly during this visit" or "no edema to extremities." • Four of the Hospital Liaison reports included the exact same statements for Gastrointestinal: "non-distended no tenderness noted." • Two of the Hospital Liaison reports, for visit dates of 8/14/13 and 8/16/13, documented the date of the last BM (bowel movement) as, "none reported today last recorded BM on 7/10/13." • One Hospital Liaison report with visit date of 8/12/13 documented the date of the last BM as "BM X 3 on 7/10/13" • Eight of 11 (72%) contained pertinent information about the individual's laboratory findings, radiology reports, medications, and skin integrity The CNE should ensure Hospital Liaison Reports are reviewed for accuracy, prior to submission to team members. The CNE should ensure they are measured in "real time." The monitoring team reviewed the Integrated Progress Notes, Physician Orders, Medication Administration Records, Hospital Transfer Form, and Post Hospital/LTAC Nursing Assessment associated with two recent hospitalizations. The review found: • On 7/29/13, Individual #259's record indicated he was hospitalized. The nursing IPN note contained sufficient documentation to indicate that the individual's chief complaint of respiratory distress was assessed timely. The nursing assessment included vital signs, oxygen saturation, and a focused assessment of the respiratory system, specific to the chief complaint. Interventions from the nursing assessment included aspiration precautions, application of oxygen in response to the decreased oxygen saturation, and immediate notification to the primary care physician. The IPN nursing SOAP note contained NANDA diagnosis, and a plan for transferring the individual to the hospital. The assessment was positive in that the Nursing Protocol Minimum Documentation Requirements	

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		were followed. The monitoring team did not find a corresponding post Hospital/ER/LTAC Nursing Assessment for the discharge of 8/4/13. Additionally, the monitoring team did not find an order for the administration of oxygen. The facility reported that it did not have Guidelines for Oxygen Administration. • On 8/9/13, Individual #313's record indicated he was sent to the emergency room and was subsequently hospitalized on 8/10/13 in response to an abnormal chest x-ray result. The IPN note contained information of physician notification of the x-ray findings and orders to transfer to the hospital. The nursing notes contained vital signs and oxygen saturation. The nursing IPN had an omission for the SOAP format and for an assessment of the respiratory system. The record contained a sufficiently completed Transfer Form and Post Hospitalization/ER/LTAC Nursing Assessment. The Nursing Department should ensure, for emergent/non-emergent events, that there is a system in place to address the management of orders for oxygen and their perimeters. Assessment and Documentation of Acute Change in Health Status: Since the last review, the nursing department implemented processes, both new and continuing, to improve communication processes with care and services related to nursing assessments and documentation of acute changes. Some of these processes included: • Improved nursing attendance at Morning Clinical Meetings that included the Hospital Liaison Nurse. • Development and Implementation of Hot Charts to ensure timely assessments. • Development and Implementation of Nurse Manager logs for oversight and supervision of protocol implementation. • The interim CNE/NOO made rounds and reviewed records on the units for individuals identified with a change in health status that were discussed in the Clinical Morning Meetings. • ODRN Work Sheet (24-hour report) information was provided to all clinical staff for pertinent changes in status for each shift to minimize delays in assessment, treatment, and follow-up. The monitoring team selected a record for review from the Clinical Morning meeting that had an acute change in health care status. The review found: • According to Individual #132's Observation Note and IPN dated 10/23/13, at 4:50 pm, the individual was "banging his head on the floor." The observation note indicated he was referred to the nurse in response to the head banging. The record documented that the nurse went outside to initiate the assessment, where the individual was found sitting in a swing. The nursing assessment documented "a small amount of redness with no open areas, face slightly (missing word) from	

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		outside." The record indicated the individual went back into his home and into the dining room, but refused an assessment. Staff were asked by the nurse to bring him to the nurses' station after he ate. The next entry was at 6:40 pm by the QIDP, documenting a contact with the individual's family regarding a transfer of the individual to the emergency room. A late entry nursing IPN at 6:25 pm documented notification to the RN. The RN documented the findings from the reporting nurse that the individual was pale, blue, pulse rate of 47, and oxygen saturation was 89%, with oxygen administered at eight liters. The RN assessment of vital signs provided a pulse of 48, oxygen saturation of 85%, with administration of eight liters of oxygen. The record contained documentation that he had projectile vomiting five times and required repeated suctioning. The record documented that the physician was notified of the assessment at 5:50 pm, and ordered a transfer via Emergency Medical Services (EMS). A late entry IPN documented the individual's oxygen was decreased from eight liters to room air. The record also documented that EMS placed the individual on eight liters of oxygen prior to transporting to the hospital. The individual was admitted to the Intensive Care Unit with a head injury, aspiration, and was placed on life support. A number of serious issues were of concern to the monitoring team: • Emergency oxygen was administered in response to abnormal vital signs (oxygen saturation), however, the emergency response system was not initiated. The facility's Emergency Response Policy defined an emergency situation as "any illness or injury that requires immediate assessment and treatment by medical staff." • The individual's record had an omission of a thorough respiratory assessment, for example, flaring of the nares, use of accessory respiratory muscles, respiratory depth, and shortness of breath. The preceding was of concern because the goal of oxygen is to relieve or prevent hypoxia, and the record had an omission of pertinent documentation related to the respiratory status. An additional concern was orders were not available in the record for the administering of oxygen. The facility reported that it did not have Oxygen Administration Guidelines. • A nursing head injury protocol was not initiated. • Documentation was not available that the head of the bed was elevated during oxygen administration, and documentation was not available that aspiration precautions were in place. He was placed in recovery position after vomiting, according to a late IPN nursing note of 9:00 pm. The preceding indicated that due to his respiratory status, oxygen support was needed, and in the prevention of aspiration, positioning was essential.	

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		Infirmary The facility continued to have a designated bed in unit 673 for enhanced medical supervision. A Medically Enhanced Supervision Policy remained in draft, as noted in the previous monitoring report. However, during rounds, the nurse educator indicated the draft policy was being followed. The CNE should follow-up with administration for processes regarding approval and implementation of policies, procedures, and guidelines, and under what authority changes can be implemented to support health and safety needs in a timely manner, while awaiting such approvals. Infection Control and Skin Integrity The Infection Control Preventionist made improvements to the facility's infection control program. Actions that supported these improvement included: • Implementation of real time monitoring of communicable disease. • Development and implementation of guidelines for monthly infection control reporting, the prevention and control of an infectious disease outbreak, and environment of care inspections. • Monitoring of hand hygiene during meal time. The Infection Control Minutes for the last six months, as noted from the previous monitoring report, and for this report were not availed in the document request, thus the monitor could not ascertain if meetings were being held. The monitoring team attended an Infection Control meeting on 10/23/13, where the relevant members were present. The meeting was facilitated by the Infection Control Preventionist (ICP). The ICP reported on findings from the conducted hand hygiene observations, environmental rounds, and trended infection reports. . During the meeting, questions were presented by the monitoring team regarding the flow of information, that is, how the ICP received time sensitive information, including culture reports, reports of infections, positive converters, and human bites. The ICP reported she did not receive direct lab reports, and often was not consistently notified of human bites, or when an antibiotic had been prescribed. The CNE should ensure all criteria related to infection control are managed under one umbrella, and that the ICP has immediate access to necessary infection control information. The data presented in the meeting were questioned by the monitoring team, specifically question marks placed in the Employee Health data related to human bites. The ICP, after the meeting, provided the monitoring team with a corrected report. The corrected report included two human bites for June 2013, one for August 2013, and one for September 2013. The employee infection data did not contain any corresponding Employee Injury/Injury Exposure report for the four human bites. The CNE should ensure processes are in place, in following standards of care in accordance with the facilities Blood Borne Pathogens policy. For each human bite there should be a corresponding	

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		investigation and follow-up by the ICP. The Infection Control data for May 2013 through September 2013 incidence of infection per 1000 resident days are from highest to lowest incidence as follows: • skin and soft tissue infections • urinary tract infections • upper respiratory infections • eye infections • aspiration pneumonia • pneumonia The data presented during the Infection Control Meeting did not provide a unified standardized classification system for documenting infections that was specific. For example, the data should include whether the infection was hospital acquired or facility acquired, and document whether urinary tract infections are associated with or without a Foley catheter. The infection control meeting did not contain information on antibiograms. The ICP should elicit the assistance of the medical and pharmacy directors to develop antibiograms reports. The pharmacy director reported the flu vaccine had been ordered and shipment was expected in the very near future. The facility was expecting flu vaccine to arrive to begin their annual flu vaccine campaign. The facility reported a 91% compliance rate with annual TB screenings. Additional information was not available as to the status of the remaining 9%. The document request, reported that the facility did not have a unified data base for monitoring individual cases. The monitoring team was provided, from the Clinic Nurse LVN, a document with a list of individuals with a positive PPD, however, it was not know as to the comprehensiveness of the report. The monitoring team suggested the ICP develop a centralized system to efficiently manage the monitoring of PPDs, PPD convertors, and annual tuberculosis assessments for positive PPDs. The information should be made accessible to the Medical Director and the CNE. The Infection Control Meeting had previously combined the skin integrity data as part of the Infection Control Meeting. The Program Compliance Nurse did an excellent job in the presentation of data during the meeting. He provided documentation that illustrated the pressure ulcer by home, stage, rate of incidence, and whether the pressure ulcer was hospital or facility acquired. June 2013 through September 2013 data showed the total number of pressure ulcers was four and all four were stage two. Three of the four (75%) were hospital acquired. The facility should continue to improve upon the standard of care	

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		by reducing the total number of all pressure ulcers to zero. The Nursing Department was in the process of developing processes to capture all skin integrity issues. The monitoring team will follow-up at the next visit. Following the Infection Control Meeting, the Clinic LVN was interviewed. The Clinic LVN stated data bases were maintained for tuberculosis screenings and some vaccinations data. The Nursing Department reported that it did not have a data base that could ascertain how many individuals were up to date with the recommended CDC vaccinations. The ICP should ensure there is a standardized data base for tracking TB screenings status and immunization status by individual. <u>Quality Assurance Activities</u> The Nursing Department worked collaboratively with the QA/QI nurse. Activities the QA/QI nurse engaged included: • Conducting 24-hour death review for individuals who had an acute change in condition or died off campus • Completing clinical death summaries • Attending clinical and administrative death reviews • Tracking and follow-up of mortality recommendations • Tracking and follow-up on Corrective Action Plans (CAPs) • Committee membership: medication variance, infection control, pharmacy and therapeutics committee • Performing inter-rater reliability for established nursing audits • Attending nursing meetings • Preparing data for QA/QI • Attending QA/QI meetings Regarding problematic findings from the nursing audits, the QA nurse provided consultation to the program compliance nurse, nurse educator, and interim CNE/NOO. Additional joint quality assurance initiatives, included HOT Charts, nurse manager logs, and a purposed flag notification system. The Nursing Compliance Officer and QA nurse made improvements to their data to include comparisons between the monitoring tools and inter-rater reliability, as recommended by the monitoring team. The comparisons were represented in graphs that included sample size, percentage comparisons between the nursing audit score, and the QA inter-reliability score. The monitoring team reviewed the data and found: • 90 of 98 (92%) nursing audits had a corresponding inter-rater reliability audit • 68 of 89 (82%) audits achieved full agreement with the inter-rater reliability	

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		The monitoring team met with the Medical Director, CNE and interim CNE/NOO, Nurse Educator, Director of QA, and QA nurse to review submissions of clinical death summaries and nursing recommendations from the death reviews. A document entitled SASSLC CAP Tracking Log (Pending) contained recommendations from death reviews resulting from deaths occurring in April 2013 and June 2013. The document had omissions of completion dates for all of the nursing recommendations. The nursing department had documented actions for the recommendations of which the monitoring team was unable to discern the status of those actions, such as a revised BM log to address documentation related to bowel and bladder. Regarding response to recommendations, the monitoring team suggested the responses by the Nursing Department should be achievable, measurable, and include specific time lines for completing. The CNE provided a CAP entitled SASSC Nursing Mortality Recommendations Log which contained revised due dates for completing the recommendations. The monitoring team at the next visit will follow-up on the status of the nursing death recommendations. For more on mortality reviews, see section L. <u>Mock Code Drills and Emergency Response</u> The monitoring team conducted inspections of emergency equipment at different times of the day and evening shift for all units. The monitoring team was pleased to find all emergency equipment was present, operational, and properly stored. The monitoring team reviewed emergency drills documentation since the last review, a total of 40 drills were conducted with 100% Pass Rate. A facility report indicated 14 individuals certifications in first aid, CPR, or ACLS applicable certification had expired. Nursing and Medical did not have delinquencies within the 14 identified. Additional information was not available for a plan to address the individual delinquencies. The facility, as a component of their emergency response discussions, reported the following regarding summer heat and hydration-related actions: • Ensuring, through monitoring, water containers outside the home remained filled throughout the day. • Increased monitoring of individuals exposed to the sun and application of sunscreen. A review of medication administration records for Individual #313, Individual #259, Individual #342, Individual #342, Individual #314, Individual #256, Individual #47, Individual #71, Individual #330, Individual #55, Individual #305, Individual #328 and Individual #347 for August2013, indicated physician orders for the application of Sunblock, however, none of the records documented the use of the Sun Block.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>M2</td><td>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.</td><td>The interim CNE/NOO continued to hold the functions of the RN Case Manager Supervisor during the vacancy of the RN Case Manager Supervisor. The interim CNE/NOO, Nurse Educator, and Nursing Compliance Officer worked with RN Case Manager to provide the necessary training and tools to execute a timely and quality nursing assessment. The nursing department on 5/15/13 implemented a Corrective Action Plan (CAP) to address timelines and quality of nursing assessments. The RN Case Manager held meetings with RN Case Manager to identify common barriers as a group and individually with RN Case Managers who were rated to be deficient/delinquent with their nursing assessments. In addition, the nursing department continued to track the individual performance of each RN Case Manager.

The monitoring team reviewed 12 individuals' Comprehensive Annual/Quarterly Nursing Assessments selected from the facility's high risk list from across all units.
19 of 24 (79%) Annual/Quarterly assessments were completed according the individual's annual ISP
13 of 24 (54%) contained an adequate analysis between the previous and current quarters
16 of 24 (66%) Annual/Quarterly nursing assessments nursing analysis/summaries sufficiently summarized the individual's health status
13 of 24 (54%) Annual/Quarterly nursing assessments contained a sufficient assessment of the high and medium health risks
15 of 24 (62%) nursing assessments were updated as indicated by the individuals health status
The facility's own Section M Nursing Compliance Meeting, for May 2013 through August 2013, reported the following:

<table><tr><td></td><td>May</td><td>June</td><td>July</td><td>August</td><td>Average</td></tr><tr><td>Timelines of Assessments</td><td>91.39%</td><td>84.61%</td><td>91.48%</td><td>76.34%</td><td>86%</td></tr><tr><td>Quality of Assessments</td><td>53%</td><td>58%</td><td>77%</td><td>88%</td><td>69%</td></tr></table>The monitoring team reviewed six of the most recent community discharges and found:
One of the six (16%) discharge packets contained a copy of the IRRF
None of the six (0%) sufficiently addressed the health status of the individual
None of the six (0%) discharge packets contained the most recent nursing assessment to provide baseline health information
None of the six (0%) included the individual's current immunization record
None of the six (0%) discharge packets contained a copy the individual's IHCP</td><td>Noncompliance</td></tr>
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		• None of the six (0%) Nursing Discharge Summaries provided information for what an emergency would look like for the individual • Two of the six (33%) Nursing Discharge Summaries contained sufficient special instructions • None of the six (0%) Nursing Discharge Summaries contained attachments for Moses/Discus Individual #316's packet included information in his structural and functional assessment that he "receives a reinforcer every instance he attends work for one hour or more." The Nursing Discharge Summary did not include information corresponding to how his diet or drink/food reinforcer would be managed in the community. The individual also had diagnosis of an external hemorrhoid and constipation; special instructions were not available regarding his bowel habits or the current treatment for the hemorrhoid. Individual #83's Nursing Discharge Summary contained a medical diagnosis of alopecia due to trichotillomania, which were not explained in the Nursing Discharge Summary. The individual also had a history of MRSA cellulitis. The Nursing Discharge Summary did not address the need for infection control education. Individual #97's took a medication that required laboratory testing monthly for a complete blood count. The prescription renewal of the medication was dependent upon the results from the laboratory findings. The Nursing Discharge Summary did not contain sufficient information to ensure continuity of care, or that coordination of services had been established, in order to meet the health care needs related to his medication. Considering that many community homes do have onsite nursing services, the Nursing Discharge Summary should be informative and explanatory in order to facilitate continuity of care. Consideration should be given to developing a more robust nursing discharge summary that is individualized. The facility should also consider developing Discharge Guidelines to address continuity of care issues, as noted in the preceding examples.	

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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.	Nursing Acute Care Plans continued to be problematic: most were "canned" and were not individualized, and most continued to be in place for weeks or months after the individual's acute illness or injury had resolved. The monitoring team reviewed 12 individuals with the most recently completed Acute Care Plans for acute illness and injury. The review found : • None of four (0%) of the Acute Care Plans were individualized • None of the four (0%) included relevant nursing protocols • Two of four (50%) contained signatures of the Home Managers, validating training on the ACP • Three of four (75%) had sufficient goals • Three of four (75%) had baseline data described the acute care event • Two of four (50%) contained sufficient interventions • Two of four (50%) contained staff instructions • Two of four (50%) were for acute illness • One of four (25%) was for an infection The monitoring team requested 12 records with the most current ISP dates to review Admission, Annual, and Quarterly Comprehensive Assessments and completed Individualized Health Care Plans. • 11 of 12 (92%) individuals had IHCPS for all risk ratings • 9 of 12 (75%) IHCPs instructions were written in terms the Direct Support Professional could likely understand • 8 of 12 (66%) IHCPs contained sufficient action steps to address the risk • 1 of 2 (50%) Change of Status IHCPs contained sufficient action steps to address the risk associated with the change of health care status The self-assessment for IHCPs reported May 100%, June 62.5%, July 66.5%, August 100%. No information for September. The average for May-August 2013 was 82%. Although the Nurse Educator indicated that protocols had been implemented and that the nursing department was working toward improved IHCPs, there was much work to do here. The Nurse Educator should collaborate with the Nurse Managers, Direct Care Nursing Staff, and RN Case Managers to develop competency training case examples that include the application of critical thinking.	Noncompliance

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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.	Training/Training Records Reviewed The monitoring team was pleased to see that the Nurse Educator had put in place a data base to track each of the nurse's educational courses and competencies levels. The Nurse Educator presented information in the Nursing Competencies Report and Dashboard Competencies Report. The Nurse Educator explained the target quantity referred to the number of nurses to be trained for each competency. The Dashboard Competencies Report provided the following:	Noncompliance

Competency	Total Completed	Target Quantity	Difference
1. G-tube Insertion	38	62	-24
2. Medication Administration(annual)	59	62	-3
3. Tracheostomy Suctioning	35	67	-32
4. Tracheostomy Cleaning	0	62	-62
5. Nebulizer Treatments with respiratory assessment	43	62	-19
6. Glucometer (Control Testing)	42	62	-20
7. Urinary Catheterization	40	62	--22
8. Enteral Nutrition	42	62	-22
9. Insulin administration	59	62	-3
10. Breast exams	39	62	-23
11. Blood Glucose Test	43	62	-19
12. Hemmoccult tests	48	62	-14
13. Suprapubic caths	9	61	-53
14. Tracheostomy Dislodgement	4	62	-58
15. Enteral Medication Administration	59	62	-3
16. Vital Signs	47	62	-15
17. Injections Subcutaneous	59	62	-3
18. Injections Intradermal	4	62	-3
19. Injections Intramuscular	59	62	-2
20. Injections Z-Track	59	62	-3
21. Skin Management Wound Prevention	6	62	-56
22. Venipuncture	7	62	-55
23. Documentation	1	62	-61
24. Hospital Report Policy and Comm. with Hospital	1	62	-60
25. Med Admin for IDD	58	62	-4
Totals	781		-594

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		The breakdown by percentages on the Dashboard illustrated the percentage of the 25 competencies competed were as follows. • 90% completion for seven of the skill/competencies. • 70% completion for two of the skill/competencies. • 60% completion for one of the skill/competency. • 50% completion for six of the skill/competencies. • 20% completion for one of the skill/competency. • 10% or less for completion for eight skill/competencies The preceding information did not include information for the number/percent of nurses by title, RN, LVN that had completed the state mandatory trainings, for example, MOSBY by Chapter Trainings, Protocol Cards, or documents for acknowledgement of changes in policy, procedures, or guidelines. According to the Nurse Educator, all but six nurses had completed the state required training. Problems associated with obtaining completion skill/competencies have a causal relationship between the numbers of nurses that can be accommodated in the classroom. The areas designated for classroom instruction and competency assessment had a maximum capacity of four, because the space was also used as an office. In addition to space needs, there was a lack of sufficient training/equipment for demonstrating skill/competency, as mentioned in the monitoring team's last report. Review of IPN, Observation Notes, and ACPs for select individuals found: Individual #314 • 10/3/13 at 9:40 am, the IPN indicated that staff reported that the individual had bleeding from around her stoma. The nurse observations documented "no active bleeding from the skin, Red and abraised appearance. No drainage, swelling, or increase temp to skin." The record documented a telephone order from the individual's primary care provider. A topical medication was ordered for three times a day, for five days and PRN. The nurse documented in the assessment "impaired skin around stoma related to friction." The IPN note contained documentation that staff were to report to the nurse for any itching or rubbing of the area. • The review was problematic for nursing protocol because minimum documentation was not fully implemented. The documentation requirements when contacting the PCP were not fully implemented. o Omission of full implementation of nursing protocol for minimum documentation requirements. o Omission of full documentation requirements when contacting the PCP.	

#	Provision	Assessment of Status	Compliance
		o Medication Administration Record for the prescribed medications did not contain the route of administration. o Omission for evidence for an assessment as to factors for the underlying reason for the "Red and abraised appearance." o Omission of an Acute Health Care Plan to address skin integrity issues. o Omission of written staff instructions in the individual's record. Individual #342 • 7/2/13 at 8:10 am, the IPN indicated staff reported a new injury on the individual's face. A nursing assessment documented "swelling to bilateral side of nose, bruising and redness noted to bilateral sides of nose and next to inner eyes." The assessment was for risk for infection. The plan of care documented "neuro checks initiated, monitor, and staff to report concerns." • 7/3/13 at 5:30 pm, the individual was assessed and reported edema to sides of nose. The nursing plan of care included application of ice for five minutes, and neuro checks continue for 24 hours. • 7/3/13 at 8:00 am, the individual was assessed with" increased swelling to sides of nose underneath eyes." Vital signs were taken, the plan of care documented neuro checks completed, continue to monitor, requested MD follow-up, and staff to report concerns. • 7/3/13 at 10:00 am, the individual was seen by his primary care provider, the assessment was a possible fractured nose. • 7/3/13 at 12:15 am, the nursing note indicated an x-ray was taken of the nose, and the individual had a new helmet with face shield. • 7/3/13, the Nursing IPN stated the x-ray shoed mildly displaced nasal bone fracture. The physician was notified and the individual was transferred to the Emergency Room. • The record was problematic for: o Omission for documentation of neuro check sheet in the record. o Omission of full implementation nursing protocol for head injury. o Omission of full vital signs: oxygen saturation. o Omission of prompt notification to the physician based upon signs and symptoms from a suspected injury. The Nurse Educator was observed by the monitoring team to be very approachable and accessible to the nursing staff, and to the medical staff for educational/training supports. One of the examples was observed when a PCP approached the Nurse Educator requesting training for staff for one of the units regarding seizure management.	

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		The Nurse Educator reported that he offered training on all shifts in order to ensure there was not disruption in the delivery of nursing care on the units. Activities conducted by the Nurse Educator included: • Medication Pass Observations inter-rater reliability. • Medication Variance Training for Reporting Medication Variances (8/13). • Medication Observation Report /Tracking Medication Pass Observations. • Presentations Community Health Fairs for recruitment of nursing. • Collaboration and coordination with nursing schools for nursing trainee observations at SASSLC. • New Orientation Training (NEO) for nurses. • Observing and Reporting Clinical Indicators as a part of NEO. • Integration of Training on Protocol Cards as part of NEO Training for Nurses. Although there were notable improvements by the Nurse Educator in educational activities, nursing policies, procedures, and protocols, these had not yet been sufficiently put in place to meet the individuals' needs. The CNE should ensure there is a plan that includes timelines for completing training competencies.	
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 conducted a comprehensive review of 12 records requested by the monitoring team, for the last three months and current month, and reviewed 11 recent Integrated Risk Rating Forms and Individual Health Care Plans. • None of 11 (0%) were written in person centered language. • None of 11 (0%) indicated how the individual participated in the health care goals. • None of 11 (0%) contained references regarding how the individual would participate in the health care plan. • 7 of 11 (63%) included sufficient nursing assessments to assist the team in developing appropriate plans sufficient to meet the individuals health care needs. • 7 of 11 (63%) were sufficiently integrated among all appropriate disciplines. • 6 of 11 (54%) identified appropriate clinical indicators to be monitored and the frequency of the monitoring The monitoring team's findings were comparable with the facility's self-assessment that documented 5 of 10 records (50%) reviewed had appropriate identification of risk. Five Aspiration Trigger Data Sheets and IPNs were identified from the 12 requested records by the monitoring team for individuals selected as having high risks for aspiration: Individual #313, Individual #328, Individual #71, Individual #347, and Individual #314).	Noncompliance

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		The review found: • Four of Five (80%) Aspiration Trigger Data Sheets contained data (one was blank). • None of five (0%) had individualized aspiration triggers identified. • Four of five (80%) were reviewed weekly by the RN Case Manager • One of five (20%) was filled out daily, on each shift The facility was diligently working with RN Case Managers and the ISP process toward a more integrated process with the IRRF and Integrated Health Care Plan, however, much continued work was needed here, as risk and risk factors were not fully realized.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	<u>Medication Administration:</u> The monitoring team conducted 19 medication pass observations and interviewed 13 nurses. A medication observation pass was conducted in each of the units at various times of the day and evening during the week of the onsite visit. The monitoring team was accompanied by the Nurse Educator for all medication passes. The monitoring team applied the same audit tool utilized by the facility to conduct Medication Pass Observations. These observations included oral and crushed medications, medications administered via tube, and medications given with different mediums (e.g., applesauce, pudding, thickened liquids). The findings are as follows: • 19 of 19 (100%) medication observations identified the individual prior to administration. • 19 of 19 (100%) medication observations the nurse refer to the PNMP prior to beginning administration of medication. • 19 of 19 (100%) medication observations the nurse ensured the individual was in proper position prior to medication administration. • 19 of 19 (100%) the nurse checked the MAR for allergies prior to administration. • 19 of 19 (100%) medications and storage areas were secured before/during/after administration. • 19 of 19 (100%) medications were administered according to prescription in terms of right person, right drug, right dosage, right time, right route and right for of drug. • 18 of 19 (95%) followed standards of infection control practice • 10 of 19 (52%) provided instruction to the individual or his support staff regarding side effects • 11 of 19 (56%) verified the individual had swallowed their medication The facility had instituted safe medication practices that included ensuring the right individual was identified to receive his or her medication. This medication safety practice was successful through the attentiveness of DSPs who assisted in controlling traffic at the	Noncompliance

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		medication door, and identifying the individual with the nurse. The monitoring team was also impressed by the efforts by DSPs to assist the individuals with their hand hygiene prior to obtaining their medications. <u>Medication Room Inspections/Refrigerators/Glucose Monitoring</u> The monitoring team reviewed the submitted temperature check sheet and found different versions of the form. Some of the versions did not include guidance for the temperature ranges or delineate if the refrigerator was solely used for medications, or individuals' mediums for administering medications. Guidance on some of the Temperature Check Sheets indicated the refrigerator was to be checked three times a day (once each shift), however, a number of the sheets had an X for the 11-7 shift. Twenty-five of 29 (86%) documented the refrigerator/freezer temperature. The facility should consider the development of a standardized document. The facility conducted its own monthly Medication Inspections. For the month of August 2013 there was an audit for each unit (and the dental clinic) for a total of 11 inspections. The results were: Four of 11 (36%) inspections did not reference the finding of expired medications. Six individuals had glucometers. Six of six (100%) of the glucometers had a documented glucose control level in the acceptable range of the highs and lows set by the manufacturer. Six of six (100%) contained documentation that monthly quality control checks were conducted. <u>Documentation:</u> The monitoring team requested and reviewed the Nursing Department Master Signature Legend for nurses. Most of the signatures and titles on the Master Signature Legend were legible. A number of the sheets contained signatures written in the lower margins of the sheets. None of the Master Signature sheet contained a date of the signature, therefore, the monitoring team was unable to determine if the blank spaces for the pre-printed individual nurse names was an omission or due to a vacancy. <u>Storage:</u> Scheduled drugs were observed as being maintained under double lock and there were records documenting the accountability of those drugs. The monitoring team conducted focused reviews of the storage of external and internal medications and their associated expiration dates of medications on all units. Most medications were stored appropriately. • The monitoring team observed medications that were expired, improperly stored, or did not contain a current date after being opened.	

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		Medication Variance Committee Meetings/Medication Variances The facility stated in its self-assessment Medication Variance Meetings were not held for numerous months and that the process had currently been reinstated to address reconciliations of medications. The monitoring team was provided with minutes from May 2013 and September 2013. The monitoring team attended the Medication Variance Committee Meeting on 10/23/13. The Medication Variance Committee was attended by committee members. The meeting was facilitated by the CNE designee: the Nurse Compliance Officer. The meeting did not include, by discipline, in-depth discussions with regard to medication variances. The data presented at the meeting did not include August 2013 and September 2013 nursing medication variances. The monitoring team was later provided the number of medication variances by discipline. Eight medication variances were documented for August 2013 and three for September 2013. Additionally, data were not made available for medication reconciliation for August 2013 and September 2013. The Nurse Educator interviewed the nurse educator, nurse managers, and direct care nurses on the unit to ascertain their understanding of how medication variances are reported. Although the Nurse Educator had placed a detailed guide of how to report a medication variance dated 8/13 on units, it was evident that the nurses were not familiar with the process. As noted in the previous monitoring report, the facility reportedly, until August 2013 had continued to use the system of calling in the medication variance to a designated phone number. The September 2013 Medication Variance Meeting minutes also referenced establishing a call in line for reconciliation of medications. The monitoring team requested, from the pharmacist, examples of the paper medication variance reports that were used when medication errors were called in to the designated number. Three medication variances for three individuals (Individual #71, Individual #213, and Individual #178) were provided. Errors were reported for the months of June 2013 and July 2013. The review found: • One of three (33%) contained information regarding corrective actions taken. • One of the three (33%) contained both pages of the SSLC 053 Medication Variance Form. • Three of three (100%) were discovered; one, however, was discovered after 54 days due to a transcribing a complete order The monitoring team also reviewed 10 of the most recent medication variances, for Individual #247, Individual #295, Individual #62, Individual #96, Individual #37, Individual #335, and Individual #338. Of the 10 medication variances, three individuals had two medication variances (Individual #295, Individual #62 and Individual #335). The	

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		findings are as follows: • One of 10 (10%) of the three medication variances contained information regarding corrective actions taken. • Six of 10 (60%) were discovered within 24 hours of the variance, of the remaining four: one was discovered on the 10th day, one on the sixth day, and one on the fifth day. • Three of 10 (30%) of the medication variances were documented for the section header draft/final as final. • 10 of 10 (100%)of the medication variances contained documentation of corrective actions • Eight of 10 (80%) variance node was prescribing, one was documentation, and one was other. • One of 10 (10%) Severity Index for the medication variance was C. • Seven of 10 (70%) documented notification to the physician and included the time of notification. The monitoring team reviewed the MAR, IPN, physician orders, and ODRN report for individual #74 and individual #172. The monitoring team requested the actual medication variance during the onsite visit. The facility was unable to locate the information. • The nursing IPN of 6/13/13 at 8:55 am documented the occurrence of a medication error, of which Individual #74 had received Individual #172's morning medications. The IPN note contained documentation of notification to the individual's PCP. The individual was seen by his PCP on 6/13/13 at 10:00 am, and orders were received to monitor. The nursing staff documented on the follow-up notes, "monitor for change." The document had omissions for what signs and symptoms of change should be observed as a result of receiving the wrong medications. The facility conducted a Root Cause Analysis (RCA) on medication variance on 6/20/13. The RCA documented included typed information for the participants. The Team Leader was the Nursing Compliance Officer and the only typed name in the document. The signature sheet contained three signatures, two of which were legible. The RCA documented the event, described the event, and reviewed the sequence of events. Contributing factors to the event on the RCA included that the nurse and DSP did not verify the individual, and that staffing was inadequate to verify and control traffic at the door. The facility documented three prevention strategies in ranking order from highest to lowest priority: advise nurses to gain control of their environment and consider including Nursing Orientation, speak to unit directors on staffing home to ensure there is team work, and provide requirements of identifiers with nursing staff. Risk reduction actions taken included conducting an reenactment of	

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the event by the Medication Variance Committee, remedial education to the nurse committing the error, and transfer to another team and medication observation pass follow-up for two months.
The review did not include team members who on a day-to-day basis actually administer medication and thereby were more familiar with the processes. The remediation did not contain measurable outcomes. For example, information was not included regarding a revision or redesign of systems to prevent the re-occurrence. Thus, events analyzed in silo fashion (i.e., by a single department) had less-than-thorough analysis and intervention.
The information was transferred to a Fishbone Cause and Effect Diagram. The diagram was presented in the QA/QI meeting as a quality assurance initiative.
The nursing department, without formal training in RCA, are recognized for their efforts in their attempts to improve upon medication safety. The SASSLC Medication Variance Policy #053 Referenced used the Joint Commission on Accreditation of Health Care Organizations (JACHO) RCA models. The facility should consider if an RCA methodology will continued be used to improve care and minimize risk for medication errors, that there is an investment of training from an authoritative external source for staff conducting the RCA or similar methodology (also see sections E and L3).

The following were the medication variance and reconciliation of medications by month:

Medication Variances 2013						
	April	May	June	July	August	September
Dental	Not Reported				11	1
Medical	0	0	8	4	6	3
Multiple Disciplines	0	0	5	1	12	3
Nursing	127	137	46	63	8	7
Pharmacy	24	47	25	36	44	12
Total	151	184	84	104	81	23
Medication Reconciliation 2013						
	April	May	June	July	August	September
Number Medications Returned to Pharmacy	3,551	4,211	3,061	3,042	No data available	No data available
Number Medications Unreconciled	788	418	276	150	No data available	No data available
Medications Reconciled	2,763	3,793	2,785	2,892	No data available	No data available
Percentage Medications Reconciled	78%	90%	91%	95%	No data available	No data available

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		As mentioned in the last monitoring team report, there continued to be a disparity between the number of unreconciled medications and the number of medication variances. The facility should ensure each medication is reconciled. Each unreconciled medication should have a corresponding medication variance. The monitoring team suggests the CNE implement a shift-to-shift medication count of the individuals' medications to ensure individuals are receiving their medications, until such time it can be demonstrated 100% reconciliation of medications. <u>Oversight and Monitoring</u> The Nursing Department began, in July 2013, tracking the number of medication passes required and the number completed. The Medication Observation Report indicated 32 of 54 (59%) medication observations were completed for the third quarter, July to September 2013. The Nurse Educator provided 10 medication observations passes inter-rater reliability. The monitoring team was unable to discern validation of inter-rater reliability without comparison information of agreement within the inter-rater reliability process. The facility reported its topical medication audits and diabetic insulin audits were suspended in January 2013, and the facility planned to resume the audit in November 2013. The monitoring team will follow-up and review at the next visit, the preceding information regarding audits and inter-rater reliability. <u>Pharmacy and Therapeutics Committee Meetings</u> Minutes from the April 2013 and August 2013 Pharmacy and Therapeutics Committee meetings were reviewed by the monitoring team. The April 2013 minutes included information presented by the CNE regarding the quarterly medication variance report for March 2013, documenting 5,411 medication doses returned to the pharmacy, and of those, 3,821 (70.6%) had been reconciled. The minutes also contained discussions regarding monitoring team recommendations from the previous visits, however, the minutes did not contain documentation of follow-up action steps for those discussion items. The August 2013 minutes referenced that the previous CNE reported the facility was doing much better with medication reconciliation. The minutes also included the statement "The medication variance process rolled out by the State Office was implemented 8/1/13." The minutes did not include any further discussion as to what the new process entailed, or how the new process had impacted changes/reductions of the	

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		numbers of medications reconciled. The August 2013 Pharmacy and Therapeutics Committee minutes addressed the utilization of the right resource when crushing medications. The nursing staff relied on a cheat sheet for medications in making determinations whether or not the medication could be crushed, prior to administration. The minutes included an audit that included a random selected sample of all individuals at SASSLC. Twenty-six individuals were identified for the review. The diet texture and instructions on the PNMP were identified for each individual. Nursing staff participated in the survey by documenting whether or not, for those individuals in the sample, medication was crushed prior to administration. The findings from the result indicated medications should be crushed in accordance with the PNMP instructions. The audit indicated one individual should have received her medications crushed. No additional information was available regarding whether a medication variance was completed as a result of the finding. For more information on the Pharmacy and Therapeutics Committee, please refer to N8. To move in the direction of substantial compliance the facility should ensure the Medication Variance Policy is fully operational.	

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, 5/15/13 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 Pharmacy and Therapeutics Committee Meeting Notes o Medication Variance Review Committee Meeting Notes o Polypharmacy Committee Meeting Minutes o Pharmacy Clinical Intervention Report/Notes Extracts o Adverse Drug Reactions Reports o Drug Utilization Calendar o Drug Utilization Evaluations • Phenobarbitol • Prolia o Quarterly Drug Regimen Review Schedule o Quarterly Drug Regimen Reviews for the following individuals: • Individual #201, Individual #242, Individual #145, Individual #92, Individual #255, Individual #106, Individual #199, Individual #235, Individual #53, Individual #23, Individual #200, Individual #174, Individual #74, Individual #277, Individual #197, Individual #254, Individual #80, Individual #10, Individual #3, Individual #213, Individual #113, Individual #22, Individual #147 o MOSES and/or DISCUS Evaluations for the following individuals • Individual #74, Individual #257, Individual #14, Individual #178, Individual #340 Individual #261, Individual #72,Individual #204, Individual #198, Individual #47, Individual #137, Individual #68, Individual #2, Individual #303, Individual #150, Individual #155, Individual #89, Individual #285, Individual #183, Individual #97, Individual #270, Individual #140, Individual #125, Individual #425

	Interviews and Meetings Held: o Sharon Tramonte, PharmD, Lead Pharmacist o Nicole Cupples, PharmD, Clinical Pharmacist o David Espino, MD, Medical Director o David Bessman, MD, Primary Care Physician o Linda Fortmeier–Saucier, DNP, FNP-BC, RN, Family Nurse Practitioner o John Sadberry, MD Primary Care Physician o Mandy Pena, RN, QA Nurse o Robert Zertuche, RN, Program Compliance Nurse Observations Conducted: o Pharmacy and Therapeutics Committee Meeting o Medication Variance Committee Meeting o Polypharmacy Oversight Committee Meeting o Daily Clinical Services Meetings o Medical Staff Meeting o Medical Continuous Quality Improvement Meeting
	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. In many ways, the self-assessment was improved because it covered more areas assessed by the monitoring team. Yet, in other ways the assessment was not forthright. There were areas that the clinical pharmacist was aware needed to be addressed, but were not. That was not helpful in accurately assessing the status of a provision. For example, for provision N5, the monitoring team unequivocally stated that maintaining substantial compliance would require that the facility assess the status of completion of the side effects rating tools for individuals who did not receive psychotropic medications. This was thoroughly discussed during the last review and compliance report. Yet, there was no metric for this in the self-assessment, even when knowing that it would be reviewed. For the Intelligent Alerts, the self-assessment alluded to problems stating there was no consistent trend in the number of intelligent alerts, but the "pharmacist consistently contacted the prescriber when additional monitoring is required." There was overwhelming evidence that the Intelligent Alerts were being declined and this was not being addressed. There should have been some metric of measurement in the self-assessment. That would have likely impacted the facility's self-rating of substantial compliance, but it would have been a more appropriate and accurate assessment. Similar thinking applies to the provision N4. The pharmacists made many recommendations to the prescribers, but many of the recommendations were not accepted. The monitoring team has clearly indicated that the standard is applicable to both prospective and retrospective recommendations.

	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 in addition to the recommendations. 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, and N7. For provision item N6 and N8, the facility rated itself in noncompliance. The monitoring team found the facility to be in substantial compliance with N2, N3, N4, and N7. The monitoring team rated provision items N1, N5, N6, and N8 in noncompliance.
	Summary of Monitor's Assessment: San Antonio State Supported Living Center faced unique challenges because medications were dispensed at the San Antonio State Hospital (SASH) and not the facility. Therefore, SASSLC did not have a true pharmacy department. There were two clinical pharmacists. The facility also employed a pharmacy technician who actually worked at the state hospital. There was no department head, but one clinical pharmacist functioned in a lead role and was involved in many activities. Overall, progress was observed in some areas and practices were maintained in other areas. There was unfortunately a failure to address a few well established issues, which resulted in regression in other areas. There appeared to be increased documentation of interactions between prescribers and pharmacists including recordation of order clarifications, Intelligent Alerts, and retrospective recommendations made during clinics. Physician orders at the facility presented major challenges to such a degree that a decision was made to implement changes that allowed some orders to be clarified without contacting the prescribers. Intelligent Alerts were implemented in December 2012, but the prescribers frequently opted to not follow the monitoring guidelines. Quarterly drug regimen reviews were completed and for the most part were done well. The monitoring team noticed a new trend of stacking information or failing to remove outdated information, which affected the accuracy of the evaluations. Monitoring for the metabolic risks was addressed through the QDRRs, but additional attention was needed in this area and staff could have benefitted from education on the association between metabolic syndrome, diabetes, and cardiovascular disease. The facility continued to have considerable problems with the completion of the MOSES and DISCUS evaluations. The monitoring team could not determine what individuals needed evaluations based on the use of non-psychotropic medications and neither could facility staff. It was reported that a corrective action plan was in progress. New problems were surfaced with regards to physicians responding to the recommendations of the pharmacists. The monitoring team has consistently stated that recommendations apply to prospective and retrospective recommendations. This has been documented in numerous reports. Yet, the facility continued to address this only from the perspective of the QDRRs. Even though the clinical

	pharmacists consistently documented that prescribers "do not accept" recommendations made retrospectively. Prescribers were not obligated to accept the recommendations of the pharmacists. However, the Settlement Agreement required documentation of a justification when this occurred. ADRs were reported by clinical pharmacists. The lead clinical pharmacist stated that the physicians reviewed the ADR reports. When asked for evidence this was done, there was no evidence that the medical staff had appropriately reviewed the ADRs. There was no consistent IPN documentation and the ADR forms were not signed. The physician review entries were not actually completed by the medical providers. Additionally, the dates on the ADR forms documented delays between the discovery of the reaction and the actual reported date of physician review. DUEs were completed and reported to the P&T Committee. Supplemental DUEs were also completed in response to FDA alerts. Corrective actions were implemented as warranted. The medication variance system began to make some progress following the last review, but changes in the system in August 2013 left the status at the time of the compliance review unknown. Data for the months of August 2013 and September 2013 were unreported. The system did not appear to be a true multidisciplinary one. Although prescriber variances occurred, observations of the medication variance committee meeting indicated that the only errors addressed were those of nursing and pharmacy. Meeting minutes also failed to document discussion related to other disciplines. The system at the time of the compliance review was ineffective and hampered by disorganization, poor record keeping, and staff that required additional training in several areas.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed	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. A new order clarification process was implemented. This process had two pathways based on whether the missing information was considered critical or non-critical: • If the missing information was critical, the pharmacist contacted the prescriber by the preferred contact number. The home was also contacted. The monitoring team noticed that most of the documentation provided indicated contact via fax. • If the missing information was not critical, the pharmacist wrote an order clarification. The order was sent to the medical staff office and the physician signed the order. The process above summarizes the content of the flowchart provided to the monitoring team. Through discussion with the clinical pharmacist, medical director, medical staff,	Noncompliance

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	dosage is not consistent with Facility policy or current drug literature.	medical compliance nurse, and observations, the monitoring team learned the following with regards to non-critical clarifications: • The SASH pharmacist wrote an order clarification. The medication was dispensed based on the clarification written. The order was delivered to the medical staff office later that day, specifically to the medical compliance nurse who sorted the orders and gave them to providers at the next daily clinical meeting for review and signature. The clinical pharmacist reported this was done to avoid physician fatigue due to the significant number of problems the facility had with improperly written medication orders. It was reported that although the problem was extensive, the number of providers involved was not. Moreover, the medical director stated that this was being restricted to a very limited set of situations. However, this was not defined in an officially adopted procedure nor was this limitation evident. The monitoring team reviewed copies of orders and found some that were not signed for two to three days. Several providers were involved, and definite provider patterns were noted. The order clarification process was a major systems change with a significant impact on the prospective review of medication orders and provision N1 of the Settlement Agreement. Nevertheless, the decision to implement these changes was not discussed with the state pharmacy or medical services coordinators. Even more troubling was the finding that a medication error, related to this process and involving several medications, occurred on 9/10/13. The SASH pharmacist clarified the order, but did so incorrectly. Per the variance spreadsheet, "Pharmacy generated the order, but failed to note incorrect route. Order clarification order was written with incorrect route." This resulted in the individual receiving multiple medications by the wrong route. Specific information was not presented in the medication variance spreadsheet, but it was documented that this was an actual error that reached the individual and the medications were administered. Wrong route errors have the potential to be very serious, especially when a medication is administered orally to an individual who should receive the medication through an enteral tube. The feasibility of this process, particularly allowing medications to be dispensed prior to clarification by physicians, should be reviewed by state office. The monitoring team requested documentation of interactions between pharmacists and prescribers. The facility submitted a single 68-page document that included all prospective and retrospective communications inclusive of pharmacy and clinic interactions that occurred from March 2013 through September 2013. The information was provided in the notes extracts. The format of the notes extracts did not lend itself to data extraction and it was, therefore, difficult to clearly identify those issues that pertained to the prospective reviews relevant to provision N1.	

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		The prospective comments were related to clarification of orders via the order clarification process, Intelligent Alerts, and drug interactions. Retrospective documentation included entries related to psychiatry and neurology clinics where recommendations were made regarding drug dosages, lab monitoring, and even completion of the MOSES and DISCUS evaluations. The comments provided very good documentation of many aspects of care occurring in the facility. Notwithstanding the difficulty in use of the document, the monitoring team gathered a great deal of information through review of the notes extracts. There were numerous problems that were documented, such as prescribers declining Intelligent Alert monitoring, multiple accounts of overdue lab monitoring and clinical monitoring such as EKG and eye evaluations that were past due. It was also documented that one prescriber would not participate in the order clarification process and refused to accept the order sheets and/or sign them. SASSLC implemented the Intelligent Alerts in December 2012. At the time of the compliance review, the drugs monitored included carbamazepine, digoxin, levothyroxine, lithium, phenytoin, valproic acid, warfarin, quetiapine, potassium, and phenobarbitol. SASSLC had recently added potassium to the list of medications monitored. They believed this to be a recommendation of the monitoring team, however, the monitoring team was only ensuring that the facility followed the guidelines that were issued by state office. Phenobarbital was also added as a recommendation of a recent facility DUE. The value of the Intelligent Alerts at the facility was questionable. The self-assessment noted that there was no consistent trend in the number of intelligent alerts. It further documented that the pharmacists consistently contacted the prescriber when additional monitoring was required. The assessment failed to note that prescribers frequently declined to follow the recommendations. Thus, when the Intelligent Alerts fired and the prescriber was notified that there was a need to have a lab done, the prescriber simply declined. This was most striking in the area of monitoring related to the use of psychotropic medications. One consequence of this was that there were a substantial number of entries associated with psychiatry clinics that were related to laboratories and other studies that were overdue. While the medical provider has the freedom to deviate from clinical guidelines, the Settlement Agreement requires documentation of an explanation in the IPN when the pharmacist makes an actual recommendation and the clinician chooses not to accept. The notes extracts repeatedly documented “declined” and “did not accept” for many recommendations. The following are just a few examples of the issues documented in the notes extracts • 8/5/13: Vimpat new order written on 7/30/13 not initiated due to missing frequency	

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		• 8/19/13: No heart rate or blood pressure monitoring ordered along with increase in Seroquel dose; vital sign monitoring declined • 8/23/13: Valproic acid lab monitoring declined for intelligent alert • 8/30/13: Initiated order clarification for topiramate; 9/3/13: Received order • 8/30/13: Order missing indication; 9/5/13: Order clarified • 8/9/13: Faxed IA for Depakote new order; 8/14/13: Received faxed IA; physician ordered valproic acid level, but deferred CBC level • 5/24/13: Faxed IA for Seroquel dose change; 6/13/13: Physician reminded of increased blood pressure monitoring requirement during clinic; the order was never written • 6/10/13: Faxed IA for Seroquel change; 6/11/13: physician defers increased blood pressure monitoring • 5/20/13: IA for Depakene order; no level or CBC ordered • 6/10/10: IA for Seroquel changes; physician declined blood pressure monitoring • 6/20/13: Faxed IA; 6/21/13 received IA for Depakote; physician defers CBC and valproic acid level, will follow clinically for adverse effects Notwithstanding the evidence that the pharmacists were communicating with the prescribers, the monitoring team was concerned about the findings associated with this provision. The recently implemented order clarification process, more specifically the state hospital's ability to dispense medications without contacting the physician, was problematic and presented opportunities for significant errors. It also appeared that the Intelligent Alert module was not accomplishing its intended purpose at SASSLC. The medical staff, more often than not, elected to ignore the alerts and there was no evidence that the medical director had addressed this with the medical staff. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance for the reasons cited above. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The order clarification process should be reviewed to determine if it is appropriate for use at the facility. 2. The medical director should develop a plan of correction to address the ongoing issues with physician order writing at the facility. 3. Prescribers with problematic practices should be counseled. Systems should not be changed to accommodate single providers. 4. Facility management should require department heads discuss systems changes that impact the Settlement Agreement with the appropriate state discipline coordinators.	

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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.	Twenty-four 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. The 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. In some instances, the exact values were provided while in other cases the documentation of values was done by exception. Normal ranges were included in the table. Documentation by exception proved problematic in some situations. For example, it is difficult to understand the true clinical relevance of an elevated alkaline phosphatase when other liver chemistries are not provided. Similarly, documentation of an isolated hemoglobin is less useful when other values are not provided. An emerging practice of stacking information was observed. Bullets were added to reviews without removing old information. This resulted in conflicting information being presented in various sections of the reports or irrelevant information remaining that should have been either removed or revised. 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 some clinical issues/areas for improvement that should be addressed. The following are a few examples: • Individual #74, 9/6/13: This 59 year old male had a ferritin level of 19 which was noted by the clinical pharmacist "low ferritin- he is currently not receiving treatment." The key issue here was the lack of a recommendation to address the etiology of the low ferritin. This individual had a low ferritin of undetermined etiology. As has been noted in numerous reports, iron loss in adult males requires evaluation. • Individual #3, 10/9/13: This individual had a relatively new onset of seizures. The comments related to the onset were repeated from one QDRR to the next and this made it difficult to understand the relevance. The exact statements were made without noting the year in multiple QDRRs, thus, it was difficult to determine when this event actually occurred. o The practice of simply repeating information without editing, updating, or deleting as appropriate should be discontinued. • Individual #23,8/27/13: This individual had elevated glucoses of 140 and 130.	Substantial compliance

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		Notwithstanding these elevations, there was no recommendation to obtain a HbA1c or to have more frequent monitoring of blood glucoses even though the pharmacist noted in the comments that no HbA1c was done. • Individual #53, 6/29/13: No CBZ level obtained since admission. An Intelligent Alert should have fired with the new order upon admission (and perhaps it did) and a baseline level should have been determined on this newly admitted individual. • Individual #200, 8/27/13: This individual had a diagnosis of diabetes mellitus, but there was no mention of renal protection with ACE/ARB. Other screenings were audited via the medical compliance nurse. Also, the diagnosis of diabetes was established. Thus, the focus should have been on management of diabetes and not on discussion of metabolic syndrome (the pre-cursor to development of diabetes). • Individual #201, 7/17/13: This individual had chronic kidney disease secondary to lithium use and was followed by a nephrologist. The clinical pharmacist noted that the nephrology consults were not located in the active records. It should be noted that the lab matrix guidelines were more than likely not adequate for this individual with diabetes who had anemia, a creatinine of two, and a creatinine clearance of 41. This QDRR again added information without deleting old information. The <u>most recent</u> HbA1c was recorded in various sections of the document. The values differed (< 6 and 6.3). This practice, seen in many reviews, increased the length of reviews and provided conflicting and inaccurate data. Overall, the clinical pharmacists did a very good job in thoroughly completing the evaluations in a timely manner. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. The facility should continue to conduct timely and clinically relevant evaluations in order to maintain substantial compliance. This is emphasized due to the history of losing substantial compliance based on the failure to meet the required timelines. The facility should also address the issues noted in the comments above.	

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N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The 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> Medication polypharmacy was addressed in every QDRR reviewed. The pharmacist consistently made recommendations for reduction of polypharmacy as warranted. The monitoring team attended the Polypharmacy Oversight Committee meeting during the week of the review. Psychotropic polypharmacy is 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. Unfortunately, several QDRRs included comments that current MOSES and DISCUS evaluations were not present in the active records at the time the QDRR was completed. The notes extracts included many recommendations from the psychiatry and neurology clinics related to medication side effects inclusive of the anticholinergic burden. <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, HbA1c, weight, lipid panels, and blood pressure. The QDRR reports consistently included a section/statement related to metabolic risk that provided comments on the relevant parameters. Based on documentation in the notes extracts, many of the monitoring parameters were not actually completed in a timely manner. The concept of monitoring of metabolic syndrome presented some challenges once the individual was determined to have a diagnosis of diabetes mellitus. Individuals with a diagnosis of diabetes continued to have discussions related to assessment of risk of metabolic syndrome. The metabolic syndrome can be defined as the co-occurrence of metabolic risk factors for both type 2 diabetes and cardiovascular disease. Metabolic syndrome is an important risk factor for subsequent development of type 2 diabetes and/or cardiovascular disease. Thus, once the individual has a diagnosis of type 2 diabetes, the discussion of risk of metabolic syndrome is no longer the primary issue.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		In the simplest terms, metabolic syndrome increases the risk for diabetes and heart disease and can be considered a condition that precedes diabetes. Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of substantial compliance. In order for this provision item to remain in substantial compliance, there must be evidence that the monitoring for the metabolic and endocrine risk occurs in accordance with facility guidelines. There must be documentation of adequate clinical justification if that does not occur. The monitoring team also recommends that educational activities related to risk assessment particularly related to the metabolic syndrome be provided to staff.	
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. This has been clearly stated in previous reviews, yet the self –assessment continues to assess only the responses to the QDRRs. Prospective Recommendations Prospective recommendations were generated at the time new orders were written. Much of the documentation related to prospective recommendations concerned drug interactions, order clarifications and Intelligent Alerts. As previously discussed in section N1, the documentation in the notes extracts provided evidence that the medical staff declined to follow the recommendations of the pharmacists with regards to the Intelligent Alerts. That is, when the pharmacists contacted the prescribers with notification that labs or other monitoring was required, it appeared that the prescribers declined to follow the recommendations. Retrospective Recommendations The clinical pharmacists also made formal recommendations during clinics and when completing the QDRRs. The majority of QDRRs indicated that the prescribers accepted the recommendations of the pharmacists. Explanations were provided on the QDRR report when the recommendation was not accepted. The generous documentation on the part of the clinical pharmacists pointed to problems in this area. The notes extracts included a bevy of recommendations made during the neurology and psychiatry clinics. As previously noted, providers were not obligated to accept recommendations. The clinical pharmacists were recording the responses of the providers to the recommendations as "accepted" or "not accepted." The medical director will need to conduct further evaluation on the responses of the medical staff, particularly with regards to compliance with monitoring guidelines. Staff should be counseled	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		regarding the Settlement Agreement requirement to "document in the individual's medical record a clinical justification why the recommendation is not followed." This is a broad requirement that pertains to all formal recommendations made by the pharmacists. Compliance Rating and Recommendations This provision will remain in substantial compliance. In order for the facility to maintain substantial compliance with this provision item, there must be evidence that the medical staff continue to accept and implement the recommendations of the clinical pharmacists. The medical staff should clearly note in the IPN a clinically justifiable explanation when recommendations are not accepted. There should be evidence that the medical director has assessed the concerns highlighted in this report and taken appropriate actions as deemed appropriate. Documentation of corrective actions should be maintained.	
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. Maintaining 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 conducted the reviews, the evaluation required review and completion by a physician. It was reported that the primary providers completed the evaluations when individuals did not receive psychiatric services. 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. For the MOSES evaluations included in the record sample, only page one was submitted. For the same sample, several records included electronic copies of the MOSES evaluations hence no prescriber review was found. The findings are summarized below:	Noncompliance

#	Provision	Assessment of Status	Compliance
		The following data summarizes the evaluations that were selected and submitted by the facility: Twenty-four MOSES evaluations were reviewed for timeliness and completion: • 24 of 24 (100%) evaluations were signed and dated by the prescriber • 23 of 24 (96%) evaluations documented no action necessary • 1 of 24 (4%) evaluations documented actions taken, such as drug changes and monitoring Twenty four DISCUS evaluations were reviewed for timelines and completion: • 24 of 24 (100%) evaluations were signed and dated by the prescriber • 19 of 24 (79%) evaluations indicated the absence of TD • 1 of 24 (4%) evaluations indicated the presence of TD • 1 of 24 (4%) evaluations included other comments • 3 of 24 (12%) evaluations did not include a physician conclusion The following data summarizes the most recent evaluations that were included in the record sample: Ten MOSES evaluations were reviewed for timeliness and completion: • 6 of 10 (60%) evaluations were incompletely submitted • 4 of 10 (40%)evaluations were submitted in electronic format and included no prescriber review and conclusion Eight DISCUS evaluations were reviewed for timelines and completion: • 7 of 8 (87%) evaluations were signed and/or dated by the prescriber • 4 of 8 (50%) evaluations indicated the absence of TD • 2 of 8 (25%) evaluations were electronic and included no prescriber conclusion • 2 of 8 (25%) evaluations did not include a prescriber conclusion (blank) During interviews with the medical director and clinical pharmacist, the clinical pharmacist reported that a list of individuals who required MOSES and DISCUS evaluations was maintained. That list was submitted, however, that list was only for those individuals who received psychiatric services. Similar to what was observed during the April 2013 compliance review, the facility was not tracking those individuals who required monitoring due to the use of non-psychiatric medications inclusive of some AEDs and Reglan. The pharmacist reported that the pharmacy department was in the process of developing a list.	

#	Provision	Assessment of Status	Compliance
		The QDRRs also frequently commented on outstanding MOSES and DISCUS evaluations and incomplete MOSES/DISCUS evaluations. Comments were seen regarding the need to complete a MOSES every six months and DISCUS quarterly for individuals receiving metoclopramide. In the case of the QDRR for Individual #53, the psychiatrist responded by documenting "Physician assessments are finalized in AVATAR on a separate document. From my understanding the nurse finalizes the MOSES and DISCUS." Eight of the 24 QDRRs (42%) reviewed by the monitoring team included a comment regarding the lack of a prescriber review or the lack of a recent MOSES and/or DISCUS evaluation. The clinical pharmacists even made notations in the notes extracts regarding the prescribers' requirements to properly complete the MOSES and DISCUS evaluations. The comments primarily centered on the lack of a prescriber review or the fact that the evaluations were outstanding. Although these rating instruments served as a valuable source of information, record reviews did not reveal any documentation, on the part of the primary providers, of discussion of this relevant information. The neurology clinic template included the scores of the most recent MOSES and DISCUS evaluations, but the neurologists 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 remained in substantial compliance at the April 2013 compliance review. However, continued substantial compliance required that the facility address (1) issues related to physician completion of the documents, (2) the requirement to complete evaluations for individuals receiving non-psychotropic drugs, and (3) the utilization of the information by providers. At the time of the compliance review, the facility was unable to provide information regarding which individuals required evaluation based on the use on non-psychotropic agents. Problems persisted with completion of the prescriber reviews, and there was no evidence that the primary providers utilized or even reviewed this information to any degree. <u>Compliance Rating and Recommendations</u> The monitoring team disagrees with the facility's self-rating of substantial compliance. To move in the direction of substantial compliance, the facility must take several actions: 1. The evaluation tools must be completed in a timely and adequate manner. 2. The deficiencies above should be addressed.	

#	Provision	Assessment of Status	Compliance
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	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, probability score, severity score, P&T report date, and ADR confirmation. The facility continued to struggle with the basic components of the process, such as timely reporting and review. In addition to this, there was also difficulty in setting a threshold for review based on a severity scale. The facility had not defined a threshold for review in its current policy. The facility rated itself in noncompliance with this provision item even though the clinical pharmacist reported that ADRs were reviewed by the prescribing physician and were reviewed promptly in the next schedule P&T Committee. The current ADR report forms included a section for physician, pharmacist, and P&T Committee review. None of the sections required signatures to verify that the comments were authentic. It was noted that there were substantial delays between the dates that some events were noted and the dates that reviews occurred by a medical provider. The facility had no documentary evidence that the ADRs were reviewed by a physician. The forms were not signed by the medical provider. It appeared that the data entry was completed by the pharmacist. Although the monitoring team had repeatedly made recommendations to have the primary care provider review and sign the ADR forms, the documents submitted to the monitoring team were not signed and many were draft reports. Finalized reports were requested for review. More than a week following the compliance review, the monitoring team received additional reports, many of which remained in draft format. Many now had signatures, but they were not linked to the physician review comments. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. The monitoring team offers the following recommendations: 1. The medical director should work with the medical staff and encourage them to report ADRs. 2. The primary providers responsible for the overall management of health care should complete the physician review of the ADR form (with psychiatry if necessary) and sign the form. There should be documentation in the IPN of adverse drug reactions. 3. The facility policy should be revised to include a severity scale that can be used as a trigger to complete an intense case review or other type of in depth analysis. 4. The medical department/pharmacy should maintain documentation of training provided to staff.	Noncompliance

#	Provision	Assessment of Status	Compliance
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 maintained a DUE calendar and completed one DUE each quarter. A DUE on Phenobarbital was completed in August. In February 2013 a drug utilization evaluation was completed on individuals treated with phenobarbital, The results of this DUE included a recommendation for another DUE to be performed specifically to be examining the drug level monitoring following dosage change. The DUE was presented at the August 2013 P&T Committee. The committee recommended adding Phenobarbital to the Intelligent Alerts. The Prolia DUE was presented at the P&T Committee meeting held during the week of the compliance review. The DUE was completed based on a case analysis of one individual, who received Prolia and who was hospitalized twice secondary to serious infections. Thirteen individuals who reviewed the medication were reviewed. The DUE did not point to any clear correlation with an increase incidence in infections associated with Prolia. There were no specific recommendations other than monitoring and aggressive treatment of infections. Generally, the DUEs were thorough and provided clinically relevant information for the medical staff. More than 20 ad hoc DUEs related to FDA alerts and warnings were also completed. The facility did not have a procedure related to completion of DUEs. The monitoring team has recommended in the past that the facility thoroughly outline the DUE process in an operational procedure and include this in the pharmacy policy and procedure manual. The requirement for issuing notification for FDA alerts (DUE/FDA Alerts) should be included in the procedure. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of substantial compliance. The monitoring team offers the following recommendations: 1. As recommended in previous reports, the facility should develop a procedure that outlines the DUE process. This should be included in the pharmacy department's policy and procedure manual. 2. The DUE process should be clearly separated from the requirement to provided notification of FDA alerts. Consideration should be given to renaming information based on FDA information. Drug Alerts is one potential consideration.	Substantial Compliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></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 Medication Variance Committee was required to meet monthly, but only two 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 colspan="7">Medication Variances 2013</td></tr>
<tr><td></td><td>Feb</td><td>Mar</td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td></tr>
<tr><td colspan="7">Discipline</td></tr>
<tr><td>Nursing</td><td>158</td><td>274</td><td>127</td><td>137</td><td>46</td><td>63</td></tr>
<tr><td>Pharmacy</td><td>51</td><td>108</td><td>24</td><td>41</td><td>25</td><td>36</td></tr>
<tr><td>Medical</td><td>0</td><td>2</td><td>0</td><td>0</td><td>5</td><td>4</td></tr>
<tr><td>Multi</td><td>0</td><td>1</td><td>0</td><td>0</td><td>5</td><td>1</td></tr>
<tr><td>Dental</td><td>0</td><td>0</td><td>0</td><td>0</td><td>3</td><td>0</td></tr>
<tr><td>Dietary</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td colspan="7">Node</td></tr>
<tr><td>Administration</td><td>153</td><td>265</td><td>122</td><td>134</td><td>45</td><td>47</td></tr>
<tr><td>Dispensing</td><td>51</td><td>108</td><td>25</td><td>40</td><td>23</td><td>35</td></tr>
<tr><td>Documentation</td><td>5</td><td>9</td><td>4</td><td>3</td><td>0</td><td>14</td></tr>
<tr><td>Doc/Tran</td><td>0</td><td>0</td><td>0</td><td>1</td><td>11</td><td>0</td></tr>
<tr><td>Prescribing</td><td>0</td><td>2</td><td>0</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td>Pres/Doc</td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Transcription</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>7</td></tr>
<tr><td>Other</td><td>0</td><td>0</td><td>0</td><td>0</td><td>3</td><td>1</td></tr>
<tr><td>Pres/Disp</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>Total</td><td>209</td><td>385</td><td>151</td><td>178</td><td>85</td><td>104</td></tr>
</table>
Data were reviewed during the medication variance committee meeting attended by the monitoring team during the week of the compliance review. The meeting was facilitated by the nursing compliance nurse and clinical pharmacist, both of whom gave presentations on data from their departments. The focus of the nursing presentation was the increasing reconciliation rates. In fact, it was reported that reconciliation was greater than 90% in four of the last five months. It was also reported that there was one category E/F variance in September 2012 and none since that time. With regards to pharmacy variances, the median number of variances was reported to be 30. Omissions were the most frequent type.

As presentations were made, numerous questions should have surfaced with regards to the data that were presented. Yet, the participants did not pose any questions. There were no attempts to scrutinize the data beyond the surface analysis. Although state policy required all disciplines to discuss medication errors and corrective actions, there was no discussion of prescribing errors. Throughout the conduct of this review, physician order writing was repeatedly cited as a significant burden for the pharmacy department and the facility. The monitoring team reviewed the only two sets of meeting minutes</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		provided and noted a complete lack of discussion related to prescribing errors. This was disconcerting considering the magnitude of the problem based on discussions with the clinical pharmacist and the fact that this was addressed in the April 2013 report. It was eventually explained that the physician order problems were usually resolved through the order clarifications. The clinical pharmacist reported during interviews that nursing was no longer reporting medication variances. This finding was affirmed during the meeting. One nursing manager stated there was no time to complete paperwork once the system changed on 8/1/13. It was further explained that there were problems with the new system, variances were not being reported, and reconciliations were not occurring as required. Hence, data for August 2013 and September 2013 were not included in the facility's report. Notwithstanding the facility's much lauded progress of recent months, at the time of the review all progress was essentially negated. Ostensibly, SASSLC had no reliable information at the time of the compliance review on the status of the medication variances because it was unequivocally reported during the meeting that the nursing department was not reporting variances and reconciling medications. Although nursing was not reporting variances, there were data related to pharmacy and prescribing variances for the months of August 2013 and September 2013. The monitoring team made a specific request for that data. Thirteen pages of variances were submitted which had not been tallied. Almost all were related to dispensing and prescribing errors. The data indicated that prescribing errors were indeed problematic. For example, it appeared that ergocalciferol 8,000 IU/ml was written at a dose of 8,000 IU. It was not clear how this was clarified because the pharmacy was apparently allowed to dispense some orders without actually contacting the prescriber. Signatures for the clarification were obtained on the next working day. As noted in section N1, this practice had the potential to result in adverse outcomes. During the medication variance meeting, the monitoring team requested information related to a variance involving Individual #74 because it involved the receipt of "wrong medications." This error occurred on 6/13/13. The individual received another individual's medications. Facility staff could not provide any information about the medications that were involved. The program compliance nurse presented a cause and effect diagram that was completed explaining that a root cause analysis was conducted related to this medication variance, which was classified as a category C variance. He further explained that the nurse was removed from duty. The QA nurse reported that increased monitoring of vital signs was done for the individual. The fact that no additional information was available appeared unusual given that a root cause analysis was conducted.	

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		Such analyses are usually only taken for events of a serious nature that cross a defined threshold or have been designated as a sentinel event. The medication variance form was requested. Some 24 hours after the form was requested the monitoring team was informed that the document was lost and no further information was available. A review of the active record showed that there was a nursing entry on 6/13/13 and another on 6/14/13. There was no medical evaluation until 6/17/13. At that time, there was an IPN entry that noted the EKG showed a NSR and psychiatry was notified. There was no follow-up evaluation. A review of the physician orders showed that a verbal order was given by the medical provider on 6/13/13 at 8:55 am to hold am meds and perform vital signs every shift. This was not followed by a medical evaluation. This error demonstrated a multitude of deficiencies related to the facility's medication variance system in terms of reporting, documentation, follow-up, data analysis, problem solving, medical care, and record keeping. The example discussed above as well as other examples were evidence that that facility staff needed clarification on the concepts of causal and contributory factors, and root cause analysis. Throughout the week, the term root cause analysis was repeatedly incorrectly utilized (see section E of this report). The variance was categorized as a Level C variance even though enhanced vital sign monitoring was implemented. Per state policy, this was at a minimum a Level D variance. The reason for the root cause analysis was not clear. The monitoring team had no further information because the active records did not provide any information on what medications were received. The medication section on the spreadsheet remained blank and the monitoring team was not provided the medication variance reporting form. Although nursing was not reporting variances, there were data related to pharmacy and prescribing variances for the months of August 2013 and September 2013. The monitoring team made a specific request for the data. This 13-page document offered compelling evidence of the many problems that were occurring within the early stages (prescribing and dispensing) of the medication use system over a two-month period. The significant number of issues related to prescribing and order writing was a very serious issue that did not translate into a high number of actual variances only because they were detected at some other step in the system. When there were failures in the checks, such as the clarification error discussed in N1, actual variances occurred. For example, on 9/3/13, it appeared that an order was written for ergocalciferol. The variance spreadsheet documented, "dose was not 8000 IU. The	

#	Provision	Assessment of Status	Compliance
		strength of the oral drops was 8,000 IU/ml." The exact order problem was not documented nor was the exact mechanism of clarification. However, it appeared that the error was discovered at the point of dispensing. Overall, this system appeared to be in a state of disarray. The meeting attended was poorly organized. There was no agenda and no information provided to participants until the monitoring team requested copies of the data. Discussions were limited to issues of nursing and pharmacy, which was not consistent with state guidelines. The status of nursing variances and medication reconciliation was unknown. Record keeping related to medication variances was inadequate as well. It appeared that SASSLC had many issues to address to improve in the area of medication safety. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The facility must resolve the problems within the nursing department related to reporting medication variances. 2. The facility must maintain processes for medication reconciliation. 3. The medical director must address prescribing errors. The facility director/designee should have oversight in ensuring that this occurs per sate policy. 4. As noted in previous reports, every discipline head should discuss error rates and actions taken to correct problems during the variance meetings. Due to the substantial deficits in this program, the monitoring team recommends that a plan of correction be drafted and additional administrative oversight be provided until the plan is successfully completed.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o SASSLC client list o Admissions list o Physical Nutritional Management Policy o Habilitation Therapy Services Policy o PNMT Staff list, back-ups, 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 and P QA Reports o PNMT Evaluation template o PNMT Meeting documentation submitted o Pneumonia Committee meeting minutes o Medical Meeting minutes o List of individuals on PNMT caseload o List of individuals referred to the PNMT in the last 12 months o List of Individuals Discharged from the PNMT in the last six months o PNM spreadsheets o Individuals with PNM Needs o Dining Plan Template o Falls PIT documentation o Compliance Monitoring template o Completed Compliance Monitoring sheets submitted o Completed Effectiveness Monitoring sheets submitted o Monitoring Frequencies for Each Individual as of 9/13/13 o Corrective Actions for Compliance Monitoring o Criteria for Corrective Action Plan o Flow Charts for Monitoring (Physical Management, Meal, and Communication) o List of individuals with PNMP monitoring in the last quarter o NEO curriculum materials related to PNM, tests and checklists o Annual Refresher curriculum materials related to PNM o NEO Training Agenda Schedule (October) o Documentation of staff training submitted 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 List of individuals who have difficulty swallowing 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 Documentation related to choking event for Individual #318 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 APEN Evaluations for Individual #331, Individual #301, Individual #164, Individual #228, Individual #96, Individual #37, Individual #112, Individual #281and Individual #108, o PNMT Assessments and ISPs submitted for the following: • Individual #317, Individual #171, Individual #56, Individual #302, Individual #204, Individual #106, Individual #154, Individual #313, and Individual #226. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124,

	Individual #204. o PNMP section in Individual Notebooks for the following: • Individual #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. <u>Interviews and Meetings Held</u>: o Margaret Delgado Gaitan, MA, CCC-SLP, Director of Habilitation Therapies o Patricia Delgado, RN o Tracy Brazier, RD, LD o Allison Block Trammell, MS, CCC/SLP o Joanna VanHoove, OTR o Edward Harris, PT Various supervisors and direct support staff o Weight Committee meeting o PNMT meeting <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas o ISPA Meeting for Individual #47
	Facility Self-Assessment: The self-assessment completed by Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director, was significantly improved. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of habilitation staff. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals.

	Ms. Delgado-Gaitan and her staff were on track to ensure that progress will be made for the next review. Progress continued across all aspects of this provision, particularly in O.1, O.2, and O.4. The plan outlined was a sound one and combined with the findings of this report should guide them to make greater strides over the next six months. Benchmarks should be established in measurable terms and used to establish measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in noncompliance with each of the provisions in O. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings for O.2 through O.8, however, sufficient achievements had been demonstrated to meet the requirements for substantial compliance in O.1.
	Summary of Monitor's Assessment: As in previous reviews, it was evident that a tremendous amount of work had been done in this area. There was a fully constituted PNMT. All the current members were consistent with the previous visit and all but the dietitian had served in this role since early in this review period. They implemented recommendations related to streamlining their documentation, tracking the established measurable outcomes in the minutes while keeping the meetings organized and on point. Observations during this onsite visit revealed that clear improvement had been made in each of these areas. A suggestion was to more consistently document target dates for actions to promote timely completion and to assist with subsequent reviews by their team. It is critical that the IDTs initiate timely referral for individuals who meet the established criteria. Referral to the PNMT is not to suggest that the IDTs are not doing their job well, but is rather a reflection of the complexity of the individual's needs and the urgency for intervention. There was clear improvement in streamlining the content of the weekly documentation, but there was need to better organize it, such that they could readily access information from a historical perspective and, most importantly, that it would become more user friend to the IDTs and medical staff. During the meetings observed, the team demonstrated excellent discussion and problem solving. Their assessments and other documentation, however, did not clearly and concisely reflect that. The facility should also consider a collaboration to examine the process for weight management to ensure there is consistency in the methods used for weighing individuals, measuring height, and the notification of the proper staff related to changes in weights that are significant. The Mealtime Coordinators were now in place and appeared to understand their role. Homes 673 and 674 generally were improved based on observations made by the monitoring team, but need to continue to be diligent related to food textures and proper positioning.

	Approximately 70% of staff were able to answer questions about the supports they provided. Others required significant prompts before they could answer correctly. In general, there continued to be issues related to ensuring there were sufficient staff to provide the necessary supports for individuals who need prompts throughout the meal related to bite size and pace of eating. There continued to be errors in diet texture not caught by the kitchen staff in the home, the tray line staff and staff at the table. The monitoring team had to intervene several times for individuals who were not served the correct diet texture. Hygiene was also an issue that needs to be evaluated (particularly in home 668). The methods used to clean the tables, placemats, mealtime cards, and table cloths between individuals were sloppy posing great risk for cross contamination. Positioning continued to improve, but not sufficiently in the day programs and active treatment areas in the homes. There was a need to re-position throughout the day and to check the position of individuals after mechanical lift transfers. The transfer does not end when the individual is placed in the seat. The therapists were in the process of evaluating the issue related to seating devices, but should also include other positioning in bed and recliners for example. <u>Samples for Section O:</u> Sample O.1 consisted of a non-random sample of 21 individuals, 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 individuals at SASSLC who received enteral nutrition. Some of these individuals might also have been included in one of the other two samples.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner,	SASSLC used the state-issued PNM policy (#012.3, effective 3/4/13), though had not formally operationalized it. • The facility did not have a single comprehensive PNM policy that addressed the scope of PNM issues outlined below, but rather, through a combination of facility policies, guidelines and procedural documents, generally outlined a complete and comprehensive system of Physical Nutritional Management. Though each of the following elements were not specifically outlined in those documents, these were clearly in practice at the time of this onsite review: o Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); o The annual review process of an individual's PNMP as part of the individual's ISP; o The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; o The roles and responsibilities of the PNMT; o The composition of the facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; o Description of the role and responsibilities of the PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); o The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; o Requirements for continuing education for PNMT members; o Referral process and entrance criteria for the PNMT; o Discharge criteria from the PNMT; o Assessment process; o Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; o The PNMT consultation process with the IDT; o Method for establishing triggers/thresholds; o Evaluation process for individuals who are enterally fed; o PNMT follow-up; o Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; o A comprehensive PNM monitoring process designed to addresses all areas of	Substantial Compliance

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	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.	the PNMP, including: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, ▪ Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), ▪ Identification of monitors and their roles and responsibilities, ▪ Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, ▪ Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and ▪ Frequency of monitoring to be provided to all levels of risk. o A system of effectiveness monitoring; and o Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. <u>Core PNMT Membership</u>: The PNMT at SASSLC included the appropriate disciplines as defined in the Settlement Agreement. Each was a part-time team member who had other clinical duties, with the exception of the nurse, which was a full time position. Team members included the following with start dates: • Patricia Delgado, RN (May 2011) • Tracy Brazier, RD, LD (February 2013) • Allison Block Trammell, MS, CCC/SLP (November 2010) • Joanna VanHoove, OTR (December 2011) • Edward Harris, PT (September 2011) All team members were consistent with the previous review. Back-ups for each position had been assigned. The OTR had been assigned since December 2011 and each of the others was assigned within the last six months. <u>Consultation with Medical Providers and IDT Members</u> The medical consultant to the PNMT was Dr. Espino, Medical Services Director. Other medical providers also attended as needed to address issues for individuals on their caseloads as discussed during the PNMT meetings.	

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		There were 36 meetings held between 5/2/13 and 10/24/13 (one additional meeting on 8/23/13 was to only discuss weight trends and was not included in this analysis). The physicians at SASSLC routinely attended PNMT meetings as follows: • Medical Director (67% of weekly meetings and 11% of individual meetings) • Primary Care Provider, included the primary physician and/or nurse practitioner (41% of weekly meetings and 33% of individual meetings) • Both the Medical Director and a PCP attended 19% of all the meetings held. While at least one and/or the other attended 72% of all meetings held. In addition to actual attendance at PNMT meetings, effective medical consultation and support was consistently provided in other ways. For example, Dr. Lilani Muthali, the state office discipline coordinator, attended a PNMT meeting on 7/25/13. The PNMT RN or designee also attended daily morning medical meetings, pneumonia committee meetings, and others in which the physicians also participated consistently. Daily Medical Provider Meeting minutes were submitted for 8/7/13 through 9/23/13. Attendance by the PNMT representative was clearly recorded for 15 meetings; overall attendance by a PNMT representative (generally the RN), for which documentation was clearly evident, was approximately 94%. Habilitation Therapy also documented morning meeting attendance: the PNMT RN or other PNMT/Habilitation Therapies was noted for 110 of 116 of these (95%). The reports from these meetings were discussed by the PNMT in order to update the status of individuals on their caseload, to track others with PNM concerns, and to identify individuals who met criterion for referral to the team. The PNMT RN also served as the liaison between the PNMT and the physicians by personally meeting with them to discuss pertinent issues and to ask questions, as indicated. PNMT assessments were reviewed with the physicians and in some cases these were signed. Further collaboration related to specific individuals was documented in the IPNs (e.g., Individual #325). • For 31 of 36 PNMT meetings (86%) held from 5/2/13 to 10/24/13, there was evidence of participation by IDT members, including: PCP, QIDP, RNCM, psychology, DSP, home supervisor, Habilitation Therapy, and psychiatry and/or pharmacy. The IDT members also consistently reviewed the PNMT assessments, signed the PNMT assessments (Individual #333, Individual #56, Individual #277, Individual #313, and Individual #259), participated in related ISPA meetings, and other needed activities. PNMT members also routinely attended ISPs and ISPA meetings for the individuals they reviewed or who were referred to the PNMT. This provided significant additional opportunities for collaboration in assessment, planning, implementation of interventions	

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		and actions, follow-up, and monitoring. <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 per license identification cards submitted. • 5 of 5 core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. Collectively, the team members had approximately 91 years of experience in their respective fields and, with the exception of the dietitian, each had more than three years experience with individuals with intellectual disabilities and physical nutritional management related concerns. • 5 of 5 PNMT staff (100%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferable to the population served within the past 12 months. The exception was the RD, who had only four contact hours to date, however, she had only been assigned to the team since February 2013. An extensive number of courses were attended by four of the five team members, averaging over 50 contact hours each. • Edward Harris, DPT (35 contact hours in the last two years) • Patricia Delgado, RN (63 contact hours in the last two years) • Allison Block-Trammell, MS, CCC-SLP (75.75 contact hours in the last two years) • Joanna VanHoove, OTR (51 contact hours in the last two years) • Tracy Brazier, RD., LD (26 hours in the last two years) Additional continuing education was documented for each of the back-up team members (PT, OT, RD, RN, and SLP). Ongoing continuing education related to PNM and transferrable to the population served is essential to ensuring that an adequate level of expertise is maintained for all team members, individually and collectively via cross training. <u>PNMT Meetings</u> • Since 5/2/13, all PNMT meeting minutes (100%) included (a) referrals, (b) review of individual health status, (c) PNMT actions, and (d) follow-up. Since 9/5/13, goals and exit criteria were clearly stated, but updates related to (e) outcomes/progress toward established goals and exit criteria were not as clearly outlined on a consistent basis.	

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		The dates that goals were established for individuals on the active caseload could not be clearly identified in the minutes and, thus, it was not possible to determine where the individual was related to progress toward goals. For example, in the minutes dated 9/5/13, two individuals listed as active (Individual #313 and Individual #171) had goals, but the individual's status related to these was not documented. In the case of Individual #171, discharge was pending. The date that his goals were established could not be determined by the reader. In another case, on 9/12/13, Individual #233 was discussed related to discharge from the PNMT following a fall with hip fracture. While there were numerous recommendations, it was not clear if she was to continue to be active or was to be discharged. Without clearly stated goals there was no rationale to continue or to terminate. Meeting minutes were submitted for 5/2/13 to 10/24/13 (a total of 37 meetings). Attendance tracking was available for each and in some cases sign-in sheets were also submitted. • Since the last onsite review, the team met on a weekly basis for 24 of 26 weeks (92%) and met twice in six of those weeks, well exceeding the criterion of meeting at least once weekly for 90% of weeks. A number of the extra meetings were individual specific meetings to address assessment findings, for example. Based on review of the minutes, attendance by core PNMT members and/or back-ups for the meetings conducted during this time frame was: • RN: 37/37 (100%) by core member • PT: 37/37 (100%) by core member • OT: 29/37 (78%) by core member, 4/37 (11%) for back-up, 89% overall • SLP: 34/37 (92%) by core member, 1/37 (3%) for back-up, 95% overall • RD: 23/37 (62%) by core member, 8/37 (22%) for back-up, 84% overall Attendance was generally above criterion of 80% for core team and well above 90% overall, though slightly lower for OT and below criterion for the RD. It was noted, however, that attendance was improved in recent months and that issues related to absences had been resolved. The meeting minutes were maintained in a table format and included the following elements: • Member attendance • Individual reviewed (referrals and active caseload) • Level of PNMT involvement • Current weight	

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		• Ideal body weight range • Reason for referral • PNMT goals (though only since September 2013) • Discussion • Recommendations • Due dates (inconsistent) • Date of next review Other issues tracked for review, discussion, and action included hospitalizations, changes in health status, and weekly incident reviews (choking, aspiration, respiratory compromise, skin integrity, falls, weight, gastrointestinal concerns, and seizures, for example), Daily Medical Meeting, and IMRT findings and reports. Incident dates, risk levels associated with the incidents, level of PNMT involvement needed, recommendations, and due dates were not consistently and clearly addressed for each individual. The general content appeared to be present across the minutes and, as previously recommended by the monitoring team, the PNMT had streamlined the level of detail and organization of the meetings. These changes appeared to be useful to the PNMT and to any reader of the minutes. • The facility PNMT had a sustainable system fully implemented for resolution of systemic issues and concerns. This was integrated into the policies in place and evidenced in the monthly QA reports. There was a system of corrective action plans in the case that system issues were identified. They addressed the following: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT are collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting): ▪ A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan): ▪ Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary; and ▪ If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues.	

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		Examples of identified system issues addressed were PNMT referrals and the Falls Improvement Team. Section O requires that the PNMP be reviewed at the individual's annual individual 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 PNMT. These aspects, though outlined in O.1 of the Settlement Agreement, are reviewed in O.3 below. The monitoring team determined that the facility was in substantial compliance with this provision of section O. It was expected that the attendance by the core team RD would continue to be consistent with the established criteria of 80%, and 90% with back-up.	
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 (229 per the list submitted) were provided a PNMP, thereby ensuring that, as per the Settlement Agreement, 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") were reported to be provided a current PNMP. There were 21 individuals identified with no PNM needs. These lists were maintained and updated as required. Based on lists of individuals with identified PNM concerns, there were individuals who (a) Required physical assistance for positioning associated with swallowing: 21 individuals, (b) Were dependent on others to eat: 62 individuals, (c) Had difficulty swallowing: 203 individuals, and/or (d) Were considered to be at medium or high risk of choking (approximately 144 individuals) or aspiration (approximately 105 individuals). • Of those identified in any of these categories (collectively, "individuals having physical or nutritional management problems"), each (100%) was listed with a PNMP. There was one incident of choking documented since the previous review (Individual #318). The event resulted in staff performing abdominal thrusts (Heimlich). The event occurred at lunch on 5/8/13 and the SLP conducted an assessment during the evening meal that same day. It was determined by the SLP, based on review of the case and staff interviews, that this was not likely a true choking incident, but rather cough with struggle because he was making sounds during the incident and the vitals take at the time did not indicate distress. There was no diet texture change made, though encouragement to drink throughout his meal and to minimize talking while eating were added to his dining plan.	Noncompliance

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		Improvements were noted in the completion of the risk rating tools, as evidenced by the ISP observed during this onsite review and based on review of the IRRFs. Action plans were not provided in the same manner as during the previous reviews. Rather, the plans to address specific health risk issues were included in the IRRFs and IHCPs consistent with current state policy and practice. <u>PNMT Referral Process</u> Per the State Physical Nutritional Management policy #012.3 (3/4/13), individuals identified by the IDT who were at high risk as defined by the At Risk policy (#006) and for whom the IDT was not able to achieve a satisfactory outcome or remediate the risk level, may be referred to the PNMT by the PCP, PNMT, or IDT for assessment and recommendations for interventions and supports. More specific criteria guidelines for IDT referral to the PNMT at SASSLC were also included in this policy, though individual circumstances and risk levels would dictate more or less stringent criteria: • Two choking episodes 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: o Aspiration Pneumonia; o GI Issues o Fractures; o Skin Integrity; and o Seizures • New or proposed enteral feeding; • Unresolved vomiting (more than 3 in 30 days, not related to viral infection); • Significant/unplanned/verified weight loss or gain of o More than 5 pounds in one month; o 3 or more pounds per month for three consecutive months or 7.5% of body weight per month for 3 consecutive months; or o 10% of body weight in 6 months; • Any Stage III or IV decubitus, or any Stage II with delayed healing; or • Fracture of a long bone, spine, or hip There were no established timelines within which to review and determine a need for PNMT involvement. Training had been provided to IDTs in the past. Over the last six months, the PNMT sent out monthly reminders with the criteria attached to promote more timely referrals to the PNMT. There were seven individuals listed on the current active caseload for the PNMT (Individual #302, Individual #313, Individual #277, Individual #56, Individual #106,	

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		Individual #325, and Individual #226). A document submitted related to the referrals to the PNMT in the last 12 months, listed 14 individuals. It could not be determined how many of these were self-referred versus those referred by their IDT. A PNMT incident log was maintained. It tracked the incidence of health issues that may have required referral to the PNMT. Ideally this should be recognized by the IDT in a timely manner, but this was reported to be problematic. Otherwise, the PNMT identified these concerns and solicited a referral at that time. This system appeared to be effective in most cases (e.g., Individual #259 and Individual #226). While this system was very thorough, there appeared to be some individuals who likely should have received a PNMT evaluation and did not. • For example, Individual #233 experienced a fall resulting in a fracture on 9/8/13 and the referral to the PNMT was made on 9/9/13. A post-hospitalization ISPA was reportedly held (date was not clear from the PNMT meeting minutes 9/12/13). The PNMT reviewed the status of this case on that date and appeared to determine that this issue was to be managed by the IDT, despite the fact that this was a fracture of the right hip and that she had a right hip replacement in 1991. Thus, this incident met criteria for referral, and assessment would have been indicated. The PNMT meeting minutes indicated that she was currently in medical management mode, which was reasonable, but follow-up would be expected to determine a need for PNMT assessment and intervention. The next review date was marked as "not applicable," implying that they had not determined any need for this. Seven of the individuals referred, discharged, and/or on the current active caseload were included in the Sample 0.1 selected by the monitoring team (Individual #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #47, and Individual #204). There was no evidence of a PNMT evaluation in the individual records for Individual #325, Individual #259, Individual #267, and Individual #47. PNMT evaluations were also contained in the individual records for Individual #313, Individual #277, Individual #56, and Individual #204. Onsite requests produced evaluations for Individual #154, Individual #254, Individual #226, Individual #302, Individual #317, Individual #106 and Individual #171. No assessment was submitted for Individual #164. Though the PNMT members appeared to attend ISPAs for many individuals, there were limited numbers of ISPAs documenting that the IDT considered the need for referral to the PNMT. With records submitted there were very limited ISPAs submitted and those even remotely related to the PNMT were for Individual #47, Individual #325, Individual #313, and Individual #267. None of these specifically recommended a referral to the PNMT. They generally referred to existing supports and services by the PNMT at the time of the ISPA. The PNMT evaluations identified the reason for referral, but the referral source was	

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		clearly stated only in assessments for Individual #171 (IDT-referred) and for Individual #313 and Individual #226 (self-referred). This metric could not be completed given the limitations in documentation by the IDTs. Further the PNMT did not clearly identify the referral source or dates of referrals, in some cases, in the meeting minutes: • In __ of the __ individual records reviewed (%) when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. It was noted, however, that in most cases, for issues documented in the assessments, the referrals had been made, regardless of source in a timely manner. It could not be determined in all cases that this was within five days of an event or threshold met warranting referral There were two individuals who had received enteral tube placements since the previous review (Individual #56 and Individual #325). • 2 of 2 individuals who received a feeding tube since the last review (100%) had been referred to the PNMT prior to the placement of the tube. The following metric did not apply: • __ of __ individuals who received an emergency feeding tube placement (%) since the last review had been referred to the PNMT after the emergency feeding tube placement. Incidence of conditions in various PNM-related risk areas were clearly tracked by the team and entered into the PNMT meeting minutes and the Incident Log for easy reference. Consideration of at least the following issues for tracking was consistently indicated: • Weight • Fractures • Falls • Skin Breakdown • Pneumonia • Aspiration • Respiratory Compromise • Constipation • Bowel Obstruction • GI Concerns • Seizures	

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		• Emesis • Fluid Imbalance • MBSS • PICA • Choking • Hospitalizations/Change in Health Status • New or Possible Enteral Tube Placement • Other <u>PNMT Assessment</u> 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. Assessments submitted included the following: • Individual #56 (6/13/13), every other page was missing in copy submitted • Individual #226 (9/12/13), every other page was missing in copy submitted • Individual #313 (7/3/13) • Individual #154 (10/18/12) • Individual #106 (9/27/12) • Individual #171 (2/7/13) • Individual #204 (2/28/13), every other page was missing in copy submitted • Individual #277 (6/27/13) • Individual #317 (1/31/13) • Individual #302 (8/9/12) • Individual #254 (5/23/13) Of these, only three assessments were complete and had been dated during the last six months (Individual #277, Individual #313, and Individual #254) and, therefore, these were the assessments used for the review and analysis below (0.2). • 0 of 3 PNMT assessments submitted (0%) were initiated at a minimum within five working days of the referral per the dates identified in those assessments. The facility reported that the PNMT met regarding referrals within five working days and initiated an assessment, if deemed necessary, within five days of that meeting, though this was not reflected in the assessments reviewed. As a process, this was of concern to the monitoring team because there was the potential for up to a 10 day delay in the provision of supports and services by the PNMT to individuals at greatest health risk. o The date of the assessment for Individual #254 was 4/4/13, nearly two weeks after the referral. The assessment for Individual #277 was dated nearly three weeks after the referral on 6/13/13. These delays did not	

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		show a sense of urgency on the part of the PNMT to address the PNM concerns in a timely manner. • 0 of 3 PNMT assessments (0%) were completed in 30 days or less of the date of referral. The completion date could not be determined because the assessment was not dated by the PNMT clinicians in two cases. o The completion date of the assessment for Individual #254 could not be determined. It was initiated on 4/4/13. There were no dated signatures on the report, yet there were objective data reported as of 8/8/13, so it was presumed that the completion date was at least that extended. The PNMT reported various hospitalizations from 4/11/13 through 7/22/13, yet the recommendations appeared to be related to issues that could be addressed and were likely not directly impacted by the reasons for hospitalizations. The assessment could have been completed with updates or addendums completed after resolution of acute issues. Interestingly it appeared that as of 8/8/13, the PNMT discontinued their services. There was no rationale given, but rather only falls data for 2013 through August 2013 were reported at the end of the evaluation. An undated, unsigned document was submitted related to Individual #254 that stated he had been referred to the PNMT on 3/21/13 for falls, but due to repeated health concerns and deteriorating health status, his evaluation had been delayed, then discontinued. This decision was reported to have been made collaboratively (presumably with the IDT, though this was not stated) because he required medical and behavioral management. By report, he experienced no further falls after 4/4/13 and the information had been included in the PNMT meeting notes on 8/8/13. There was a PNMT IPN to that effect. This was not clearly stated in his assessment. o The assessment for Individual #277 was completed nearly two months after the referral date with no rationale given. It may have been implied that this was due to hospitalizations for aspiration pneumonia, but again, the assessment possibly could have been completed with updates or addendums completed upon resolution of the acute concerns. At a minimum, a rationale should have been provided. o The assessment for Individual #313 was completed over two months after the referral date. There was no rationale documented for this delay. Based on review of three assessments included in the sample, comprehensiveness of the PNMT assessment components was as follows: • 3 of 3 (100%) contained date of referral by the IDT (or self-referral). Referral sources were not identified in either case. This was consistent with the previous review.	

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		• 3 of 3 (100%) contained date the assessment was initiated. The first date of assessment was presumed to be the date it was initiated. This was consistent with the previous review. • 3 of 3 (100%) contained evidence of review and analysis of the individual's medical history. This was consistent with the previous review. • 3 of 3 (100%) identified the individual's current risk rating(s), including the current rationale. This was consistent with the previous review. The rationale reported for Individual #313 was more limited than the other two evaluations. • 3 of 3 (100%) included recommended risk ratings based on the PNMT's assessment and analysis of relevant data. This was consistent with the previous review. • 3 of 3 (100%) contained evidence of discussion of the individual's behaviors on the provision of PNM supports and services, including problem behaviors and skill acquisition. This was consistent with the previous review. • 3 of 3 (100%) contained assessment of current physical status. This was consistent with the previous review. • 3 of 3 (100%) contained assessment of musculoskeletal status. This was consistent with the previous review • 3 of 3 (100%) contained evaluation of motor skills. This was consistent with the previous review. • 1 of 3 (33%) contained evaluation of skin integrity. This was consistent with the previous review. Though it did not appear that Individual #277 had issues related to skin integrity (low risk), there was no statement validating this. Though Individual #313 was identified at risk related to skin integrity, there was no evidence that the PNMT thoroughly evaluated his current skin status. The nurse stated only that his hands were pink and ruddy and that he had dry skin on his lower extremities. His skin turgor was identified as "normal" for him but this was not clearly described. Further, the IDT's rationale for medium risk included eczema and puritis, multiple scratch marks from scratching and that his skin was "thin and friable." The PNMT nurse's assessment did not address these and did not constitute a thorough assessment at the time he had been referred. • 3 of 3 (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, or indicated that the individual was independent with mobility and repositioning. This was consistent with the previous review. • The PNMT appeared to consistently address positioning that may impact PNM status including during bathing and oral hygiene based on observations of these activities; • 3 of 3 (100%) contained evaluation of current assistive equipment. This was consistent with the previous review. • 0 of 3 (0%) contained nutritional assessment, including, but not limited to,	

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		history of weight and height, intake, nutritional needs, and mealtime/feeding schedule. This was a decrease from 29% in the previous review. There were no anthropometrics other than weight and height. Nutritional needs were not calculated with a comparative analysis to actual diet order and/or intake. • 3 of 3 (100%) contained a list of medications with potential side effects listed, including drug/drug and drug nutrient interactions and/or actual side effects via presentation of the comments per the pharmacist. This was consistent with the previous review. • __ of __ (NA) identified residual thresholds, if enterally nourished. None of the three individuals received enteral nutrition per the evaluations submitted. • 3 of 3 (100%) contained a tableside oral motor/swallowing assessment, including, but not limited to, mealtime observation. This was consistent with the previous review. • 3 of 3 (100%) contained information about the individual's current respiratory status based on a physical assessment. This was consistent with the previous review. • 0 of 3 (0%) contained evidence of review/analysis of lab work. Aspects of this were interspersed throughout various sections of the report, but there was no clear review of these by the team with analysis as indicated. This was consistent with the previous review. • 3 of 3 (100%) contained evidence of review/analysis of medication history over the last year and current medications, such as dosages, administration times, and side effects. This was consistent with the previous review. • 3 of 3 (100%) contained evidence of observation of the individual's supports at their home and/or day/work programs. This was consistent with the previous review. • 3 of 3 (100%) contained evidence that the PNMT conducted hands-on assessment. This was consistent with the previous review. • 3 of 3 (100%) identified the potential causes of the individual's physical and nutritional management problems. • 3 of 3 (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. This was consistent with the previous review. • __ of __ (NA%) contained recommendations for measurable skill acquisition programs, as appropriate . This did not appear to be indicated at the time of the assessments for these individuals based on the assessment findings. • 1 of 3 (33%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. This was an improvement from 0% in the previous review.	

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		• 3 of 3 (100%) 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 there were no specific indicators for when nursing staff should contact the PNMT. This was an improvement from 0% in the previous review. • 3 of 3 (100%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e., revision of the individual's PNMP). This was consistent with the previous review. • 3 of 3 (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. This was an improvement form 57% in the previous review. 3 of 3 (100%) contained discussion as to whether existing supports were effective or appropriate. This was consistent with the previous review. • 1 of 3 (33%) contained signatures of all core team members (or alternate), with dates of signature. This was an improvement from 0% in the previous review. Signatures were noted on the assessment for Individual #277, but not for Individual #254. Dates of signatures were not noted in either report, though both were noted for in Individual #313's assessment. Compliance with each of the 30 elements above was 100% for 24 of the 30 (80%) elements. Four others were at 33% or below and two were not applicable to these individuals. All areas were maintained or improved since the last review, with the exception of nutritional assessment and review of laboratory values. Objective clinical indicators should be established for individuals followed by the PNMT as part of the assessment's recommendations because they may serve as clues for potential change in status. These should be integrated into the IHCPs. These will not likely be the same objectives identified for discharge from the PNMT. • For example, key clinical indicators should be identified that alert the IDT that the individual may need an increase in intervention or monitoring and may be as basic as vital signs or meal refusals. In the case of Individual #254, one of the objectives "no hospitalizations for aspiration pneumonia for three months." This was an appropriate discharge criterion, but there would likely be other clinical indicators noted before that point at which time specific interventions and supports would be required to prevent him from reaching that level. The IHCPs and PNMPs for individuals with physical or nutritional management difficulties require effectiveness monitoring of individual-specific objective clinical data to determine the efficacy of the interventions (of which PNMT interventions are a part). PNMT review would be necessary to determine if the plan was being implemented as written, if staff were adequately trained, etc. If the team determined that interventions were not	

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		effective, the IDT/PNMT should revise these interventions. Plans should be revised within 24 hours, or sooner if the concern was critical, when a change was indicated. This should be collaborative between the PNMT and the IDT. <u>Integration of PNMT Recommendations into IHCPs and/or ISPs/ISPAs</u> There were three individuals who were on the PNMT active caseload who were included in Sample O.1 (Individual #277, Individual #313, and Individual #56). PNMT assessments and all other PNMT-related documentation had been requested with the individual records for each of the individuals in the sample as well as for eight others on the PNMT caseload (O.2). As described above, most of the assessments in these two samples were missing every other page and, as such, could not be used for the following analysis. Only three were complete, current, and submitted as follows: • PNMT Assessment (within last 12 months): Individual #313, Individual #254, and Individual #277 • Current ISP: Individual #313, Individual #254, and Individual #277 • Current IRRF: Individual #313, Individual #254, and Individual #277 • Current IHCP: Individual #313, Individual #254, and Individual #277 • Current PNMP: Individual #313, Individual #254, and Individual #277 The following metrics could only be reviewed for Individual #277, Individual #254, and Individual #313 due to incomplete PNMT evaluations for the other individuals: • For 1 of 3 individuals included in this review (33%), all recommendations by the PNMT were addressed/integrated in the ISP/ISPA, IRRFs, and IHCPs. There was no ISPA noted to address the findings of the PNMT for Individual #254 or Individual #277. IDT members signed the report for Individual #277, so clearly they were aware of the recommendations. The assessment was completed on 6/27/13 and by 7/6/13 he had already been diagnosed with a subsequent episode of aspiration pneumonia. An ISPA was conducted on that date to develop the Change of Status IHCP and all PNMT recommendations were integrated into that plan. PNMT members were present at that meeting. Only in the case of Individual #313, was full integration noted across all of these. Plans resulting from PNMT recommendations included the following components: • In the 3 plans reviewed (0%), the individual's identified PNM needs as presented in the PNMT assessment were addressed. As there was a page missing from the IHCP for Individual #277, dated 7/16/13, this could not be fully assessed by the monitoring team. Of the 14 recommendations listed in the PNMT evaluation, there were eight addressed in the COS/IHCP. It was presumed that the others were addressed as well, but this could not be verified. • In __ of the __ individuals for whom HOBE assessments were conducted (NA), the	

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		HOBE recommendations were integrated into individuals' plans. It did not appear that a full HOBE had been completed for any of these three individuals because only monitoring of their bed positioning was reported. • In 3 of 3 plans (100%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the IHCP only. • In 1 of 3 plans (33%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. There were only implementation dates listed in the plan for Individual #277, but completion dates were not. Duration of monitoring was clearly stated, however. One of the missing actions included DSP training related to suction toothbrushing. It could not be determined if a due date was identified. The format itself did not provide a place for this, but rather only implementation and completion dates. As such, it would not be possible for any team member to determine if actions were completed in a timely manner as outlined. All of the elements were present in the plans for Individual #313. • In 0 of 3 plans reviewed (0%), the specific clinical indicators of health status to be monitored were included. • In 3 of 3 plans reviewed (100%), the frequency of monitoring was included. <u>PNMT Follow-up and Problem Resolution</u> Each of the recommendations identified in the PNMT assessment was not clearly and consistently tracked through to completion. The format of documentation made it difficult to track original recommendations and those required as a function of ongoing review. Intervals of PNMT review were clearly stated, however, and these appeared to occur on a timely basis as recommended. A system that addresses implementation of recommendations and other actions should be developed to permit the PNMT (meeting minutes) and others to readily review this information (IPNs). The IPNs were consistently entered by the PNMT, but did not always accurately reflect actions taken, outcomes, and dates of completion. Guidelines for these should be developed. <u>Individuals Discharged from the PNMT</u> Five individuals were discharged from the PNMT in the last six months (Individual #164, Individual #171, Individual #47, Individual #106, and Individual #204). For individuals discharged by the PNMT: • There was evidence of ISPA meetings held to discuss the discharge of the individual from the PNMT to the IDT for 3 of 5 individuals (60%): Individual #47, Individual #106, and Individual #171. In the other cases, there was PNMT documentation that clearly stated that discharge was occurring, but the discharge	

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		rationale and plan were not. • Discharge summaries for 2 of 5 individuals (40%) provided objective clinical data to justify the discharge and to identify any new or outstanding recommendations for integration into the IHCP. A nursing IPN for Individual #106 (10/4/13) stated that he was discharged from PNMT services, but did not include clear statements of what goals were achieved and how. There were no IPNs written by the PNMT related to discharge per the documents submitted for review. • 3 of 5 individuals (60%) had evidence of ISPA documentation and/or action plan that included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy (Individual #171, Individual #106, and Individual #47). As stated in previous reports, an effective PNM program requires that the referral to the PNMT occur in a timely manner, so as to capitalize on the collective expertise of the team members. There is urgency to complete PNMT assessments. Even so, 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. At this time, the SASSLC PNMT appeared to understand this responsibility, though referrals from the IDT were not made and assessments were not completed in a timely manner. The team is commended for its hard work, expertise, and follow-up, though continued related to the content and thoroughness of the documentation of their work is indicated as outlined above. The facility self-rated this provision in noncompliance and the monitoring team concurred. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Assessments should be initiated within five days of referral and completed within 30 days. 2. PNMT recommendations should be addressed by the IDT and documented via the ISP process with an ISPA to integrate all findings and these should then be integrated into the IHCP, PNMP, IRRF, and/or other plans (as indicated). While all recommendations may not be implemented by the IDT/PNMT, each should be discussed with rationale documented to accept these or not. 3. A discharge summary should be completed that provides objective clinical data to justify the discharge. This may be via a report or IPN by the PNMT. All outstanding recommendations should be integrated into the IHCP with specific criteria established for referral back to the PNMT. An ISPA should be held to discuss the terms of discharge and documented.	

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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 ISP meeting. For individuals with therapeutic needs, teams will need to provide clear justification if they decide that therapists involved in the individual's care and treatment do not need to attend. For individuals in Samples O.1, attendance by key IDT members for review and approval of the PNMP included the following for current ISPs (18): • Medical: 17% (3/18) • Psychiatry: 6% (1/18) • Nursing: 100% (18/18) • RD: 6% (1/18), most, however, were attended by the technician only • Physical Therapy: 61% (11/18) • Communication: 78% (14/18) • Occupational Therapy: 44% (8/18) • Psychology: 61% (11/18) • DSP: 61% (11/18) • Dental: 0% (0/18) • Pharmacy: 0% (0/18) Though requested, pre-ISP documentation related to required attendance was submitted for Individual #277 only. In some other cases, the sign-in sheet designated whether that team member was required to attend. Analysis was as follows: • Individual #135: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, four were identified as required to attend the ISP. Of those, all four were present. • Individual #142: No pre-ISP submitted and no designation on the sign-in sheet. • Individual #25: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, five were identified as required to attend the ISP. Of those, only three were present. • Individual #124: No pre-ISP submitted and no designation on the sign-in sheet. • Individual #36: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, five were identified as required to attend the ISP. Of those, only three were present.	Noncompliance

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		• Individual #23: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, three were identified as required to attend the ISP. Of those, only two were present. • Individual #94: No pre-ISP submitted and no designation on the sign-in sheet. • Individual #331: No pre-ISP submitted and no designation on the sign-in sheet. • Individual #222: No pre-ISP submitted and no designation on the sign-in sheet. • Individual #236: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, six were identified as required to attend the ISP. Of those, five were present. • Individual #24: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, two were identified as required to attend the ISP. Of those, both were present. • Individual #204: No pre-ISP submitted and no designation on the sign-in sheet. • Individual #94: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, five were identified as required to attend the ISP. Of those, all were present. • Individual #56: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, seven were identified as required to attend the ISP. Of those, five were present. • Individual #259: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, nine were identified as required to attend the ISP. Of those, all were present. • Individual #277: The pre-ISP list of required attendance was submitted. Of the disciplines listed above, four were identified as required to attend the ISP. Of those, only three were present. • Individual #325: No pre-ISP submitted. Of the disciplines listed above, per the sign-in sheet, four were identified as required to attend the ISP. Of those, three were present. • Individual #47: No pre-ISP submitted and no designation on the sign-in sheet. Of the individuals, for whom required attendees were designated (11), full attendance consistent with those designations was noted for only four (36%) ISP meetings. At least one representative from Habilitation Therapies attended 17/18 of the meetings (94%) for those in the sample (all but Individual #277, for whom PT was a designated attendee), though Habilitation Therapies staff were in attendance as designated for only seven of 11 ISPs (64%). • 16 of 18 PNMPs (89%) were reviewed by the individual's IDT in the annual ISP meeting. This generally was limited to a generic statement to the effect that the plans were reviewed and revised as needed. Thus, they lacked statements as to the	

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		effectiveness of these plans or specified changes as needed with rationale. The plans for Individual #124, Individual #222, Individual #135, Individual #24, Individual #236, Individual #259, Individual #56, and Individual #142 were more specific. PNMPs cannot be reviewed and revised in a comprehensive manner by the IDTs unless each of the key team members is present to participate in that process. The new pre-ISP process identifies which team members are required to attend the ISP meeting and the needs for review of the PNMP and other PNM-related issues should be considered when making this determination. Actual attendance should be consistent with these designations. <u>PNMP Format and Content</u> Review of findings for PNMPs of individuals included in Sample O.1 (the plan for Individual #236 was missing page 2): • PNMPs for 20 of 20 individuals (100%) were current within the last 12 months. This was consistent with the previous review. • PNMPs for 20 of 20 individuals (100%) included a list of PNM risk levels and individual triggers. This was consistent with the previous review. • In 14 of 20 PNMPs (70%), there were large and clear photographs with instructions. Though some copies were submitted were black and white, the originals were prepared in color. This was a decrease from 82% in the previous review. • 20 of 20 PNMPs (100%) identified the assistive equipment required by the individual, though rationale or purpose was not consistently identified. This was consistent with the previous review. • In 12 of 13 PNMPs (92%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and/or pictorial instructions were provided. In some cases, however, the pictures showed the individual in poor alignment (Individual #227, Individual #236). These provided a poor reference for staff. In some cases, the black and white photos were not clear enough to discern the necessary detail for proper alignment and support (Individual #36). The clinicians should ensure that only color photos are used for staff reference. • In 17 of 20 PNMPs (85%), positioning was adequately described per the individuals' assessments or the individual was described as independent (all except Individual #222, Individual #124, and Individual #135). This was with a decrease from 100% in the previous review. • In 20 of 20 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. This was consistent with the previous	

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		review. • In 13 of 20 PNMPs (65%), bathing instructions were provided. Some only described level of assistance and did not address positioning. This was a decrease from 100% in the previous review. • In 18 of 20 (90%) PNMPs, toileting-related instructions were provided, including check and change. This was an improvement from 71% in the previous review. • In 13 of 13 (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. This was consistent with the previous review. • In 20 of 20 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. This was consistent with the previous review. • 21 of 21 individuals' (100%) Dining Plans were current within the last 12 months. This was consistent with the previous review. • 9 of 21 individuals had feeding tubes with no oral intake and one other who ate orally. 9 of 9 PNMPs/dining plans (100%) specifically stated that the individual was to receive nothing by mouth, when indicated. This was consistent with the previous review. • In 12 of 20 PNMPs (60%) and 21/21 dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. This was with a decrease from 100% in the previous review. • In 12 of 12 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. This was consistent with the previous review. • In 12 of 12 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. This was consistent with the previous review. • 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 dining utensils. This was consistent with the previous review. • In 20 of 20 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. Equipment was frequently not addressed, but rather the dining plans were referenced. This was consistent with the previous review. • In 20 of 20 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. This was consistent with the previous review.	

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		• 20 of 20 PNMPs (100%) included information related to communication (how individual communicated and how staff should communicate with individual). This is consistent with the previous review. The PNMPs reviewed were generally very good, with comprehensive content in most areas, though there had been slight regression in some areas. PNMP audits were conducted routinely and appeared to be generally effective in ensuring the content of these plans. <u>Change in Status Update for PNMPs Conducted by the IDT/PNMT</u> • For individuals for whom the changes needed to be made to the PNMP, there was no consistent ISPA documentation noting that the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. Generally, for changes that were required to the PNMP, the therapists emailed the QIDPs to inform them of the change with rationale. • For individuals for whom the PNMP was revised, the changes were consistently included in the PNMPs for staff training and implementation. Documentation in the IPNs of changes and effective dates for implementation were not consistently noted. The monitoring team concurred with the facility that they were not in compliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. IDTs need to consider review of the PNMP and other PNM-related issues when determining who is required to attend the ISPs. The IDTs should be careful if designating a Habilitation Therapy representative only. 2. Attendance at the ISP should be consistent with the designations established in the pre-ISP. 3. Address the areas of the plans that were deficient above (especially photographs). 4. Ensure that changes to the PNMP are documented via an ISPA. Documentation of those changes should also be completed by the therapists in the PNMP and IPNs.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure	<u>Monitoring Team's Observation of Staff Implementation of PNMPs</u> Dining Plans were readily available in the dining areas (and PNMPs were included in the individual notebook, though these were not immediately available in some homes). General practice guidelines (foundational training) were taught in NEO and in individual-	Noncompliance

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	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.	specific training by the therapists and PNMPCs. Based on observations conducted by the monitoring team, it was noted that: • 26 of 36+ individuals' (72%) dining plans were implemented as written. • 55 of 63+ individuals' (87%) PNMPs related to positioning and mobility were implemented as written or alignment and support were consistent with generally accepted standards. Based on additional observations: • 2 of 2 (100%) individuals' oral hygiene plans were implemented appropriately or consistent with generally accepted standards. • 8 of 8 (100%) individuals' transfer plans/repositioning were implemented appropriately or consistent with generally accepted standards. While the transfer steps were completed safely, the staff did not consistently attend to the individual's position after placement in the wheelchair, particularly when using a mechanical lift. Re-positioning is often necessary after placement to ensure that the individual is aligned properly. • (NA) individuals' bathing plans were implemented appropriately or consistent with generally accepted standards. No bathing was observed during this review, so this metric was not rated. Some additional comments: • There were several incidents of individuals who were prescribed finely chopped foods were given food items that were too large. Staff were prompted to make these corrections. The wrong diet texture was served to the individual despite several levels of checks required by kitchen staff, the line staff, Mealtime Coordinator, and the staff who was assigned to assist the individual at the table. • Errors were noted in the implementation of Dining Plans during snacks offered in a day program for Individual #61 and Individual #324. They were not provided the correct mealtime equipment and techniques were not appropriate. Monitoring needs to occur routinely in these areas, too, to ensure compliance. • In home 668, there were significant errors related to prevention of cross contamination and proper steps to sanitize the table and mats between diners. The placemats were not adequately sanitized between individuals. Wet rags were reused to wipe the area for more than one individual. The use of sanitizers was not appropriate. Wipes intended for use by individuals were used to clean placemats. Mats were wiped only with a wet rag rather than a sanitizer. In one case, food from one individual was still on the mat after having been wiped down and another individual was then permitted to sit there to eat his meal. Staff had to be prompted to address this.	

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		The facility had an extensive system established to analyze the monitoring data collected to assess staff compliance with the PNMPs and Dining Plans. Reports were generated every two months with findings as follows: • Physical Management January/February: 20% error rate March/April: 29% error rate May/June: 33% error rate July/August: 15% error rate • Mealtime January/February: 8% error rate March/April: 11% error rate May/June: 20% error rate July/August: 14% error rate The established goal was an error rate of 20% or less, and the majority of these met that objective. Errors increased in both areas in March 2013 through June 2013 and then a marked decrease in July 2013 and August 2013. Additionally, specific elements were identified as most critical to health and safety and a goal of 10% error rate or less had been set in each area. These were generally found to meet this goal, particularly in July 2013 and August 2013. All of the errors were analyzed across the facility, within each home, and trends were identified related to specific staff. Action steps were identified with a due date for each. An update was completed and reported as to the status of completion of any identified corrective actions from a previous period. This appeared to be an excellent system and the facility is commended for their work with this system, which appeared to be resulting in improvements in staff performance and compliance. Seven of 10 (70%) staff were able to answer questions related to risks and the purpose of strategies outlined in the PNMP or Dining Plan, though most required some cues and prompts. Staff should not routinely need to refer to the plans to answer these types of questions. Review of the plans and risks should be done when the staff are initially assigned for the day, and reviewed prior to implementation. Staff should have an active knowledge of the individuals to whom they are assigned on any given day: • Staff are 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. • Staff should review plans just prior to implementation of strategies, particularly	

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		at mealtime and, as such, information should be fresh on their minds. An important initiative was reported to address concerns with staff compliance. The facility had implemented Mealtime Coordinator training consistent with the statewide plan. All of the training had been completed at the time of this review and implementation had begun. The Mealtime Coordinator was seen in each of the homes. These individuals appeared to understand their role. The monitoring team concurred with the facility that they were not in compliance with this provision. The rate of errors observed continued to be too high. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Fully implement the Mealtime Coordinator system. 2. Ensure there is further focus on transfer and re-positioning techniques to improve staff performance in these areas. 3. Review procedures related to cleaning the dining table and mats between diners and provide staff training as needed.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	<u>NEO Orientation</u> Habilitation Therapies provided new employees with classroom training on foundational PNM-related skills. Class time included two days (a total of approximately 14 hours) to address the PNMP, lifting and transfers, and dining plans and eating skills. The Lifting and Transfers portion of the curriculum was taught by competency-trained CTD staff and check-offs of participants were conducted in class. Communication was addressed in a four hour time period and is addressed in section R below. The content, based on review of the curriculum materials, was very comprehensive. There was a presentation of foundational skills, with modeling by the trainers, to new employees. Practice time was provided with coaching by the trainers and then new employees were required to take a combination of written tests and/or were checked off on specific skills, using checklists. Employees were expected to pass all essential elements of the core competencies. The new employee was required to demonstrate competency of foundational skills by safely performing each step, for each foundational skill, without coaching from the validator. Upon completion of all classroom hours, the staff were assigned to a specific home and then participated in continued "on-the-job training with the PNMPCs over a full day period. The PNM aspect of this further training involved additional more individualized training at stations set up related to specific foundational competencies as follows:	Noncompliance

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		• Food textures and liquid consistencies • Wheelchair positioning • Bed positioning with head of bed elevation • Reading PNMPs and Dining Plans • Implementation of Dining Plans and PNMPs The staff training continued through the next day when the PNMPCs worked with the new employees on positioning in a wheelchair, bed positioning, and mealtime assistance. There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and CTD staff. The PNM-related core competencies (i.e., foundational skills) included in the NEO training appeared to be comprehensive. There were a number of associated knowledge and skills-based competency check-offs for most of this content. • Approximately 100% of new employees successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. <u>PNM Core Competencies for Current Staff</u> • 100% of current staff that required training successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. All staff attended annual refresher training. Staff were re-trained and retested until competence was established. • 100% of staff responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. <u>Individual-Specific Training</u> The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO. All staff had demonstrated competence in the core foundational skills through NEO and refresher training. Non-foundational training was completed for all staff in each home for the individuals who lived in that home. • All staff assigned to individuals in the samples selected by the monitoring team were trained related to the PNMP prior to the provision of services. • All staff assigned to individuals in the samples selected by the monitoring team had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) for high–risk individuals prior to the provision of services.	

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		• All staff responsible for training other staff successfully completed competency-based training for foundational competencies (core) and the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. In some cases, it was noted that some PNMPCs did not perform certain check-offs because they were not trained. These were re-validated annually, though some were slightly delinquent at the time of this review. These were scheduled for completion over the next two months. • The facility had a process to validate that staff responsible for training other staff are competent to assess other staff's competency. The monitoring team concurred that the facility was not in compliance with this provision. There were a number of significant implementation/compliance errors related to mealtimes and positioning. It appeared, however, that significant improvement had been accomplished in the area of physical management. Some of the concerns related to proper positioning appeared to be due to deficiencies in the seating systems themselves. As described in section P below, the therapists were on track to remedy these concerns and needed to develop an action plan to ensure that new and/or modified seating was provided to individuals with identified needs in a timely manner. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to focus on polishing staff performance through training, coaching, and monitoring. 2. Reinforce the role and responsibilities of the Mealtime Coordinators as well as supervisory staff in identifying and correcting staff performance errors.	
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> • Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. • Monitoring tools included adequate instructions. • The staff conducting monitoring were competent in the areas they were monitoring. There were well-designed flow charts to aid the clinicians in determining the frequency of monitoring based on risk level and supports provided. Options were varied and permitted the therapists to use their knowledge of the individual and their own clinical judgment in the decision-making process. The monitoring frequency outlined compliance monitoring by both therapists and PNMPCs. Effectiveness monitoring occurred with each	Noncompliance

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		compliance monitoring conducted by the licensed therapist. The monitoring team requested compliance monitoring forms that were completed for individuals included in Sample O.1 for the last three months. There were 133 forms completed by the PNMPCs and therapists from July 2013 through September 2013 across the 21 individuals. Forms were submitted for different areas: • Mealtime/Oral Intake (66) • PNMP (67) The PNM monitoring process did not cover an adequate balance in all areas that were likely to provoke swallowing difficulties or increase other PNM risk, based on: • 45% of the monitoring forms focused on oral intake (meals and snacks) • Breakfast: 14 forms (23%) • Lunch: 28 forms (47%) • Dinner: 14 forms (23%) • No designation: 4 forms (7%) • <1% of the monitoring forms focused on bathing (one form only completed) • 5% of the monitoring forms focused on medication administration • 3% of the monitoring forms focused on oral care. • 13% of the monitoring forms focused on positioning (wheelchair and bed) • 2% of the monitoring forms focused on transfers • 32% of the monitoring forms focused on physical management, but specifics were not identified. SASSLC did not use the Universal Compliance Monitoring Form developed by the state. The elements of that form were very general and it made it difficult to identify more discrete issues for tracking and analysis. Monitoring forms developed by SASSLC addressed individual PNMP, mealtime, and communication. The physical management monitoring was designed to address positioning the monitor was to specify which activity was observed (wheelchair, bed, or other). Some of the forms outlined the specific activity observed, but others did not mark this aspect of the form. As such, it was not possible to analyze the scope of monitoring conducted across all aspects of PNM. Each of the monitoring tools had instructions for completion by the monitors. Monitoring was completed across all shifts for each area. Completion was as follows: • 26 forms (20%) were completed before 8:00 am. • 31 forms (23%) were completed between 8:00 am and noon. • 62 forms (47%) were completed between noon and 5:00 pm.	

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		• 14 forms (11%) were completed after 5:00 pm. • 4 forms (3%) had no time designation. Compliance scores were not calculated for any of the forms submitted. Mealtime monitoring scores of 100% compliance were documented for 83% of those forms submitted. PNM monitoring scores of 100% compliance were documented for 81% of those forms. Only 20% of all the forms submitted documented any "no" answer, the majority with only one error identified (18 of 25 forms) Note that based on the scoring system, staff could perform the transfer improperly and still be scored in compliance. Further, staff could perform the transfer improperly and the equipment could be missing or broken and still be scored in compliance. This skewed the facility's self-perception of compliance. In 18 cases, the monitor did not observe a transfer for the individual. In some cases, staff were permitted to verbally describe the transfer, rather than demonstrate this skill. This is a very critical aspect of PNMP implementation and again skewed the perception of compliance. As described above, there were issues related to staff performance of transfers. There was a clearly established frequency to conduct staff compliance monitoring, and though the specific recommendations for this were not clearly outlined in OT/PT assessments (see section P). • For individuals in Sample O.1, PNM compliance monitoring forms were completed over the past three months (July, August, and September 2013) for 17 of 21 individuals (81%%). The frequency of monitoring occurred as per the individual's assessment and/or the individuals' plans/IHCPs for only four of those (19%). The other four individuals were listed with monitoring conducted during that time, but none were submitted. In addition, the forms submitted and the monitoring listed in the spreadsheets submitted were not consistent. • For individuals in Sample O.2, PNM compliance monitoring over the past three months for 0 of 3 individuals (0%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. • For the monitoring forms submitted, problems or "no" responses were noted on 25 of the 133 monitoring forms. Of these, documentation of adequate follow-up was provided on the form for 20 (80%). • Overall observations by the monitoring team did not result in similar findings with regard to PNMP and dining plan implementation as compared with the compliance data the facility's monitors reported. The monitoring team concurred that the facility was not in compliance with this provision.	

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		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: • Identify and correct issues related to the monitoring process to include the following: • Monitoring related to all aspects of the PNMP (transfers, tooth brushing, bathing, and medication administration, specifically) • Consider a method to calculate the percentage of compliance on the form. • Review the frequent use of "N/A", particularly for key aspects of the PNM monitoring process. The repeated use of this designation, would significantly skew the results and not provide an adequate picture of staff performance across all elements of PNM.	
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.	<u>Effectiveness Monitoring</u> There was also a system established for routine evidence of effectiveness monitoring by the therapists. As described in O.6 above, this process was paired with compliance monitoring and completed by licensed therapists. Of the 133 forms submitted for 15 individuals in Sample O.1, seven appeared to have been completed as recommended. There were clear guidelines established for frequency and a form to guide the review. There were significant inconsistencies in the completion of these. The forms were different and it was not clear as to which was the most current. These forms were not filed in the individual record and, as such, there was no permanent record of each review. These reviews of PNM supports should specifically address the effectiveness of the strategies as implemented and to the impact on identified health and/or safety concerns. For 11 of the 21 individuals, there was effectiveness monitoring conducted based on identified risk areas. Objective clinical data were not generally identified in the individuals' IHCPs/risk action plans. In addition, this was not consistent in that one monitoring addressed the risk areas and another did not for the same individual. Effectiveness monitoring should include programs across all environments and not only in the home. This was not consistent as most were conducted in the home only. The Habilitation Therapy department may want to consider using tracking logs that include supports and services provided. The therapists could use the PNMT Event Log to summarize the individual's health status for the period of review. The effectiveness monitoring spreadsheet could track findings and the timeliness of the monitoring in addition to the findings. The monitoring team concurred with SASSLC's finding for noncompliance with this provision. It was a concern that not all strategies would necessarily be reviewed using the current approach. For example, at the time of the observation, the therapist might	Noncompliance

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		observe positioning, but not necessarily transfers. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish clear guidelines for completion of this monitoring. Audits may be indicated to improve consistency. 2. Address effectiveness monitoring across all aspects of the plans or other indirect supports and services. These should occur across all environments and not only in the home. 3. Ensure the tracking system tracks timeliness of effectiveness monitoring as recommended, in addition to the findings.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>Evaluation of Individuals who Received Enteral Nutrition</u> The facility maintained and updated a list of individuals who were enterally fed. There was a list of individuals that identified approximately 50 individuals who received enteral nutrition (20% of the current census). Forty-one were identified as NPO and the others received some level of oral intake. • 10 of 10 individuals (100%) who received enteral nutrition (Sample O. 3) were evaluated at a minimum annually based on the APENs submitted. • 0 of 10 individuals with APENs submitted (0%) had an appropriate evaluation to determine the medical necessity of the tube since the previous review. 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 if there were potential modifications needed in preparation of transition to oral intake. Also, there was not sufficient oral motor review to address potential for any level of oral intake or interventions that may be indicated. • The APENs were completed, but the actual discussion by the team related to the medical necessity of the team was not possible because the ISPs were not available for eight of the individuals. For the other two (Individual #24 and Individual #331), neither clearly addressed the medical necessity of enteral nutrition in the IRRF or ISP. • __ of the __ individuals who received enteral nourishment and were admitted since the last review (NA) 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> • Individuals who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. None,	Noncompliance

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		however, clearly reflected assessment by the SLP and/or OT regarding oral motor status as to whether the individual was a candidate for an oral motor treatment program (to improve potential for intake by mouth or for improved saliva control). Justification for/or against oral motor treatment or potential PO intake should be included as a part of assessment findings. As previously stated, they also did not reflect adequate assessment by the dietitian. • __ of the __ individuals (NA) who were identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake (%) had a comprehensive plan outlining the treatment or return to PO process. • __ of the __ individuals' (NA) plans to return to oral eating were based on the results of the IDT's discussion and were integrated in the IHCP, ISP, and/or an ISPA. • __ of the __ individuals' (NA) plans to return to oral eating in the IHCP related to enteral nutrition were implemented in a timely manner. • __ of __ staff responsible (NA) for implementation of these oral intake plans (%) were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. • __ of the __ individuals' plans (NA) were monitored as outlined in the plan. 0 of 0 individuals' plans were modified by the IDT. • For __ of __ of these individuals' (NA) plans, the IDT met and interventions were reviewed and changed, as appropriate, in a timely manner. 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: • 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. The monitoring team concurred with SASSLC's finding for noncompliance with this provision. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish protocol related to the completion of assessments, especially related to	

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		nutrition and oral motor evaluation, on an annual basis to determine the medical necessity of all individuals with enteral nutrition. 2. Ensure that discussion related to medical necessity and return to oral intake are clearly documented in the ISP/IRRF and IHCP as appropriate.	

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o SASSLC client list o Admissions list o 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 SASSLC Integration of Clinical Services for Habilitation Therapy o Guidelines for the Frequency of OT/PT Evaluations o Updating Habilitation Therapy Plans o Evaluation and Implementation Process o Guidelines for Habilitation Therapy Objective Recommendations o Individuals with PNM Needs o Dining Plan Template o Compliance Monitoring templates 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 Documentation 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 submitted o PNM/Assistive Equipment Maintenance Log o List of Individuals Who Received Direct OT and/or PT Services o OT/PT Assessment template and instructions o OT/PT Assessment Tracking Log o Sample OT/PT Assessments OT/PT Assessments for individuals recently admitted to SASSLC: o Individual #53 o OT/PT Assessments, ISPs, ISPAs, and other documentation related to OT/PT intervention for the following individuals: • Individual #164, Individual #154, Individual #254, Individual #171, Individual #106, Individual #317, Individual #302, and Individual #226. o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. o PNMP section in Individual Notebooks for the following: • Individual #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. o Dining Plans for last 12 months, Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #56, Individual #325, Individual #277, Individual #259, Individual #267,

	Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. Interviews and Meetings Held: o Margaret Delgado, Gaitan, MA, CCC-SLP, Director of Habilitation Therapies o Cynthia Buckmeyer, PTA o Edward Harris, DPT o JoAnna VanHoove, OTR o Jose Gallana, PT o Retha Morgan Skinner, MOT, OTR o Wilfredo Diaz, DPT o Hab technicians and PNMPCs o Various supervisors and direct support staff Observations Conducted: o Living areas o Dining rooms o Day programs o Work areas o ISPA Meeting for Individual #47
	Facility Self-Assessment: The self-assessment completed by Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director, was significantly improved. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team. Modifications to P.1 and P.3 in particular were indicated because there were now no metrics related to OT/PT staffing and continuing education; PNMP monitoring is reviewed in section O only. Findings were generally reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Delgado-Gaitan and her staff were on track to ensure that progress will be made for the next review. They were achieved substantial compliance in P.1 with a focus on timeliness of assessments. Progress had continued and the plan outlined was a sound one and combined with the findings of this report, should guide them to make greater strides over the next six months. Benchmarks should be established in measurable terms and used to establish measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since

	the last review. The facility rated itself in noncompliance with each of the provisions in P. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: As in previous reviews, it was evident that a tremendous amount of work had been done in this area. The OTs and PTs continued to work as a team under the strong leadership of Ms. Delgado-Gaitan. Though many improvements were noted related to the assessments, there remained a pattern of delinquent completion of these. The findings reflected in the self-assessment and during the interviews with the staff, were not consistent with the assessment log submitted to the monitoring team. Resolution of this discrepancy was advised. Further, clarification as to the use of the Assessments of Current Status versus use of the Comprehensive Evaluations was needed. The clinicians continued to need to allocate more time to direct therapy interventions and real time modeling/coaching with staff in the homes and day programs. The therapists demonstrated continued efforts to implement a more effective evaluation process to identify properties needed for support and function. They were encouraged to develop a plan with projected timelines for the evaluation and design, fabrication, and delivery of new or modified systems. They appeared to be on the right track with many of the new systems they completed, but will have some catching up to do to ensure that others in need of improved systems get those in a timely manner. There was significant improvement in the quality of OT/PT assessments for this review period. • There were improvements in 12 (55%) of the elements. • There was regression in one of the elements (5%). • Seven others were consistent with the previous review, each at 100%. • The average for all 10 assessments was approximately 92%. o 2 of 10 assessments (20%) contained 100% of the 22 elements listed above. o 8 of 10 assessments (80%) contained 90% or more of the elements listed above. o 9 of 10 assessments (90%) contained 80% or more of the elements listed above. There was a clearly established audit system in place that should address the deficits noted. The primary concern, however, was the timeliness of assessments, which was calculated at 63% for the sample reviewed, but 81% based on the facility's tracking log. Though improvements were evident, the OT/PT supports and services were not consistently integrated into the ISPs, though this may have been a function of the timeliness issues. Attendance by Habilitation Therapy staff was inconsistent and the pre-ISP designations did not appear to be based on a sound rationale related to services provided and individual need. The frequency and documentation of effectiveness monitoring by the clinicians should be reviewed, with remedies identified for resolution. <u>Samples for Section P:</u> • Sample P.1: 21 individuals for whom an individual record and the most current OT/PT/SLP

	assessment was submitted. • Sample P.2: 1 individual newly admitted in the last six months for whom a current assessment was submitted. • P.3: 8 individuals who were provided direct OT and/or PT services per the list submitted.

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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.	<u>Assessments</u> The following individuals in Samples P.1 and P.3 had Comprehensive Evaluations current within the last 12 months: • Individual #259 (4/11/13) • Individual #24 (6/26/13) • Individual #325 (12/18/12) • Individual #313 (9/24/13) • Individual #23 (11/12/12) • Individual #267 (8/22/13) • Individual #222 (1/30/13) • Individual #277 (8/6/13) • Individual #54 (8/8/13) • Individual #127 (9/3/13) • Individual #72 (11/30/12) The Assessment of Current Status was not considered a stand-alone evaluation, but rather served as an addendum or update to the previous Comprehensive Evaluation. Both should be contained in the individual record. The following individuals had Updates/Assessments of Current Status completed within the last 12 months and each had an associated Comprehensive Evaluation contained in his or her individual record: • Individual #124 (3/25/13) • Individual #23 (5/21/13) • Individual #94 (6/19/13) • Individual #331 (7/9/13) • Individual #142 (2/1/13) There was no Comprehensive Evaluation contained in the individual records with the Assessments of Current Status for the following individuals: • Individual #227 (9/25/13) • Individual #36 (3/5/13) • Individual #47 (4/17/13) • Individual #77 (9/16/13) • Individual #135 (1/24/13) • Individual #25 (1/29/13)	Substantial Compliance

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		• Individual #204 (1/3/13) • Individual #56 (5/23/13) The individual record was not requested for this individual, but rather only the most current OT/PT assessment, which was an Assessment of Current Status. • Individual #11 (9/17/13) The Comprehensive Evaluation for Individual #236 (10/24/11) indicated that his supports should be reviewed at least annually via an Update/Assessment of Current Status, but there was no evidence that this had been done in his active record. The facility reported, however, that the annual assessment had been completed. Though the monitoring team acknowledged this report, the assessment was not considered complete because it was not contained in the record. Comprehensive Evaluations submitted were identified as OT/PT evaluations for some individuals (Individual #236, Individual #259, Individual #24, Individual #331, Individual #94, and Individual #124). Others included content contributed by the OT, PT and SLP, though communication assessments were completed as a separate document and are reviewed in section R below (Individual #325, Individual #313, Individual #23, Individual #267, and Individual #222). <u>Timeliness of Assessments</u> One individual was admitted to SASSLC since the last review. A Comprehensive Evaluation was submitted for Individual #53. • 1 of 1 individual in Sample P.2 (100%) received an OT/PT assessment within 30 days of admission based on the Admission Activity list and the signature dates on the assessment. This was consistent with the previous review. The following metric was not applied because SASSLC did not use an OT/PT screening at the time of this review: • If screenings were completed, ___ of ___ individuals (%) identified with therapy needs through a screening (%), received a comprehensive OT/PT assessment within 30 days of identification. As typical, there were not a large number of admissions to SASSLC. Therefore, the development of a strong, but brief, screening to rule out a need for assessment for individuals newly admitted (rather than the lengthier document currently used) may be considered. As described above, there were 25 current OT/PT evaluations submitted for individuals in Samples P.1 and P.3. Also, ISPs were submitted for all 25 of 25 individuals included in	

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		Samples P.1 and P.3. Of the 25 ISPs, 22 were current within the last 12 months with three expiring during the month of this review (Individual #313, Individual #227, and Individual #77). The current ISP dates were identified in the assessments submitted for these three individuals and these were used to assess compliance with the following metric. Timeliness of the current OT/PT assessments was as follows: • 15 of 25 individuals' OT/PT assessments or updates (60%) were dated as completed at least 10 working days prior to the annual ISP. This was an improvement from 17% in the previous review. • There were 125 assessments listed in the facility's tracking log for ISPs dated 3/26/13 through 9/24/13. Two others included in the list were new admissions and two others listed as "not applicable" (perhaps an assessment was not required, Individual #271 and Individual #14). Based on this log, 56% of the assessments were performed on, or prior to, the designated due date. This was an improvement from 26% in the previous review. Since 8/1/13, the on-time percentage was actually 81%. There were seven assessments since that time listed as delinquent, though by report, there had been some confusion about the due dates related to holidays for three of those. If these were counted as on time, the percentage of timeliness rose slightly to 86%. Further, 94% of all assessments were completed prior to the ISP. The facility reported that for assessments completed as due since 8/1/13 to the time of this review, 100% had been completed on or prior to the due date 10 days before the ISP and the assessment log validated 96% on time through 9/10/13. • 25 of 25 assessments (100%) were current within 12 months for individuals in Sample P.1 and P.3 who were provided PNM supports and services. This was generally consistent with the previous review. The facility reported that there were three OT/PT teams at SASSLC and two of these had been 100% and 97% compliant with on-time assessments for ISPs from 5/1/13 through 10/31/13. The third team was only at 54% during this same time period, attributed largely to one clinician (who was no longer employed at the facility). As a result and as described above the on-time percentages had risen significantly for this team and overall data reflected a significant improvement and stabilization of this over the course of this review period. <u>OT/PT Assessment</u> Only current Comprehensive Evaluations included in Sample P.1 and P.3 were included in the following analysis, with the exception of the assessment for Individual #313 as it was incomplete as per the copy submitted (missing pages 11 and 12). The elements listed below are the minimum basic elements necessary for an adequate comprehensive OT/PT assessment. The assessment format and content guidelines generally required that these elements be in the assessments. Based on review of Sample P.1, the analysis for	

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		comprehensiveness of the OT/PT/SLP assessments was as follows: • 10 of 10 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review. This should be the completion date considered for the metric above related to 10 working days before the ISP. • 10 of 10 assessments (100%) included medical diagnoses. This was an improvement from 11% in the previous review. • 10 of 10 assessments (100%) included medical history. This was consistent with the previous review. • 9 of 10 assessments (90%) documented analysis of the impact of diagnoses and relevance of medical history to functional status. This was an improvement from 50% in the previous review. • 10 of 10 assessments (100%) addressed health status over the last year. This was consistent with the previous review. • 9 of 10 assessments (90%) included comparative analysis that clearly analyzed health status compared with previous years or assessments. • 10 of 10 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. This was consistent with the previous review. • 9 of 10 assessments (90%) listed medications and potential side effects relevant to functional status. This was an improvement from 72% in the previous review. • 10 of 10 assessments (100%) included individual preferences, strengths, and needs. This was consistent with the previous review. • 10 of 10 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). This was an improvement from 61% in the previous review. • 10 of 10 assessments (100%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This was an improvement from 94% in the previous review. • Nine individuals in the samples reviewed required a wheelchair. Seven of nine assessments (78%) provided a description of the current seating system with a rationale for each component and need for changes to the system outlined as indicated, also with sufficient rationale. This was an improvement from 65% in the previous review. • 10 of 10 assessments (100%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This was an improvement from 78% in the previous review. • 8 of 10 individuals' OT/PT assessments (80%) offered a comparative analysis of current functional motor and activities of daily living skills with previous	

#	Provision	Assessment of Status	Compliance
		assessments. This was a decrease from 89% in the previous review. • 9 of 10 assessments (90%) included documentation of the efficacy and/or introduction of new supports in the PNMP which address the individual's PNM risk levels. This is a new metric since the previous review. • 9 of 10 assessments (90%) included discussion of the individual's potential to develop new functional skills. This was an improvement from 22% in the previous review. • 10 of 10 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct OT/PT interventions and/or skill acquisition programs as indicated for individuals with identified needs. This was consistent with the previous review. • 10 of 10 assessments (100%) included a monitoring schedule. This was an improvement from 67% in the previous review. • 10 of 10 assessments (100%) included a re-assessment schedule. This was an improvement from 94% in the previous review. • 10 of 10 assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This was consistent with the previous review. • 2 of 10 assessments (20%) detailed the supports and services needed for successful community living. This was an increase from 6% in the previous review. • 10 of 10 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This was an improvement from 94% in the previous review. The following metric was not addressed because there were discrepancies as to the function of the Assessment of Current Status. These generally pertained as to whether these were stand-alone assessments or merely addendums to the previous Comprehensive Assessment. If considered to be an addendum, the existing Comprehensive Assessment should be available in the individual record with each subsequent Assessment of Current Status, until such time the comprehensive was repeated (i.e., in three years, or other established interval per policy or assessment recommendation). At that time, each would be purged and replaced by the new Comprehensive Assessment and the cycle would be repeated. There were new assessment formats recently developed by the state and had been distributed. The facility was unclear at this time as to the outcome of these changes at the time of this review. They were attending the annual Habilitation Therapies conference scheduled later in October 2013 and hoped for further clarification at that time. • For ___ of ___ individuals for whom Updates/Assessments of Current Status were completed, the updates provided the individuals' current status, a description of	

#	Provision	Assessment of Status	Compliance
		the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data from the previous year and monitoring and re-assessment schedules. There were 12 individuals in Sample P.1 with current Updates/Assessments of Current Status and only five had associated Comprehensive Assessments contained in the individual records (Individual #142, Individual #331, Individual #23, Individual #124, and Individual #94). Further findings revealed continued improvements related to OT/PT assessments as follows: • There were improvements in 12 (55%) of the elements. • There was regression in one of the elements (5%). • Seven others were consistent with the previous review, each at 100%. • The average for all 10 assessments was approximately 92%. o 2 of 10 assessments (20%) contained 100% of the 22 elements listed above. o 8 of 10 assessments (80%) contained 90% or more of the elements listed above. o 9 of 10 assessments (90%) contained 80% or more of the elements listed above. There was significant improvement in the quality of OT/PT assessments for this review period and the average for all evaluations in the sample was 92% related to inclusion of the essential elements. There was a clearly established audit system in place that would address the deficits noted above. There had been a significant improvement of on-time assessments submitted since 8/1/13 of at or near 100% submitted on or prior to the due date of 10 days prior to the ISP. The monitoring team finds this provision in substantial compliance at this time. It is expected that resolution of the identified issues with regard to the essential elements and on-time completion of OT/PT assessments 10 working days prior to the ISP will be effectively maintained over the next six months as evidenced by: 1. Assessments are completed by the due dates (10 days prior to ISP). 2. Deficits in the elements are found to be less than 90%. 3. The function and format of the Assessment of Current Status are clarified. 4. Further changes to the assessment formats are implemented as discussed at the time that this report was being written and that additional modifications may occur during this time. 5. Completed assessments are filed in the individual records.	

#	Provision	Assessment of Status	Compliance
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>Direct OT/PT Interventions:</u> There were five individuals listed as participating in direct OT and/or PT. Three other individuals included in Sample P.1 also participated in direct therapy (Individual #313, Individual #124, and Individual #204). All eight were included for review in Sample P.3 as follows. • For 8 of 8 individuals (100%), an OT/PT assessment or consult identified the need for OT/PT intervention with rationale. • 6 of 8 individuals had direct intervention plans (75%) implemented within 30 days of creation, or sooner as indicated by the individual's health and safety. o A PT assessment dated 1/10/13 recommended direct PT for Individual #72 and established measurable objectives. There was no evidence that this was implemented until 3/15/13. o A PT assessment dated 1/10/13 recommended direct PT for Individual #227 and established measurable objectives. There was no evidence that this was implemented until 3/15/13. • For 0 of 8 individuals (0%), there were objectives related to functional individual outcomes included in the ISP or ISPA. • For 3 of 3 individual's record (100%) whose therapy had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. The system for documentation was consistent for each of the individuals reviewed. The rationale and plan with measurable and functional objectives was noted in most cases. Most of the documentation submitted was in the form of separate progress notes filed in the Habilitation Therapy tab of the individual record rather than in the IPNs. Progress notes/IPNs: • 8 of 8 individuals receiving direct OT/PT Services (100%) were provided with comprehensive progress notes (IPNs) at least monthly that contained each of the indicators listed below: o 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); o A description of the benefit of the program; o Identification of the consistency of implementation; and o Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Indirect OT/PT Interventions: The primary indirect OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Refer to section O.3 above regarding PNMP format, content and integration into the ISP and section S for skill acquisition plans. Implementation of PNMPs is addressed in section O.5. Integration of OT/PT Interventions, Supports and Services in the ISP Review of the PNMP and Dining Plans are required by the IDT at least annually during the ISP meeting. This requires that key team members be present, including the OT and/or PT clinicians. The current system required that the IDT designate which team members were required to attend the ISP during the pre-ISP meeting. Pre-ISP meeting documentation was requested for each individual in Sample P.1, though documentation was not submitted. This designation was marked on the sign-in sheets for 14 individuals as follows: • Both OT and PT required to attend (6), 2 of 6 (33%) compliance • Only OT required to attend (6), 3 of 6 (50%) compliance • Only PT required to attend (0) • Neither OT or PT required to attend (2), 2 of 2 (100%) compliance In total, only seven ISPs were attended by OT and/or PT as designated. In 10 cases, there was no designation and in one case there was no sign-in sheet submitted. In two cases, the PT attended the meeting and signed as representing OT, when both disciplines were required to attend (Individual #54 and Individual #267). In two other cases, only OT attended when both disciplines were required to attend, though the OT did not sign as the PT representative. In three cases, only PT attended when only OT was required, though the PT did not sign as the OT representative. Review of the ISPs for Samples P.1 and P.3 submitted was as follows: • 88% (22 of 25) of the ISPs submitted were current within the last 12 months, though three had expired during the month of this review (Individual #77, Individual #313, Individual #227). • 96% (24 of 25) of the current ISPs had attached signature sheets. • 24% (6 of 25) of the current ISPs with signature pages submitted were attended by both the OT and PT. • 40% (10 of 25) were attended by PT only. • 12% (3 of 25) was attended by OT only. • 20% (5 of 25) of the current ISPs had no representation by an OT or PT, though each had PNM needs. In two of those cases, neither OT nor PT was designated as required to attend (Individual #24 and Individual #277). Individual #24, however, had significant PNM needs, while Individual #277 had significantly	

#	Provision	Assessment of Status	Compliance
		fewer concerns, though he did have a PNMP. Further: • For 19 of 25 individuals (76%), an OT or PT attended the ISP meeting if the individual was receiving any direct or indirect OT/PT service. Justification for not attending was not clearly documented. • For 9 of 25 individuals in Sample P.1 and P.3 (36%), the ISP addressed recommendations outlined in the current OT/PT assessment, though the frequency of monitoring as recommended was rarely included in the ISP. Many recommendations were generally-referenced rather than individually-designed, particularly in the review of the PNMP. o Individual #24, Individual #11, Individual #54, Individual #72, Individual #277, Individual #124, Individual #23, Individual #135, Individual #222, Individual #267: All recommendations from the OT/PT evaluation were not addressed in the ISP, IRRF, and/or IHCP. In some cases, the IRRF or IHCP were not submitted. o Individual #56: The ISP dated 6/6/13 referenced each of the recommendations, however, the recommendation for a SAP was not included as an action. o The ISP for Individual #259 indicated that a follow-up meeting would be held one month after his ISP to discuss his safety equipment, a voice output device and his new wheelchair. There was no evidence of an ISPA related to this submitted with his individual record. o Individual #227: The ISP dated 10/16/12 was for the previous year and the recommendations in the current OT/PT evaluation (9/25/13) could not be reconciled. o Individual #236: The OT/PT evaluation dated 10/24/11 was not current and recommendations could not be reconciled with his most current ISP (11/14/12). o Individual #331: The OT/PT evaluation (7/9/13) was completed after the ISP on 7/2/13 and, as such, the recommendations were not included. There was no evidence of a subsequent ISPA to integrate the recommendations upon completion of the evaluation. o Individual #77: The ISP dated 10/9/12 was for the previous year and the recommendations in the current OT/PT evaluation (9/25/13) could not be reconciled. o Individual #313: The last two pages of his OT/PT evaluation dated 9/24/13 were missing per the copy submitted and, as such, the recommendations could not be reconciled with his ISP. • For 0 of 3 individuals in Sample P.1 (0%) who had an OT and/or PT consult assessment/update submitted in the individual records (Individual #313,	

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		Individual #227, and Individual #204), an ISPA addressed recommendations. • For 20 of 21 individuals reviewed in the sample for whom individual records were selected by the monitoring team (95%), the PNMP was updated within 30 days of the ISP. Individual #47's ISP was held on 5/21/3 and her PNMP was not updated until 6/10/13. This element was self-rated to be in noncompliance and the monitoring team concurred with the self-assessment. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Rationale in the pre-ISP process for therapist attendance or non-attendance at the ISP needs to be sound and clearly supported. 2. Representation by OT and/or PT should be reconciled with the IDT during the pre-ISP process and should be consistent with the designation by the team. 3. OT and PT supports must clearly be outlined in the ISP. In the case that interventions are initiated outside the scheduled annual ISP, an ISPA must document initiation of the service, report progress and termination with rationale.	
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.	<u>Competency-Based Training</u> 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.	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	The facility did not have a single comprehensive OT/PT policy, but rather the state policy and adjunctive documents that included all of the following elements and were in practice at the time of this review: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Definition of the monitoring process for the status of individuals with identified occupational and physical therapy needs; • Definition of the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Identification of monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	needs of each individual; • Identification of monitors and their roles and responsibilities; • Definition of a formal schedule for monitoring to occur; • Process for re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requirement that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identification of the frequency of assessments; • Definition of how individuals' OT/PT needs will be identified and reviewed; and • Requirements for documentation for individuals receiving direct services. <u>Monitoring System</u> • The facility implemented a system for the adequate monitoring of PNMPs. Staff compliance monitoring for implementation of PNMPs and the condition and availability of adaptive equipment was implemented at SASSLC. This was addressed in sections O.6 and O.7 above. There was a system established for routine effectiveness monitoring by the therapists. This was consistently noted for direct therapy interventions via monthly progress notes, though not generally in the IPNs, but rather in separate notes written and filed in the Habilitation Therapy tab of the individual record. Effectiveness monitoring was conducted by the OT and PT clinicians via the same form used to monitor compliance. A designated section of this form addressed the health risk interventions associated with the PNMP and/or Dining Plan, actual health events related to the risk concerns addressed by these plans and a judgment as to their effectiveness. While this was an effective means to accomplish this, there was no documentary evidence that this had been completed in the individual record. This was also not clearly referenced in the annual assessments, but rather only compliance monitoring was addressed in those reports. The frequency was established via the flow chart described in section O.6 above. A spreadsheet was also submitted which documented the recommended Monitoring Frequencies for Each Individual as of 9/13/13. This was more generally stated in the annual assessments with a more detailed description contained in this document. These frequencies were compared to the Individuals for Whom Monitoring Tools Were Completed In the Last Quarter document (XII.14). This included monitoring conducted in 2012 (only a few entries) and February 2013 through September 2013, rather than only the last quarter, though the majority of entries were listed from June through September.	

#	Provision	Assessment of Status	Compliance
		• Based on review of the individual records submitted, monitoring was documented per the established frequency for 7 of 21 individuals in Sample P.1 (33%). • For 5 of 5 individuals observed in Sample P.1 (100%), positioning devices and mealtime adaptive equipment identified in the PNMP were clean and in proper working condition. • Per the Maintenance Log submitted, 18 of 18 individuals included in Sample P.1 for whom adaptive equipment was noted to be in disrepair or needing replacement (100%), equipment was repaired or replaced within 30 days, generally on the same day or within 48 hours. • Per the OT/PT Assessment of Current Status for Individual #124 dated 3/25/13, it was identified that the leg rests required adjustment due to excessive length. At the time of this onsite review, the monitoring team noted that this was at least one of the issues related to her wheelchair. Clearly this had not been addressed in a reasonable time frame, nearly seven months later. This element was self-rated to be in noncompliance and the monitoring team concurred with this finding. There was a comprehensive policy that outlined essential elements related to monitoring and OT/PT supports and services. There was a system of staff compliance monitoring and effectiveness monitoring, though compliance with the established frequency was inconsistent. This was reviewed further in sections O.6 and O.7 above. To continue to move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish benchmarks and a tracking system and schedule for quarterly effectiveness monitoring by OTs and PTs. 2. Conduct audits and staff training as to the process expected for effectiveness monitoring. 3. Address documentation of this monitoring to ensure that there is documentation in the individual record related to completion, findings, and further action(s) required.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy #15: Dental Services, dated 8/15/13 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 o Listing, Individuals Receiving Treatment with TIVA o Complete Dental Records for the following individuals: • Individual #67, Individual #268, Individual #110, Individual #167, Individual #294, Individual #135, Individual #24, Individual #260, Individual #87, Individual #317, Interviews and Meetings Held: o Alvydas Kukleris, DDS, Dental Director o David Espino, MD, Medical Director o Amy Jo Hush, RDH, Dental Hygienist Observations Conducted: o Dental Clinic o Informal observation of oral hygiene regimens in residences
	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. The monitoring team had been previously informed that that self-assessment was standardized for all SSLCs. In recent months, a new expanded self-assessment was utilized that included 36 items. SASSLCs self-assessment only included 13 items and, therefore, was not the same self-assessment template being used by other facilities. For provision Q1, it addressed compliance with annual exams, emergency care, verification of positioning, effectiveness of pretreatment sedation, etc. Items for provision Q2 included appointment data and assessments of desensitization plans. The dental director will need to clarify with the state dental services coordinator the requirements for the self-assessment. Generally, the self-assessment should look at the same types of items that are 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: Overall, there was progress noted in the provision of dental services since the last compliance review. Individuals were completing annual assessments in a timely manner and being assessed for use of sedation and TIVA when needed to complete more extensive work, such as restorations and extractions. Oral hygiene continued to present challenges for the facility. Records documented that individuals came to clinic with clear evidence of poor home care. Individuals were seen in clinic for prophylactic treatments and returned a few months later with a heavy build up of tartar, calculus, and mouth debris. There was no evidence that there was a facility level plan to address the problem. Individuals had oral care plans and employees received training. Even so, data showed 35% of individuals had poor oral hygiene ratings and initiatives implemented by the clinic were not successful and ultimately abandoned. The suction toothbrushing program became more defined, but the follow-up and assessment of outcomes were not totally clear. The current policy did not define how implementation was monitored. Documentation of care was improved. The primary documentation was in the dental progress/treatment notes. The IPN entries included pointer notes. The progress notes were typed in SOAP format and contained adequate information. The majority of failed appointments was due to missed appointments for which there was no known reason. The number of refusals was relatively low. The facility had no effective means for addressing those at the time of the review. Several individuals continued to have delays in care related to the consent process. The delays now were mostly due to the need to have HRC approval for the use of sedation. There were several examples of unacceptable delays in care.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>Q1</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.</td><td>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.

<u>Staffing</u>
The dental director began working at the facility in September 2012 and assumed the directorship in November 2012. The dental director reported to the medical director. The hygienist and dental assistant were supervised by the dental director. All were full time employees. There were no staffing changes since the last compliance review.

<u>Provision of Services</u>
The dental clinic had three operatories and provided services five days a week. Dental services 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.

<table>
<tr><td colspan="6">Clinic Appointments 2013</td></tr>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td><td>Jul</td><td>Aug</td></tr>
<tr><td>Preventive</td><td>50</td><td>35</td><td>54</td><td>43</td><td>32</td></tr>
<tr><td>Emergency</td><td>4</td><td>1</td><td>2</td><td>1</td><td>4</td></tr>
<tr><td>Extractions</td><td>5</td><td>4</td><td>1</td><td>1</td><td>3</td></tr>
<tr><td>Restorative</td><td>15</td><td>11</td><td>2</td><td>13</td><td>6</td></tr>
<tr><td>Total</td><td>112</td><td>92</td><td>97</td><td>100</td><td>93</td></tr>
</table>

The overall number of appointments did not include the appointments for individuals referred to the community dentist. In August 2013, five individuals completed dental work off campus under general anesthesia. Each individual had completed one consultation prior to receiving treatment. Treatment ranged from prophylactic care and restorations to multiple extractions. Dental notes indicated “restorations as noted,” so the monitoring team did not have additional information on the number of restorations.

Several individuals had extractions completed in the SASSLC dental clinic with the use of TIVA. Most individuals had one to three teeth extracted. Several of them had extractions after a lengthy waiting period to have consent obtained. One individual was identified who needed extensive work, possibly a full mouth extraction. Examples are provided in section Q2.

<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</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		by phone to discuss care with the primary providers. Radiographs The monitoring team discussed the requirement for radiographs with the facility dentist. There was no specific frequency established for completion of radiographs at the facility. The dental director indicated that, generally, the ADA guidelines were followed. Individuals at low risk received radiographs every two years and those at high risk had more frequent radiographs. The need for x-rays was assessed at least annually and documented in the annual dental assessment (exam). This appeared to be a reasonable approach. The monitoring team recommends that the dental director develop a policy related to dental radiographs that outlines the ADA's criteria based on risk assessment. Oral Surgery There were no referrals to the oral surgeon. Referrals were made to a general dentist who provided care under general anesthesia in a hospital setting. The individuals referred were generally those who were older or who had complex medical problems. Oral Hygiene The facility continued to monitor the oral hygiene ratings of the individuals. The following data were reported: Oral Hygiene Ratings 2013 Jan - Mar / Apr - June / July - Aug Good: 22 / 22 / 21 Fair: 46 / 43 / 44 Poor: 32 / 35 / 35 Total: 141 / 208 / 102 The overall hygiene ratings did not show any significant changes since the last review. The changes that did occur were unfavorable with small decreases in the percentage of good and fair and slight increases in the percentage of poor. Documentation in the active records frequently indicated that home care was poor as evidenced by the presence of debris in the mouth and calculus build up on the teeth. Home training was conducted in the past, but was reported to be unsuccessful by clinic staff. They believed that home staff was relying on this training for routine toothbrushing. Therefore, home training was terminated. During the April 2013 review, the clinic staff reported that a toothbrushing clinic was implemented on 4/1/13 and was conducted once a week. Six individuals were seen in the clinic and provided oral hygiene training. The facility had not clearly defined the criteria that would be used to select the individuals at that time. The clinic was subsequently discontinued due to poor attendance.	

#	Provision	Assessment of Status	Compliance
		The monitoring team was interested in how this information was utilized by the quality department and if any further analysis of the data was conducted to determine trends, or problem areas that needed focus. The dental director indicated that there had not been any further discussion of the hygiene data or failures of the various projects. It was clear that the efforts of the dental clinic were not impacting the overall problematic trend that was seen in the facility with regards to oral hygiene. The clinic staff could not provide any evidence of a facility level plan to address poor oral hygiene scores. Over a three-year period, this had been an ongoing concern yet there had been no adequate facility level response to address the issue of daily oral care. 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. Each of the annual dental assessments documented the review of the PNMP and attention to positioning. It was also reported that the clinic utilized an angle finder to ensure correct wheelchair positioning. <u>Suction Toothbrushing</u> Thirty-six individuals received suction toothbrushing. Chlorhexidine and Biotene were now alternated at 14-day cycles. As reported during discussions with clinic staff, individuals were identified by the dentist who discussed the recommendation with the primary care provider. If there was agreement by the IDT, the dentist proceeded with writing orders for the treatment. The suction toothbrushing policy did not describe this process. In fact, it the policy provided very little detail about the process. It stated who qualified for suction toothbrushing, but did not state how the individuals would be identified. According to the policy, individuals at risk for aspiration, those who received enteral nutrition and those with a diagnosis of oral dysphagia may be prescribed a treatment that included suction toothbrushing. It did not describe how the individuals would be identified, which provider was responsible for writing the order, or how the facility would ensure the treatments were provided. The facility needs an operational procedure that describes every aspect of the program such that any new staff could read the procedure and have fair knowledge of how the program operates. The suction toothbrushing policy was implemented on 8/12/13. <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. The monitoring team was provided a copy of an email issued by CTD stating the facility had a compliance rate of 99.5%. The exact training and group were not specified.	

#	Provision	Assessment of Status	Compliance
		Compliance Rating and Recommendations The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: • The facility must address the current problem of oral care provided in the homes and the resulting oral hygiene ratings. • The dental services policy should be revised to clarify the provision of emergency care. • The suction toothbrushing policy should be revised to clearly outline the program. Consideration should be given to how individuals will be identified to ensure that all potential candidates are assessed.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	Policies and Procedures The monitoring team requested all facility (local) policies related to the provision of dental care. SASSLC submitted two new policies for suction toothbrushing and chlorhexidine use. Those policies are discussed in section Q1 under Oral Hygiene and suction toothbrushing. As noted in the April 2013 review, the standard operating procedure manual was still under review. The dental department needs to have a dental department manual that includes all policies, procedures, and guidelines involving the provision of dental services to ensure that all aspects of dental services are covered. That manual should be readily retrievable and available for review by staff. Topics should include, but not be limited to: • General operations of clinic and staffing • Informed consent • Dental radiographs • Oral hygiene tracking • Dental recall • Dental sedation • Anesthesia - medical clearance, recovery • General anesthesia personnel • Infection control • Training • Dental emergencies • Oral care Some policies may not be under the purview of the dental department, however, policies such as informed consent and the HRC review process should also be included the manual. Local policies should be updated to reflect changes in state dental policies. The department should also ensure that policies are reviewed on an annual basis and	Noncompliance

#	Provision	Assessment of Status	Compliance
		updated as required. Dental Records Dental records consisted of IPN entries, exam reports (annual exams), and dental progress/treatment records and oral sedation progress notes. The entries made in the dental progress treatment record were done in SOAP format and were typed. When individuals were seen in dental clinic, an entry or pointer note was made in the IPN that indicated that the individual was evaluated. Annual/Comprehensive 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 within 365 days of the prior assessment were considered to be in compliance. The available data were used to calculate compliance rates that are summarized below.	

Annual Assessment Compliance 2013						
	Mar	Apr	May	Jun	Jul	Aug
No. of Exams Completed	12	17	22	23	12	21
% Timely Completion	92	88	95	96	100	95

There was a significant improvement in the completion of the assessments. The Overall compliance for the six month reporting period was 94.5%. There was also improvement in the documentation of the assessments. The complete dental records were submitted for 10 individuals. Records included the annual exams, dental progress treatment records The following is a summary of information found in the annual assessments (exams):

- 9 of 10 (90%) assessments included an entry on cooperation
- 10 of 10 (100%) assessments had entries for oral hygiene and periodontal conditions
- 10 of 10 (100%) assessments included documentation of oral cancer screenings
- 8 of 10 (80%) assessments included documentation that oral hygiene recommendations were provided to the individual and/or staff
- 10 of 10 (100%) assessments documented the risk rating
- 10 of 10 (100%) assessments documented x-rays or the need for x-rays.

Each assessment summarized the services provided, the exam findings, types of x-rays completed, and any abnormal x-ray results. The plan of care was outlined along with the rationale when appropriate. Overall, the documentation for the assessments was good and provided the necessary information for the IDTs.

#	Provision	Assessment of Status	Compliance
		Initial Exams The facility submitted data for two individuals admitted since the last onsite review. Two of two (100%) individuals completed initial dental evaluations within 30 days. Failed Appointments The guidelines issued by state office required reporting of missed/no show appointments and refusals. A missed appointment was one that was not attended by the individual because of reasons beyond his or her control. Refusals were appointments not attended because the individual stated he or she did not want to go. The failed appointments were the total number of missed appointments and refusals. The numbers as identified and reported by SSLC are summarized in the table below:	

Failed Clinic Appointments 2013						
	Mar	Apr	May	Jun	July	Aug
Missed/No show	5	9	3	4	7	11
Refused	5	8	3	3	6	1
Failed	10	17	6	7	13	12
% Failed	15	15	7	7	13	13
Total Appointments	65	112	92	97	100	93

Each home was notified of appointments every morning between 6:30 am and 6:45 am. This was in addition to notifications that were previously sent. For the 34 missed appointments reported from April 2013 through August 2013:

- 22 of 34 (65%) had no reason
- 8 of 34 (23%) were due to staffing
- 4 of 34 (12%) were due to outings/passes

When appointments were missed, they were re-scheduled. Overall, the reported number of refusals remained low. The facility had not made any progress in addressing the individuals who refused treatment.

Dental Restraints
The reported data for the use of TIVA and anxiolysis are summarized in the table below.

General Anesthesia/Minimal Sedation						
	Mar	Apr	May	Jun	Jul	Aug
TIVA	9	8	7	3	6	8
Oral Sedation	4	0	2	6	4	0
Off Campus	0	0	0	0	0	5
Total	13	8	9	9	10	13

#	Provision	Assessment of Status	Compliance
		The facility utilized the services of a contract anesthesiologist who provided services two to three days each month. SASSLC utilized TIVA. The dental department did not have a specific set of policies related to the use of TIVA at the facility. The dental director reported that several months prior to the compliance review there were concerns related to post anesthesia monitoring, which were resolved. Policies related to post anesthesia monitoring were nursing services policies. The monitoring team did find that the dental director made comments in every assessment regarding the status of monitoring following anesthesia. The medical director and dental director should develop a set of policies regarding the use of sedation and anesthesia for the dental clinic. Those policies should address indications for use of anesthesia, evaluation of individuals prior to anesthesia, and post anesthesia monitoring of individuals. The CNE should also be involved in this process because nursing plays an important role in monitoring. <u>Strategies to Overcome Barriers to Dental Treatment</u> There had been multiple attempts to establish various workgroups and performance improvement teams, but none produced any real results. At times, there were desensitization plans in place, however, there were none at the time of the compliance review. The monitoring team met with facility staff during the week of the compliance review to discuss the next steps in addressing barriers to dental treatment. One recommendation from the monitoring team was to contact other SSLCs that were having some measure of success for information on structuring systems that address barriers through a variety of methods including, but not limited to desensitization. <u>Informed Consent</u> SASSLC continued to be plagued by challenges of the consent process. 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. As a result of this, consents were integrated with the ISP. Moreover, 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 "<u>primarily engaged in private practice</u>." The dental director now reported that the primary delays occurred after the consents were signed, but needed HRC approval. The consents were forwarded to the QIDPs in order for this to occur. Dental clinic had monthly meetings with them to discuss the status. During the week of the monitoring review, the monitoring team reviewed a list of individuals who had signed consents that needed HRC approval. The list included 29 individuals. The following are four individuals who were included on the list along with the dates that the consents were signed.	

#	Provision	Assessment of Status	Compliance
		• Individual #94, 2/1/13 • Individual #327, 11/1/12 • Individual #342, 4/24/13 • Individual #72, 2/28/13 Most individuals had consents signed three to four months prior to the review. Individual #327 had a consent signed 11 months prior to the compliance review. Clinic staff was not aware of any specific reason for a delay of nearly one year. All of these individuals were awaiting treatment. It was reported that the HRC was meeting the week of the compliance review so the staff expected that some individuals would have approval by the end of the week. While the facility had made some improvement in the consent process, the ultimate goal is to provide treatment. Clinic staff reported that the HRC process was delaying treatment. This was unfortunate because the consent process was moving faster and, overall, the delays of 12 months and longer that were previously seen were decreasing. This was seen in documentation. However, the list of individuals awaiting HRC approval for the use of sedation was evidence that this process was not efficient and needed to be reviewed. The monitoring team recognizes that completion of the HRC process is in part dependent upon the actions of other IDT members and the leadership of the QIDP. <u>Compliance Rating and Recommendations</u> The monitoring team agrees with the facility's self-rating of noncompliance. To move in the direction of substantial compliance, the monitoring team offers the following recommendations for consideration: 1. The dental director must proceed with developing adequate policies and procedures for the department. 2. Facility management should determine the reasons for the missed appointments. 3. A multidisciplinary approach is needed to develop plans and strategies for individuals who refuse dental treatment. 4. The dental and medical directors should develop policies and procedures related to the use of TIVA and sedation in the dental clinic as discussed above. 5. Facility administration must address the HRC process and the impact it is having on dental treatment.	

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 Communication Services Operational Policy #016 (9/11/13) o Current SLPs, license numbers, ASHA certification cards, caseloads o Continuing education and training completed by the SLPs since the last review o SASSLC Integration of Clinical Services for Habilitation Therapy o Guidelines for the Frequency of OT/PT Evaluations o Updating Habilitation Therapy Plans o Evaluation and Implementation Process o Guidelines for Habilitation Therapy Objective Recommendations o Facility list of new admissions since the last review o List of individual with PBSPs o Communication Evaluation Plan (9/23/13) o Tracking log of SLP assessments completed since the last review o SLP/Communication assessment template o Speech Language Pathology Screening 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 form template o Communication monitoring forms submitted o Summary reports or analyses of monitoring results o NEO Communication Training Curriculum o Communication Assessment for individuals recently admitted to SASSLC: Individual #53 o Communication Assessments, ISPs, ISPAs, SAPs and other documentation related to communication for the following individuals: • Individual #31, Individual #119, Individual #256, Individual #294, Individual #121, Individual #38 o Information from the Active Record including: ISPs, all ISPAs, signature sheets, Integrated Risk Rating forms and Action Plans, ISP reviews by QIDP, 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 #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. o PNMP section in Individual Notebooks for the following: • Individual #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. o Dining Plans for last 12 months. Monitoring sheets for the last three months, and PNMPs for last 12 months for the following: • Individual #56, Individual #325, Individual #277, Individual #259, Individual #267, Individual #313, Individual #36, Individual #142, Individual #47, Individual #77, Individual #236, and Individual #222, Individual #227, Individual #23, Individual #135, Individual #331, Individual #24, Individual #94, Individual #25, Individual #124, Individual #204. <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MA, CCC-SLP, Director of Habilitation Therapies o Allison Block-Trammell, MA, CCC-SLP o Jessica Guerra, MA, CCC/SLP o Leonor Lopez, BS, ASLP o Various supervisors and direct support staff <u>Observations Conducted</u>: o Living areas o Dining rooms o Day programs o Work areas
	Facility Self-Assessment: The self-assessment completed by Margaret Delgado-Gaitan, MS, CCC-SLP, Habilitation Therapies Director, was significantly improved. There were very clear and relevant activities conducted and these generally linked well to previous reports by the monitoring team. Actions and self-assessment activities correlated extremely well to the recommendations made by the monitoring team and reflected significant efforts on the part of communication staff. The additional leadership of Allison Block-Trammell resulted in excellent

	progress during the last six months. Findings were reported in measurable terms. Each provision listed the activities to conduct the self-assessment, results of the self-assessment, and a self-rating. There was consistent analysis of the data to support the self-ratings and action steps outlined to address identified concerns. The Habilitation Therapies department continued to demonstrate hard work and a focus on accomplishing their established goals. Ms. Delgado-Gaitan and the other speech staff were on track to ensure that progress will be made for the next review. They were very close to achieving substantial compliance, especially in R.1 and R.2, with a needed focus on timeliness of assessments and possible addition of another SLP. Progress had continued and the plan outlined was a sound one and combined with the findings of this report, should guide them to make greater strides over the next six months. Benchmarks should be established in measurable terms and used to establish measures for success and to track progress. Though much continued work was needed, the monitoring team acknowledges the work that was done since the last review. The facility rated itself in noncompliance with each of the provisions in R. While the actions taken continued to be definite steps in the direction of substantial compliance, the monitoring team concurred with these findings.
	Summary of Monitor's Assessment: There was continued, steady progress toward substantial compliance in all aspects of provision R. Efforts to improve the content of communication assessments were evident. Though improvements were noted, on-time completion of assessments continued to be problematic. The addition of the SLPA was excellent enhancement of this team. She was observed in action by the monitoring team, and she clearly understood her role. There were a significant number of communication plans and SAPs in place for individuals with communication needs and for those with behavioral concerns in combination with severe communication deficits. While the collaboration between psychology and SLPs was a strength, continued effort was indicated to ensure integration of the recommendations in the communication assessment into the PBSP. This was also needed related to the ISPs as well. The therapists were encouraged to identify when the typical prompt hierarchy approach would not be the most effective way to promote communication skill acquisition. Clinicians should consider the measurable objectives and the data collected, and then collaborate with the day programs to develop these in a creative way. As stated in previous reviews, the strategies used for active treatment in the homes needs to focus more on meaningful communication exchange rather than staff merely providing instruction. Real time modeling and coaching by the speech clinicians is needed to aid in addressing this issue. All of the SLPs worked diligently to complete assessments and identify appropriate communication supports for individuals, including AAC.

	Assessments were not consistently completed 10 days prior to the ISP, but were consistently completed prior to the meeting. The content aspect of assessments was substantially improved with compliance with the 23 essential elements averaging approximately 97%. The staff and leadership are congratulated on this significant achievement. Maintaining equipment already provided to individuals was an ongoing and costly problem. Clear expectations from administration and supervisory staff regarding the care of these is essential in order that they are always available to the individuals who need them. Further, there was a need to expand the time available for staff training on communication. Currently, the schedule identified only 30 minutes for communication and AAC in the newly added refresher course. <u>The following samples were used by the monitoring team:</u> • Sample R.1: 21 individuals included in the sample selected by the monitoring team. • Sample R.2: Individuals admitted since the last compliance review. • Sample R.3: Individuals with AAC systems selected by the monitoring team • Sample R.4: Individuals receiving direct speech services

#	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> The current Habilitation Therapies Director, Margaret Delgado-Gaitan, MS, CCC-SLP was a speech-language pathologist, but had administrative and leadership responsibilities rather than direct supports and services. There were three full time SLPs with responsibilities related primarily to communication, but who also shared responsibilities related to mealtime and dysphagia with OT. They were Allison Block-Trammell, MA, CCC-SLP, Jessica Guerra, MA, CCC/SLP, and Roland Hoffmann, MS, CCC-SLP. Allison Block-Trammel was a core PNMT member, the lead speech clinician and had reduced caseload responsibilities. Leonor Lopez, BS, ASLP was a speech assistant to the full-time SLPs, essentially serving the entire facility.. There were three budgeted positions for speech language pathologists, with all filled at the time of this review. The FTEs were listed by the facility as three with a ratio of 1:83 and this was consistent with the current census. Responsibilities of the communication therapists included, but were not limited to, conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs related to communication and dysphagia. The speech staff were assigned caseloads as follows (totals based on individual list by home and based on census of 248):	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Allison Block-Trammell: Homes 674 and 766 (approximately 60 individuals per the census list submitted). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals, as well as assignment to the PNMT and administrative duties as the lead speech clinician. Based on the documents submitted and report from the facility, at least 28 individuals in these homes presented with severe communication deficits, or were non-verbal (47%). Another seven individuals were identified with limited verbal skills (12%). All others were identified with functional communication. • Jessica Guerra: Homes 668, 670, and 673 (approximately 97 individuals). Her responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. Based on the documents submitted Based on the documents submitted and facility report, at least 70 individuals in these homes presented with severe communication deficits, or were non-verbal (72%). Another 17 individuals were identified with limited verbal skills (18%). All others were identified with functional communication skills. • Roland Hoffmann: Homes 665, 671, and 672 (approximately 93 individuals). His responsibilities in these homes included both dysphagia/mealtime and communication issues for these individuals. Based on the documents submitted at least 48 individuals in these homes presented with severe communication deficits (52%). • Leonor Lopez: All homes (approximately 248 individuals). She provided assistance and supports to the SLPs in all homes (as required and directed by the SLPs). Based on the documents submitted at least 110 individuals in these homes presented with severe communication deficits (44%). There was a Master Plan with assigned priorities related to the severity of individual communication deficits and communication assessment/support needs. By report, approximately 93% of all individuals had received a Comprehensive Evaluation, though none of those remaining had high communication needs; they were described as functionally verbal. The remaining 18 were scheduled for completion from October 2013 through February 2014. At the time that a Comprehensive Evaluation was completed, an Assessment of Current Status was subsequently completed on an annual basis for individuals who were provided supports and services. Repeat Comprehensive Evaluations were recommended and completed on a prescribed interval (i.e., every three years) as designated in the communication assessments. The list of individuals with PBSPs and replacement behaviors related to communication included 53 individuals identified with severe language deficits (nonverbal and limited verbal). Another list identified at least 57 other individuals with severe language deficits and behavior concerns.	

#	Provision	Assessment of Status	Compliance
		• SASSLC did not provide an adequate number of speech language pathologists and speech assistants with specialized training or experience to provide communication supports and services based on the process established by the facility. These caseload assignments were high based on need, though the SLPA permitted a focus of the provision of ongoing supports and services needed for individuals with communication needs. <u>Qualifications:</u> • The facility documented appropriate qualifications for licensed SLPs. • 4 of 4 speech staff (100%) were currently licensed to practice in Texas as verified online. This was consistent with the previous review. • 3 of 3 SLPs (100%) held current American Speech and Hearing Association (ASHA) certification. <u>Continuing Education:</u> Based on a review of continuing education completed since the previous review: • 4 of 4 current speech staff (100%) had completed continuing education in the last year. This was consistent with the previous review. Continuing education attended by the clinicians for which contact hours or CEUs were provided that appeared to be relevant to communication included: • Augmentative and Alternative Communication (AAC) for School Age Children with Intellectual Disabilities: Basic Strategies for Immediate Results, 1 contact hour (Guerra, Hoffmann, Lopez, and Trammell) • Rehabilitating Your Approach: Maximizing Outcomes in Patients with Cognitive Impairment, Depression, 4.5 contact hours (Guerra, Hoffmann, and Trammell) • Augmentative and Alternative Communication: Using Assessment to Guide Intervention, 1.5 contact hours (Guerra) • Dementia 101: How to Successfully Manage Dementia in Home Health, 1 contact hours (Guerra) • Assessment and Treatment for Apraxia: Overcoming the Effects on Speech and Swallowing, 6 contact hours (Guerra) • Ethical and Effective Evaluation for AAC, 2.5 contact hours (Hoffmann) • Texas Assistive Technology Network Statewide Conference, 11.25 hours (Hoffmann) • TSHA – Evidence-Based Practices for AAC Evaluations – From A and P to REC: Building the Meaning Behind Acronyms, 11 contact hours (Hoffmann and Trammell)	

#	Provision	Assessment of Status	Compliance
		The intent of ongoing continuing education is to ensure that the clinicians attain and/or expand their knowledge and expertise related to the provision of communication supports and services, particularly related to AAC. The clinicians are encouraged to continue to seek continuing education courses beyond in-house training to continue to enhance their talents relative to the provision of communication supports and services. Inservices conducted by co-workers following attendance at formal continuing education courses is an excellent method to conserve resources, yet permit all staff to benefit from the information acquired. A system to track participation in continuing education was in place at SASSLC. <u>Facility Policy:</u> There was a local policy related to communication. The local policy should generally provide clear operationalized guidelines for the delivery of communication supports and services. Each of the following elements was sufficiently addressed in the policy submitted (9/11/13) and/or a well-established procedure was currently in practice: • Roles and responsibilities of the SLPs. • Outlined assessment/update schedule including frequency and timelines for completion of new admission assessments, timelines for completion of Comprehensive Assessments, and timelines for completion of Comprehensive Assessment/Assessment of Current Status and assessments for individuals with a change in health status potentially affecting communication. • Criteria for providing an 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. The caseloads required for each speech clinician was high, impacting their ability to complete assessments in a timely manner, for the provision of direct interventions and to provide sufficient training, modeling and coaching for the implementation of communication programs and to adequately maintain the necessary equipment. The monitoring team concurred with the self-assessment of noncompliance. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Continue to aggressively recruit at least one additional SLP and consider the addition of an additional SLPA.	

#	Provision	Assessment of Status	Compliance
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 SLPs at SASSLC completed a Comprehensive Communication Evaluation and in some cases contributed to an OT/PT/SLP evaluation, though the rationale for this was not clear to the monitoring team. At the time of this review, some changes had been made to the standard format for these reports per the state office and were to have been implemented as of 10/1/13. Completion of assessments was based on the ISP schedule and reevaluation was conducted on an interval established via a policy flow chart and designated in the evaluations. Interim Updates/Assessments of Current Status were completed for individuals who received supports and services in years that a Comprehensive Evaluation was not required. ISP dates, assessment due dates, and timeliness of completion were tracked in the tracking log for individuals with ISPs scheduled from 3/26/13 to 9/24/13. There were approximately 116 individuals listed as provided an annual communication assessment (new admissions were excluded). Of those listed, only 66% had been completed on time, or within 10 days prior to the ISP. This differed significantly from the findings in the self-assessment, reported as 74% from 3/1/13 through 8/31/13. All were completed prior to the ISP, however. The facility reported that errors in their system documenting the timeliness of assessments had been corrected at this time. There was a notable improvement for assessments due for ISPs held since 7/1/13 (75%) and 80% for those held since 8/1/13. <u>Assessments Provided</u> Communication assessments were submitted as requested for the following (per date on signature page if later than the designated date of report on the first page*): • Speech Language Communication Comprehensive Assessment 1. Individual #325 (12/23/11)* 2. Individual #124 (3/26/13) 3. Individual #313 (10/9/12) 4. Individual #23 (5/31/12)* 5. Individual #94 (6/20/13)* 6. Individual #259 (4/20/12) 7. Individual #142 (1/14/13)* 8. Individual #227 (10/3/12) 9. Individual #222 (2/4/13)* 10. Individual #24 (7/12/11) 11. Individual #331 (6/22/11)* 12. Individual #77 (10/17/11)* 13. Individual #267 (8/27/12) 14. Individual #277 (12/9/11) 15. Individual #36 (3/6/12)	Noncompliance

#	Provision	Assessment of Status	Compliance
		16. Individual #25 (1/17/12) 17. Individual #31 (2/16/11) • Interim Communication Update 1. Individual #325 (12/18/12*) 2. Individual #313 (10/1/13) 3. Individual #23 (5/31/13) 4. Individual #259 (4/4/13) 5. Individual #94 (6/4/13)* 6. Individual #135 (1/14/13) 7. Individual #47 (4/22/13) 8. Individual #204 (1/7/13) 9. Individual #227 (9/27/13) 10. Individual #24 (6/26/13) 11. Individual #331 (6/17/13) 12. Individual #77 (9/9/13) 13. Individual #267 (8/21/13) 14. Individual #277 (1/4/13)* 15. Individual #36 (3/11/13) 16. Individual #236 (11/5/12) 17. Individual #31 (1/29/13) • 20 of 22 individuals (95%) in Samples R.1 and R.4, who received direct and/or indirect communication supports and services, were provided an assessment or update current within the last 12 months. This was consistent with the previous review. The assessment for Individual #56 was not submitted in his individual record as requested, but was listed as completed on 5/23/13. The assessment submitted for Individual #25 was dated 1/17/12, but was not current within the last 12 months. • 1 of 1 individual admitted since the last review (100%) received a communication assessment within 30 days of admission. This was consistent with previous review. • For 9 of 22 individuals (41%) in Samples R.1 and R.4, assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. This was consistent with the previous review. As full assessments were completed for individuals newly admitted to SASSLC, the following metric did not apply: • If screenings were completed, ___ of ___ individuals identified with therapy needs through a screening (%), received a comprehensive communication assessment within 30 days of identification.	

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		Communication Assessment: Based on review of the sample of assessments submitted and included in Samples R.1 and R.4, there were five individuals with current comprehensive assessments (Individual #142, Individual #124, Individual #222, Individual #227, and Individual #94). These were included in the analysis below. Two of the assessments reviewed had all of the essential elements necessary for an adequate comprehensive communication assessment as identified by the monitoring team, which was an substantial improvement from the previous review. The current state and local SASSLC assessment format and content guidelines generally required that these elements be contained within the assessments. The comprehensiveness of the communication assessments were as follows: • 5 of 5 assessments (100%) were signed and dated by the clinician upon completion of the written report. This was consistent with the previous review. • 5 of 5 assessments (100%) included diagnoses and relevance of impact on communication. This was improved from 95% in the previous review. • 5 of 5 assessments (100%) included individual preferences and strengths. This was consistent with the previous review. Though these were listed in most assessments, they were not consistently used to guide the development of communication strategies or AAC systems. • 5 of 5 assessments (100%) included medical history and relevance to communication. This was an improvement from 90% in the previous review. The clinicians should consider including pertinent past medical history and health status over the last year only, with better analysis of whether the individual's function was impacted as a result. • 5 of 5 assessments (100%) listed medications and discussed side effects relevant to communication. This was consistent with the previous review. • 2 of 5 assessments (40%) provided documentation of how the individual's communication abilities impacted his/her risk levels. This was a decrease from 55% in the previous review. This element required the clinicians to determine whether any areas of risk would be impacted by the individual's communication skills or whether there was any other relationship between communication and areas of risk, such as challenging behaviors. Further, the inability to express the specific source of pain or discomfort, for example, would require special supports to ensure that staff could interpret other behaviors that might provide clues for intervention. • 5 of 5 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 consistent with previous review.	

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		• 5 of 5 assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work). This was an improvement from 80% in the previous review. • 5 of 5 individuals' communication assessments (100%) 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. This was an improvement from 31% in the previous review. • 5 of 5 individuals' communication assessments (100%) included discussion of the expansion of the individuals' current abilities. This was an improvement from 65% in the previous review. • 5 of 5 individuals' communication assessments (100%) provided a discussion of the individual's potential to develop new communication skills. This was an improvement from 45% in the previous review. • 0 of 3 assessments (0%) included the effectiveness of current supports, including monitoring findings. This was consistent with the previous review. Individual #142 and Individual #222 did not require any communication supports or services. • 5 of the 5 assessments (100%) 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 was an improvement from 60% in the previous review. • 5 of 5 assessments (100%) offered a comparative analysis of health and functional status from the previous year. This was an improvement from 85%. • 5 of 5 assessments (100%) gave a comparative analysis of current communication function with previous assessments. This was an improvement from 83% in the previous review. • 5 of 5 assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This was an improvement from 70% in the previous review. • 5 of 5 assessments (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. This was an improvement from 83% in the previous review. • 5 of 5 assessments (100%) had a reassessment schedule. This was consistent with the previous review. • 5 of the 5 assessments (100%) supplied a monitoring schedule. This was an improvement from 75% in the previous review. • 5 of 5 assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems. This was an increase from 94% in the previous review. • 5 of 5 assessments (100%) made a recommendation about community referral	

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		and transition. This was an increase from 95% in the previous review. • 5 of 5 assessments (100%) included specific recommendations for services and supports in the community. This was an improvement from 65% in the previous review. • 5 of the 5 assessments (100%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. This was an increase from 55% in the previous review. Additional findings related to the communication assessments were as follows: • 5 of 5 assessments (100%) contained 90% or more of the 23 elements listed above, with an average of 97% overall. • 2 of 5 assessments (40%) contained 100% of the elements listed. • Improvements from the previous review were noted in 70% of the 23 elements. Decreases were noted for only one element. A system of assessment audits implemented by the department for the establishment of competency of the speech clinicians was well established and clearly effective. Findings based on this audit system were unclear in the self-assessment. It was reported that 30 comprehensive assessments were completed over a six month period from 4/1/13 through 8/31/13 and that 121 were audited, or 53% of assessments and that 16/21 or 76% of first drafts met competency or at least 90% of the required elements. • 11 of 15 updates (73%) were completed consistent with the established schedule, or the individuals' need. There was no evidence in the individual records for Individual #31, Individual #77, Individual #331, and Individual #24 that annual assessments had been completed, though this had been indicated based on the supports and services provided. The facility reported, however, that the annual assessments had been completed. Though the monitoring team acknowledged this report, the assessment was not considered complete because it was not contained in the active record. • 11 of 15 updates (73%) had an associated comprehensive assessment that was consistent with the established format and content guidelines. Assessments for Individual #236, Individual #204, Individual #47, and Individual #135 referenced previous Comprehensive Assessments, though these were not available in their individual records. <u>SLP and Psychology Collaboration:</u> There were 109 individuals identified with behavioral issues and co-existing severe language deficits (nonverbal or limited verbal skills). There were 59 individuals listed with PBSPs who also had replacement behaviors related to communication. This was a	

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		significant increase since the previous review. There were 10 of 22 individuals included in Samples R.1 and R.4 who were provided a PBSP to address identified behavioral concerns. Of those, the PBSPs were included in the individual record with the exception of Individual #277. • For 4 of 9 communication assessments (44%) in Samples R.1 and R.4 for individuals with identified challenging behaviors (no assessment was submitted for Individual #56), there was discussion of the communicative intent of those behaviors in the Behavioral Considerations section (Individual #94, Individual #142, Individual #227, and Individual #77). o This section also reported behaviors observed by the SLP during the assessment, communicative behaviors noted, and target and replacement behaviors per the PBSP. With the exception of Individual #77, these assessments were comprehensive rather than annual updates. o The assessments for Individual #259 adequately addressed behavioral concerns in the comprehensive evaluation dated 4/20/12, but not clearly so in the more current update on 4/4/13. o The format used for the updates did not address behavioral status of the individual or the effectiveness of communication strategies to specifically address behavior, the communicative intent of challenging behaviors or other related issues and, as such, this appeared to be omitted by most clinicians. As stated above, however, the single exception was for Individual #77. There were no special communication strategies required for Individual #142. • For the 7 individuals in Sample R.1 and R.4 with available PBSPs and communication assessments, the communication strategies identified in the assessment were generally only partially included in the PBSP, though they were clearly not consistent between the two documents for Individual #94. The PBSP for Individual #204 was an example with the most adequate integration between the PBSP and communication assessment. There were 16 meetings held to review PBSPs from 5/6/13 through 9/16/13 and a speech representative attended 15 (94%) of the meetings held. Participation in the review of PBSPs during these meetings was one opportunity to promote collaboration between psychology and the SLPs. It is understood that collaboration for assessment and development of PBSPs and communication plans may need to occur prior to the time of review by the Behavior Support Committee and, in that case, the facility is encouraged to document those efforts.	

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		Significant progress was made in this provision. The facility self-rated noncompliance, and the monitoring team concurred based on the findings reported above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Develop a plan, to include benchmarks to address the completion of communication assessments for individuals in a timely manner, while not reducing the current supports and services provided. 2. Initiate further collaboration with psychology to identify strategies to ensure integration of communication strategies in the PBSPs. 3. Clarify the function of the Comprehensive Evaluations versus the Assessments of Current Status based on the forthcoming changes as to formats as required by the State. 4. If it is determined that the Assessment of Current Status is an update to an existing Comprehensive Assessment, ensure that the Comprehensive Evaluation is not purged from the record and is present in tandem with any subsequent updates until a repeat Comprehensive is completed. 5. If the Assessment of Current Status is intended to be a stand-alone document, documentation related to behavior and the PBSP should be included to ensure that the communication strategies and behavioral strategies are consistent and well-integrated.	
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> • For 16 of 22 individuals in Samples R.1 and R.4 (73%), a SLP was in attendance at the ISP. No sign-in sheet was available for the Individual #31's ISP. Pre-ISP documentation was not submitted as requested, but a number of the sign-in sheets designated whether a team member was required to attend (13). Based on these, a SLP was required to attend 10. Actual attendance for those 10 meetings occurred as required for eight meetings (80%). No SLP was in attendance for the ISPs for Individual #77 or Individual #25, though required per the ISP. There was also no SLP in attendance for Individual #277, Individual #94, and Individual #135, though each appeared to have communication needs. • For 12 of 20 individuals (60%), communication strategies identified in the assessment were included in the ISP. These were not needed for Individual #142 or Individual #222. • In 16 of 22 ISPs for individuals with communication supports (73%), the type of AAC and/or other communication supports (e.g., Communication Dictionary, Communication Plan, strategies for staff use) were identified. • Communication Dictionaries for those who had them were reviewed at least annually by the IDT for 1 of 20 (5%), as evidenced in the ISP. Some only	Noncompliance

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		mentioned the dictionary as a support, but did not reflect IDT review. • 12 of 22 ISPs (55%) included a description of how the individual communicated and how staff should communicate with them. • 14 of 20 ISPs (70%) contained skill acquisition programs to promote communication. For Individual #142 and Individual #222, SAPs were not needed due to the level of their communication skills. • Information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports or interventions involving the SLP was included for four individuals. A number of individuals did not have these supports in place previously for review. Inservice training for the QIDPs had been conducted related to the above requirements and it was anticipated that improvements in this area will be noted during the next onsite review. <u>Individual-Specific AAC Systems:</u> Approximately 74 individuals were listed with some type of communication system. These systems were generally portable, functional, and individualized. Communication plans had been developed related to communication strategies and AAC use. There were at least 44 individuals who either used some level of sign language and/or participated in training to develop or expand this method of communication. There was only one individual who participated in direct communication therapy intervention at the time of this review (Individual #31). There were 22 individuals who were provided with an environmental control device. Communication dictionaries were also provided for a number of individuals at SASSLC. The communication dictionary is not considered AAC, but rather a reference for staff to interpret common communication efforts by the individual. This enhanced staff understanding of the individual and promotes consistent responses, but did not specifically enhance or improve the individual's expressive or receptive skills. The majority of the assessments for the individuals in Sample R.1 and R.4 provided an adequate assessment of the individual's potential for AAC use. Significant direct intervention and trials occurring in the natural environment (in situations that were most meaningful to the individual) should be utilized to identify appropriate AAC with the consistent use of training/teaching models to expose and promote interest and use of AAC across settings with attempts made for use in settings over time in order to spark interest, such as to request a favorite item, food, beverage, music, vibration, or massage.	

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		General Use AAC Devices: There were a significant number of general use communication devices. All of the general use systems noted during this onsite review were operational. The majority of those were near the dining areas and were consistently used by staff and individuals. Direct Communication Interventions: There was one individual listed as participating in direct communication-related interventions provided by the SLP (Individual #31). 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 a comparative analysis of the individual's progress or lack of progress. Records related to the provision of direct intervention for Individual #31 was reviewed (Sample R.4). This included assessments, ISPs, ISPAs, SAPs, and progress notes. Findings were as follow: • 1 of 1 individual (100%), a direct intervention plan was implemented within 30 days of the plan's creation, or sooner, as required by the individual's health or safety. • For 1 of 1 individual (100%), the current SLP assessment identified the need for direct intervention with rationale. • For 1 of 1 individual (100%), there were measurable objectives related to individual functional communication outcomes included in the ISP. • For 1 of 1 individual (100%), the therapist reported clinical data to substantiate progress and/or a lack of progress with the therapy goal(s). • For 1 of 1 individual (100%), there was a description of the benefit of the device and/or goal to the individual. • For 1 of 1 individuals (100%), consistency of implementation was documented. • For 1 of 1 individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. • The following metric was not rated as Individual #31 continued in direct therapy at the time of this review: For __ of __ individual for whom direct intervention had been discontinued, termination of the intervention was well	

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		justified and clearly documented in a timely manner. • 1 of 1 (100%) individuals receiving direct Speech Services (Sample R.4) were provided with comprehensive progress notes that contained each of the indicators listed below: o Contained information regarding whether the individual showed progress with the stated goal. o Described the benefit of device and/or goal to the individual. o Reported the consistency of implementation. o Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. o Completed at least monthly. Monthly summaries, were consistently completed, providing a graph of actual performance, readily permitting an analysis of progress related to the measurable goals and objectives. <u>Indirect Communication Supports:</u> Indirect communication supports included PNMPs, communication dictionaries, and general use AAC. These supports were identified in the annual assessment and described in a Communication Plan, which provided clearly stated instructions for staff, including pictures of specific devices as indicated. Other indirect supports were developed in the form of SAPs implemented by DSPs in the day program or work areas. Remarkably, there were over 140 SAPs, identified by the SLPs and implemented at the time of this review. This was extremely impressive, reflecting a tremendous amount of creativity and effort on the part of the clinicians. They are commended for this. The challenge is ensuring that these plans are implemented as intended and this requires real-time modeling and coaching in these environments. <u>Effectiveness Monitoring</u> This type of monitoring should address communication plans and AAC, dictionaries, and SAPS related to other indirect communication supports. The frequency of effectiveness monitoring may be based on individual risk or the intensity of supports provided, but should be conducted no less than quarterly (the annual assessment may serve as the fourth quarter review), and clearly stated in the communication assessment. This should address any changes in risk or status of the individual since the previous review and staff compliance, as well as whether the supports and/or strategies effectively met the intended need. Frequency should be included in the ISP with documentation in the IPNs. These notes should include the following:	

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		• Previously unresolved issues • PNM Risk occurrences since the previous effectiveness monitoring that impact communication • Purpose and function of the device or support • Presence and condition of equipment • Staff knowledge and compliance • Analysis of program effectiveness including progress, regression and maintenance as well as if the plan remained current and appropriate • Identification of issues with recommendations for changes as indicated including the person responsible and timelines for completion Though noted, effectiveness monitoring was not consistently conducted. The system of using the monitoring form was limited and the documentation related to effectiveness was minimal. As these forms were not filed in the individual record, there was no permanent documentation of this process. <u>Competency-Based Training and Performance Check-offs:</u> SASSLC had a system of comprehensive competency-based training regarding communication services. Training provided: • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Skill performance check-offs that included a demonstration component to assess staff. Habilitation Therapies provided new employees with classroom training on foundational communication-related skills. Class time included four hours only to address deaf awareness and AAC. The content, based on review of the curriculum materials, was comprehensive. There was a presentation of instructional content and foundational skills, with modeling by the trainers, to new employees. Practice time was provided with coaching by the trainers and then new employees were required to take a combination of written tests and were checked off on specific skills, using the checklists. Employees were expected to pass all essential elements of the core competencies. New employees were required to pass written examinations with a minimum of 80% accuracy. The new employee was required to demonstrate competency of foundational skills by accurately performing every step, on every foundation skill, without coaching from the validator or other new employee. There was no clearly stated action taken in the case that a new employee was not able to pass the check-offs, though by report, they were re-trained and the competency repeated.	

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		Shadowing was then conducted with new employees. They were not assigned a caseload, but were allowed to assist existing staff in the implementation of foundational skills in that home. During that time, staff were trained on each individual plans on the assigned home, (non-foundational skills). Competency check-offs (validation) were conducted for foundational and non-foundational skills for individuals in their assigned home. The training materials reviewed addressed most of the appropriate minimum foundational content areas listed below as of 8/30/13: • Identification of nonverbal means of communication. • Strategies to enhance individual participation in routines throughout the day • How to be an effective communication partner • Methods to enhance communication • Implementation of communication plans and programs • Benefits and use of AAC Competency tests and check-offs related to communication could not be determined for NEO as the curriculum was not submitted as requested. • 100% of new employees had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. • 100% of staff required to take the Annual Refresher class (recently added on 8/30/13). Per the curriculum submitted there was only 30 minutes allotted for this which was not sufficient to adequately address the content. Competency check-offs included: voice output devices, prompt sequence, object rings, sign language, device access, and mounting systems. It appeared as though multiple trials were permitted to pass • There was a system to establish and maintain competency for staff who provided the training, including the PNMPCs and residential coordinators. <u>Individual-Specific Competency-Based Training</u> The facility had implemented a system to identify and provide specialized training for unique supports provided to individuals that were not taught in NEO, though more skills had been added to the core training to address the most common supports. • Per the system in place, 100% of the staff assigned to individuals in the samples selected by the monitoring team were trained related to the PNMP prior to the provision of services. • Per the system described, 100% of the staff assigned to individuals in the samples selected by the monitoring team had completed competency check-offs in all specialized components of their PNMPs (i.e., non-foundational skills) prior to the provision of services.	

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		• 5 of 5 staff responsible for training other staff successfully completed competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. • The facility had a process to validate that staff responsible for training other staff are competent to assess other staff's competency. The facility self-rated noncompliance with this provision and the monitoring team concurred. Though significantly improved, there was insufficient integration of communication supports and services into the ISP. The process of effectiveness monitoring was not conducted consistently and was poorly documented given the current system. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Establish a system to track SLP attendance as described by the pre-ISPs. Negotiate identified errors before the ISP meeting. Guidelines for IDTs should be provided to assist them in making the determination as to whether an SLP was needed at the meeting and how to address the identified needs for assessment. 2. Ensure that the information in the communication assessment related to the PBSP was well integrated. Ensure that the communication strategies are effectively translated into the PBSP and that there were no contradictory statements related to function or methods of communication. 3. Address quality of implementation of indirect supports as recommended.	
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	<u>Compliance Monitoring of Implementation of Communication Supports</u> A system of compliance monitoring was established at SASSLC using the Communication Supports Monitoring Tool. This form addressed the following: • Communication plan or PNMP was available • Communication system(s) were available. • Communication system was accessible to the individual. • Communication is in good working order. • Device was implemented per the plan. • When the equipment was used, staff responded. • Staff were aware of the device or objective. • Staff described the purpose or how the device or objective should be implemented.	Noncompliance

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	available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Completed forms for communication-related compliance monitoring conducted in the last three months were requested for the individuals in Sample R.1. There were only 14 forms submitted as completed from June 2013 through September 2013 for 21 individuals. Only one form was completed by a PNMPC and all others were completed by licensed SLPs. Each of those completed by the SLPs was also marked as effectiveness monitoring as well as compliance monitoring as per policy. Compliance was as follows, though not calculated by the facility monitors: • 100%: 8 • 90%-99%: 0 • 80%-89%: 1 • 70%-79%: 0 • 60%-69%: 3 • 50%-59%: 0 • 40%-49%: 0 • 30%-39%: 0 • <30%: 0 When staff were scored at less than 80% compliance, there was no evidence of re-training and follow-up for problems identified was not consistently noted. The foundation for monitoring was of concern. The monitor was able to document a "yes" answer if the staff could verbally describe the system and its use. This greatly skewed the findings. As with other skills, compliance monitoring was intended to include observation of the staff performance of the skill by the monitor and to determine if it was performed accurately. This can only be appropriately accomplished during real time implementation. Explaining how something is done is very different from actually doing it in the context of the daily routine. For example, in the case of Individual #259, staff were not observed using the device, but "yes" was marked related to "when equipment used, staff responded and staff described the purpose. However, "no" responses were marked for the "equipment is present" and equipment was found in the right place." The element related to the working order of the device was marked as "not applicable." Compliance monitoring should address implementation of all specific communication plans (including AAC) and communication strategies across implementation of activities. This may be also accomplished as the staff are engaging in other activities on the PNMP or implementing other SAPs. Equipment should be monitored for availability, condition, and working order with routine general check-offs for how to use the equipment. Communication dictionaries should be monitored for availability and whether staff understand how to use them. There was an extensive process to review and track findings based on the monitoring conducted. Follow-up was clearly documented.	

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		The facility concluded that they were not in compliance with this provision of section R and the monitoring team concurred as described above. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Review and revise the system of communication monitoring. The system may be broken down as needed to address specific outcomes as desired based on revision of the current processes in order to shape the system as needed. 2. Establish clear procedural guidelines for effectiveness monitoring and include documentation guidelines. 3. Consider review of the current compliance monitoring forms to ensure the indicators are those that capture the status of the current supports and accuracy of implementation. 4. Consider review of the process used for effectiveness monitoring. 5. Track findings of both effectiveness and compliance monitoring. Audit for timely completion of each as per the recommendations in the assessment. Ensure that these findings are included in annual communication assessments for individuals.	

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o Individual Support Plans (ISPs) for: • Individual #114, Individual #53, Individual #183, Individual #310, Individual #333, Individual #13, Individual #256, Individual #188, Individual #259, Individual #350, Individual #35, Individual #225, Individual #340, Individual #203 o Skill Acquisition Plans (SAPs) for: • Individual #169, Individual #114, Individual #246, Individual #328, Individual #171, Individual #166, Individual #348, Individual #35, Individual #188, Individual #225, Individual #340, Individual #203 o Monthly review of SAP progress for: • Individual #225, Individual #203 o Functional Skills Assessment (FSA) for: • Individual #35, Individual #188, Individual #225, Individual #340, Individual #203 o Personal Focus Assessment (PFA) for: • Individual #35, Individual #188, Individual #225, Individual #340, Individual #203 o Vocational assessments for: • Individual #188, Individual #225, Individual #340, Individual #203 o Retirement Assessment for: • Individual #35 o Writing Behavioral Training Objectives, 7/29/13 o Skills Acquisition Observation Tool, undated o Engagement Monitoring form, 12/11/11 o Graph of Communication SAPs for individuals with severe communication deficits o Minutes of the QIDP dental desensitization meeting, 7/25/13 o List of on-campus and off-campus day and work programs, undated o List of individuals employed on and off campus, undated o Summary of community outings per residence/home for April-August 2013 o List of skill training in the community, undated o SAP documentation and progress notes training, undated o Dental desensitization meeting agenda and notes, 7/15/13 o Active treatment meeting agenda, 6/26/13 o ISPA-Program change form, 7/1/13 o Active treatment specialists primary roles, undated o Graph of skill training opportunities in the community, April 2013-September 2013 o Summary of community outings per home, April 2013-September 2013

	o List of individuals under age 22 with indication of the school attended (9 students) o ARD/IEP, ISP, ISD progress notes, and school-related ISPAs for: • Individual #113, Individual #208, Individual #203 <u>Interviews and Meetings Held</u>: o Gina Dobberstein, Music, Recreation, and Senior Program Director o Juan Villalobos, Unit I Director; David Ptomey, Unit II Director; Annette Langoria, Unit III Director o Dr. Alvydas, Dentist; Amy Jo Hush, Dental Hygienist; Charlotte Fisher, Director of Behavioral Health Services; Gina Dobberstein, Music, Recreation, and Senior Program Director o Vinne Khamphoumanivong, QIDP, Eric Saenz, QIDP, SASSLC liaisons to SAISD <u>Observations Conducted</u>: o Active treatment meeting o Observation of implementation of SAPs for: o Individual #101, Individual #60 o San Antonio Independent School District special education monthly meeting at SASSLC, 10/21/13 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. 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 allowed 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. 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: • Improvements in the quality of SAPs reviewed (S1) • Improvements in the percentage individuals with SAPs to address severe communication deficits (S1) • Improvements in individual engagement (S1) • The facility established a target engagement level for each treatment site (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) • Introduction of a new form to improve the documentation of data based decisions concerning the continuation, revision, or discontinuation of specific SAPs (S3) • Increased percentage of graphed SAP data (S3) • Expansion of the collection of SAP treatment integrity data (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) • Develop a system (e.g., spreadsheet) to ensure that appropriate action occurs for all individuals who are refusing routine dental exams (S1) • Increase the engagement of more than one individual at a time, and chose activities that are based on individual preference/interest (S1) • Ensure that all individuals have assessments of preferences and strengths (S2) • Provide documentation that assessments are completed and available to team members prior to each individual's ISP (S2) • 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 staff implementing SAPs (S3) • Establish acceptable treatment integrity levels (S3) • Increase the implementation of SAPs in the community (S3) • Establish acceptable percentages of individuals participating in community activities, and demonstrate that these levels are achieved (S3)

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	This provision item includes an assessment of skill acquisition programming, engagement of individuals in activities, and supports for educational services at SASSLC. Although there was progress since the last review, more work (discussed in detail below) is needed to bring these services, supports, and activities to a level where they can be considered to be in substantial compliance. <u>Skill Acquisition Programming</u> Individual Support Plans (ISPs) reviewed indicated that all individuals at SASSLC had multiple skill acquisition plans. Skill acquisition plans (SAPs) at SASSLC consisted of training objectives. The majority of SAPs were written and monitored by the music, recreation, and senior program director, active treatment coordinators, and active treatment specialists. Vocational coordinators wrote and monitored vocational SAPS. SAPs were implemented by direct support professionals (DSPs), rehabilitation assistants, and active treatment specialists. 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 38 SAPs across 12 individuals to assess compliance with this provision item. All of the SAPs reviewed were in the new format. Several of the SAPs the monitoring team encountered in the residences, however, were in the old format. Additionally, the facility reported that approximately 50% of the SAPs continued to be in the old format (which did not include many of the components discussed below). The facility now needs to ensure that all SAPS are written in the new format. In 28 the 38 SAPs reviewed (74%), the rationale appeared to be based on a functional need and/or preference. This was similar to the last review when 76% of SAPs were judged to have a clear rationale. It is also consistent with the facility's self-assessment, which indicated that 80% of their sample of SAPs had clear rationales. The following are examples of rationales that were judged to be based on a functional need and/or preference: • The rationale for Individual #328's SAP to activate a fan was "…through collaboration with the SLP, and based on the sensory skills assessment, activating the fan will increase her communication skills and improve her	Noncompliance

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		posture." • The rationale for Individual #169's SAP to use his speech to choose an activity said expressing desired forms of communication of wants and needs represents a functional replacement behavior for his undesired target behaviors (see K4 for a description of functional replacement behaviors). On the other hand, some rationales simply indicated that SAPs were recommended in the ISP or FSA, but were judged to not be specific enough for the reader to determine if the recommendation was based a functional need and/or preference. For example: • The rationale for Individual #225's SAP of washing clothes indicated that it was recommended in her FSA. Although her FSA suggested she was not independent in washing clothes, it was not clear that washing clothes was a preference or represented a functional SAP for Individual #225. The fact that someone can't do something is not a rationale for having a SAP. A rationale should be based on a functional need and/or preference. SASSLC should ensure that each SAP contains a clear 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. The quality of the maintenance and generalization plans were much improved compared to the last review. A generalization plan should describe how the facility plans to ensure that the	

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		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. Twenty-nine of the 38 SAPs reviewed (76%) included a plan for generalization that was consistent with the above definition. This was an improvement over the last review when 52% of generalization plans were judged to be consistent with the above definition. Additionally, 24 of the 38 SAPS reviewed (63%) included a plan for maintenance that was consistent with the above definition. This represented a sharp increase from the last review when only 21% of the maintenance plans reviewed were judged to be consistent with the above plan. An example of a generalization plan judged to be consistent with the above definition was: • The plan for generalization in Individual #188's SAP of self-administration of his Nasonex said once he's learned to self-administer the Nasonex, he can learn to self-administer additional medications. Some generalization plans were unclear or judged to be too vague to be useful to foster generalization of new skills. An example of an unacceptable plan for generalization was: • The plan for generalization in Individual #225's SAP of improving communication said the communication strategy would be used to remind her to speak loudly and say each word. Examples of good maintenance plans were: • The plan for maintenance in Individual #246 SAP of signing restroom said once she had mastered this skill she would imitate or use the sign for restroom throughout the day. • The plan for maintenance in Individual #340's SAP of brushing teeth, said once he was able to brush his teeth, he would maintain this skill by brushing his teeth on a daily basis. Examples of unacceptable maintenance plans were: • The plan for maintenance in Individual #188's SAP of brushing teeth, was once he learned to brush for one minute with verbal prompts, it will increased to two minutes; then he will be independent. • The plan for maintenance in Individual #340's SAP for washing his body said "He will continue to wash his body until after the training is complete."	

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		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). <u>Dental compliance and desensitization plans</u> Compliance and desensitization plans designed to teach individuals to tolerate dental procedures were developed by the behavioral health services department. The behavioral health services department determined if refusals to participate in dental exams were primarily due to general noncompliance, or due to fear of dental procedures. It is recommended that the facility utilize a system (e.g., spreadsheet) to ensure that appropriate action occurs for all individuals who are refusing routine dental exams. The director of behavioral health services indicated that no formal desensitization plans were completed since the last review. 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. <u>Replacement/Alternative behaviors from PBSPs as skill acquisition</u> As discussed in K9 of this report, SASSLC included replacement/alternative behaviors in each PBSP. 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. <u>Communication and language skill acquisition</u> The monitoring team was encouraged by the increase in communication SAPs. The facility's self-assessment indicated that 92% of individuals with severe communication deficits had communication SAPs. Also, see section R. <u>Service objective programming</u> The facility utilized service objectives to establish necessary services provided for individuals (e.g., brushing an individual's teeth). 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. 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 activities at SASSLC. The engagement in day programs tended to be consistently high, however, engagement in the homes varied. The observations in the homes typically involved the staff attempting to engage a small group of individuals, one individual at a time. Although the staff generally were able to engage the one individual they were working with, the majority of the other individuals appeared to no longer be engaged in the activity or discussion. Accordingly, while the staff were consistently engaged, each individual's engagement was variable. One possible reason for individuals' apparent waning attention could be the selection of activities. Some homes were discussing topics that did not appear to be geared to individuals' interest, such as "responsibility" and the "muscular system." It is suggested that staff be encouraged to attempt to engage multiple individuals at a time, and choose activities that are based on preferences and interests. The average engagement level across the facility was 63%, an improvement over the last review (i.e., 56%). The engagement data collected by the facility, however, 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 September 2013 collected by the facility, averaged 95%. 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 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 interval time sample. That is, the facility's observers watched a particular individual for three minutes and recorded engagement if that individual was engaged at any time during the three-minute	

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		observation period. It is generally acknowledged that the facility's method of data collection will yield a higher level of engagement than that used by the monitoring team. For example, in the example of staff engaging individuals one at a time, the momentary time sample used by the monitoring team would only record one individual of the group engaged. On the other hand, if the staff moved through the entire group in three minutes, the facility's method would record the same activity as all individuals in the group engaged. Although it is unlikely that both methods would yield the same percentages of engagement, they should both reflect changes in engagement across the facility. The facility continued to utilize monthly active treatment meetings with active treatment coordinators, active treatment specialists, and DSP supervisors. In the active treatment meeting observed by the monitoring team, engagement data for each treatment site were presented, and suggestions for improving engagement were discussed. Finally, since the last review, the facility established 70% as the target engagement level for each treatment site at SASSLC. <u>Engagement Observations</u>:	

Location	Engaged	Staff-to-individual ratio
Home 672	0/4	0:4
Home 672	2/2	1:2
Home 668	1/7	1:7
Home 766	0/3	1:3
Home 766	4/4	2:4
Home 670	2/8	2:8
Home 670	7/7	3:7
Home 670	3/7	3:7
Home 665	6/8	3:8
Home 665	4/5	1:5
Home 672	2/6	1:6
Home 672	2/2	1:2
Home 673	1/1	1:1
Vocational Workshop	17/18	4:18
Vocational Workshop	10 /10	3:10
Seniors program	5/7	2:7
Day program A 12	2/7	2:7
Day program A 16	12/14	3:14
Day program A 37	5/7	1:7
Home 674	3/3	1:3
Home 672	2/3	2:3
Home 670	1/5	1:5

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Home 670	1/6	1:6
Home 670	7/9	4:9

Educational Services

Nine individuals at SASSLC attended public school. This was a slight reduction from 11 and 13 at the time of the previous reviews, 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 or the special adult years vocational program. One student was 16 years old; the others were 18 or older.

Vinne Khamphoumanivong, QIDP, and Eric Saenz, QIDP, remained as the SASSLC liaisons to SAISD. They remained active in the public school programming of the individuals on their caseloads. This included regular contact with school teachers, visits to the schools, attending all ARD/IEP meetings, participating in a monthly meeting with special education administrators, and attending emergency ARD/IEP meetings.

The QIDPs included relevant content from the ARD/IEP in the SASSLC ISP. Every student had at least one or two SAPs taken directly from the skills he or she was working on at school.

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

SAISD remained highly involved with the SASSLC students and staff. This was again demonstrated by the monthly meeting at the SASSLC campus that was attended by five special education administrators from the public school. Discussion was lively and student-focused. There was good participation from the many SASSLC attendees (e.g., behavioral health services, house manager, vocational services liaison).

The monitoring team has no further recommendations regarding educational services other than the same suggestion from the time of the last review, that is, that the QIDPs be offered some inservicing on special education laws.

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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 for all of the individuals sampled. Although improving, only 54% of SAPs reviewed were clearly based on assessments. Therefore, this item was rated to be in noncompliance. SASSLC conducted annual assessments of preference, strengths, skills, and needs. At the time of the onsite review, all individuals at the facility had transitioned from the Positive Adaptive Living Survey (PALS) for the assessment of individual skills to the Functional Skills Assessment (FSA). As discussed in the last review, 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 worn, 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. To assess compliance with this item, the monitoring team requested ISPs, FSAs, preference and strengths inventories (PSIs), and vocational assessments for five individuals. The facility's self-assessment indicated that every individual had a FSA and vocational assessment, and approximately 68% of individuals had a completed preferences and strengths inventory (PSI). All individuals should have assessments of preferences and strengths. Additionally, in order to be most useful for the selection and development of SAPs, assessments should be completed and available to team members prior to the ISP. SASSLC did not provide tracking data indicating that FSAs, PSIs, and vocational assessments were completed on time (10 days prior to ISP). Overall, these five individuals had a total of 26 SAPs, and 14 of those (54%) had documentation that assessments were used to develop them. This represented an improvement from the last review when 38% of the SAPs included documentation that	Noncompliance

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		assessments were used to develop them. Examples of assessments that were used to develop SAPs included: • Individual #225's SAP to learn to independently dial the phone was based on her desire to maintain a positive relationship with her family (documented in the ISP and PSI), and her inability to independently use the phone (documented in her FSA). • Individual #35's FSA and dental assessment documented that she required assistance to adequately brush her teeth, therefore, a SAP to learn to thoroughly brush her teeth was developed. • Individual #203's ISPA indicated that he often exited the van without regard to passing vehicles, therefore, placing himself in potential harm. Accordingly, a SAP designed to teach him to look for cars before exiting the van was developed to address this safety need. Examples of SAPs where it was not clear how or if assessments impacted their development included: • Individual #340's SAP of washing his body was recommended in the FSA recommendations section, however, the bathing section of the FSA was blank, and there was no mention in his ISP or PSI as to what assessments were used to select this SAP. • Individual #203's FSA recommended a SAP for brushing teeth, however, the tooth brushing section of his FSA indicated he was independent in tooth brushing . • Individual #35 had a SAP to independently count money before giving it to the cashier, however, her FSA indicated that she was physically unable to combine coins In order to achieve substantial compliance for this provision item, SASSLC needs to ensure that all individuals have assessments of individuals' preferences, strengths, skills, and needs that are completed at least 10 days prior to the ISP. Additionally, there needs to be documentation of how assessments were used to select the individual skill acquisition plans.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and		

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	skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	SASSLC continued to make progress on this provision item, however, more work, discussed below, is necessary before it is in substantial compliance. QIDPs at SASSLC summarized SAP data monthly. Monthly reviews of SAP data for five individuals were requested to evaluate compliance with this provision item. Monthly reviews for only two individuals (i.e., Individual #225 and Individual #203) were received. All SAP data should be reviewed monthly. All SAPs reviewed (100%) contained graphed SAP data. This represented an improvement from the last review when 41% of the SAPs reviewed contained graphed data. SASSLCs self-assessment indicated that approximately 50% of all SAPs were graphed. None (0%) of the data summaries reviewed, however, clearly demonstrated data based decisions to continue, discontinue, or modify a SAP, based upon outcome data. This was similar to the last review when 2% of data summaries demonstrated data based decisions to continue, discontinue, or modify a SAP. In order to address the absence of documented data based SAP decisions, the facility recently introduced a new form to document SAP changes and reasons for the decision. 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 DSPs in the implementation of individual SAPs. As in past reviews, the monitoring team observed the implementation of SAPs to evaluate if they were implemented as written. For one SAP observed (Individual #60's communication SAP of answering questions), the DSP appeared to provide multiple verbal prompts that were not specified in the SAP training sheet. 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. Since the last review SASSLC expanded treatment integrity measures to all treatment sites. At the time of this onsite review, however, treatment integrity in the homes was only conducted on SAPs that were implemented by an active treatment specialist. It is now recommended that treatment integrity be expanded to all staff implementing SAPs in the home. The treatment integrity tool used by the facility included several questions concerning	Noncompliance

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		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 facility also recently began graphing SAP integrity data. At this point, it is recommended that measures of treatment integrity are extended to all staff implementing SAPs, acceptable treatment integrity levels are established, and that the facility document that they have achieved those integrity levels. In order to attain substantial compliance, the facility 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.	
	(b) Include to the degree practicable training opportunities in community settings.	Many individuals at SASSLC enjoyed recreational and training activities in the community. SASSLC developed a community-training database, and established community-training goals in each home. August 2013 data indicated that only one of eight homes (12%) achieved their community training goals. There was no evidence of 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 are achieved. At the time of the review, three individuals at SASSLC were competitively employed in the community. This was an improvement from the last review when two individuals were competitively employed in the community. In order to achieve substantial compliance with this provision item, the facility needs to establish minimal acceptable frequencies of recreational activities per home, and demonstrate that established levels of community recreational activities and SAP training are consistently achieved.	Noncompliance

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.2, 10/18/13, and exhibits and forms attachments o SASSLC facility-specific policies regarding most integrated setting practices • 300-21A, Facility Most Integrated Setting Practices, 12/1/11 o SASSLC organizational chart, undated, but likely September 2013 o SASSLC policy lists, 4/1/13 o List of typical meetings that occurred at SASSLC, undated but likely September 2013 o SASSLC Self-Assessment, 10/8/13 o SASSLC Action Plans, 10/8/13 o SASSLC Provision Action Information, 10/4/13 (but there was no information since the last onsite review included for section T) o SASSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/21/13 o Community Placement Report, last six+ months, 4/1/13 through 10/18/13 o List of individuals who were placed since last onsite review (11 individuals) o List of individuals who were referred for placement since the last review (24 individuals) o List of individuals who were referred and placed since the last review (4 individuals) o List of total active referrals (27 individuals) o List of individuals who requested placement, but weren't referred (0 individuals) • Documentation of activities taken for those who did not have an LAR (not applicable) • Those who requested placement, but not referred due to LAR preference (not applicable) o List of individuals who were not referred solely due to LAR preference (0) o List of rescinded referrals (1 individual) • ISPA notes regarding each rescinding (0 of the 1) • Special Review ISPA Team minutes for each rescinding (0 of the 1) o List of individuals returned to facility after community placement (0) • Related ISPA documentation (not applicable) • Root cause analysis (not applicable) 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 • 6 of 22 individuals who moved since 10/1/12, i.e., 1 year since placement, and for whom SASSLC had information). 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 (1 individual) o APC Department meeting minutes, (none) o List and job descriptions for APD staff o APC weekly reports • Detailed referral and placement one-page report for senior management, 10/23/13 • Minutes/agenda from a morning clinical meeting as an example of APD staff making a weekly presentation to the clinical staff regarding status of referrals, 8/28/13 • Statewide one page weekly enrollment report (4) o Variety of documents regarding education of individuals, LARs, family, and staff: • Provider Fair ▪ One page flier for upcoming 11/16/13 provider fair ▪ Outcome data, plans for future (none) • Community tours ▪ Tours, 5/7/13 to 10/25/13 ▪ Descriptions of how individuals responded (none) ▪ Tour participation roster listing for all individuals at facility (none) ▪ Visit with friends who have moved (1) • Work with local LA ▪ Quarterly meeting minutes, September 2013 (1) ▪ Trainings (none) • Work with local providers (none) • Facility-wide staff trainings/activities (none) • For families (none) • Brochure and facility newsletter (none) • CLOIP and PP tracking tools (none) 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), undated o APC's referral packet checklist o List of individuals who had a CLDP completed since last review (11) o DADS central office written feedback on CLDPs (2) o QA related activities • Section T QA reports, July 2013 and October 2013 presentation materials, including various graphs of referral, transition, and placement related data • QAD-SAC 1:1 monthly meeting minutes, June 2013 to September 2013 (4) o State obstacles report and SSLC addendum, FY12 data, 2/26/13 o List of each individual and reason(s) (i.e., obstacles) to referral, undated o SASSLC auditing tools for T1c2, T1c3, and T1d, including dates of discharge assessments and a 5-item quality list for each assessment. Completed forms for one individual for T1c2 and T1c3 only.

	o Latest post move monitoring form, blank, including helpful hints, October 2013 o PMM tracking sheet o Documentation of day of move items (1, for Individual #155) o Transition T4 materials for: • Individual #131 o ISPs for: • Individual #151, Individual #229, Individual #340, Individual #35, Individual #75, Individual #225, Individual #188 o Pre-ISP draft used during the pre-ISP meeting: • (none) o Draft ISP used during the ISP meeting: • Individual #241, Individual #55 o CLDPs for: • Individual #145, Individual #15, Individual #133, Individual #316, Individual #85, Individual #97, Individual #83, Individual #155 o Draft CLDP for: • Individual #350 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 #123: 90 • Individual #51: 45, 90 • Individual #134: 7, 45, 90 • Individual #344: 7, 45, 90 • Individual #195; 7, 45, 90 • Individual #15: 45, 90 • Individual #146: 45, 90 • Individual #133: 7, 45, 90 • Individual #316: 7, 45, 90 • Individual #85: 7, 45, 90 • Individual #97: 7, 45 • Individual #83: 7 • Individual #155: 7 o Potentially Disrupted Community Placement form, completed for: • Individual #195 <u>Interviews and Meetings Held</u>: o Tania Fak, Admissions and Placement Coordinator o Darlene Morales, Post Move Monitor o Group home staff and managers at Just Like Home agency

	Observations Conducted: o CLDP meeting for: • Individual #350 o ISP and/or pre-ISP meetings for: • Individual #241, Individual #55 o Community group home and day program visit for post move monitoring for: • Individual #85
	Facility Self-Assessment The self-assessment for section T was vastly improved from any previous self-assessment. The new APC put a lot of work into trying to list out activities that were more in line with what the monitoring team looks at than ever before. She reported, and it was evident, that she worked from the previous monitoring report. After having spent time talking with the monitoring team about the self-assessment, each provision, what is expected to be demonstrated, criteria, and data, the APC is likely to have a more useful, valid, and accurate self-assessment for the next review. She included various graphs and charts in the self-assessment. Some of these data sets and presentations were only in the self-assessment. These data should not appear only in the self-assessment, but should be part of the set of data in her QA program (see T1a).
	Summary of Monitor's Assessment SASSLC made progress in some areas of section T, primarily in the continued transition and placement of individuals into the community. Staffing changes competed with the facility's ability to progress in many areas of section T. 11 individuals had been placed in the community since the last onsite review. 27 individuals were on the active referral list. This was by far the largest number of individuals ever to be on the active referral list at SASSLC. Of the 22 individuals who moved in the past 12 months, 6 were reported to have had one or more untoward events that occurred within the past six months (28%). Of these 6, all 6 (100%) were successfully resolved or managed. Many annual ISP assessments included a statement/recommendation regarding most integrated setting. The implementation of a new standardized statement will likely result in a statement being present in all assessments. IDTs were not specifically identifying what it was that was an obstacle to referral. If they did, perhaps an appropriate action plan would be developed. Consider that many stated that individual choice was an obstacle, even though the obstacle was LAR preference.

	There was a thorough living options discussion during the ISPs observed, but an adequate description of a thorough discussion was not evident in the written ISPs. CLDPs were developed for each individual who was referred. A CLDP meeting was conducted during the onsite review and was observed by the monitoring team. It was a good, lively meeting, with lots of participation from the individual and most attendees. More information and detail regarding the training of provider staff, and preparation of the provider were necessary (T1c1). Discharge assessments were completed for all relevant disciplines, however, they did not focus upon the needs of the individual in his or her new setting and how supports might be provided in the new home and day settings. The lists of pre-move and post-move supports were identified in the CLDPs. More work was needed to ensure that these lists were comprehensive and worded in measurable, verifiable terms (T1e). A quality assurance program for CLDPs and section T was not yet in place, however, the APC had made some good progress in assembling a set of relevant data regarding referral, transition, and placement activities. Post move monitoring continued to be implemented as required and maintained substantial compliance. 36 post move monitorings for 16 individuals were completed since the last onsite review. They were done timely and thoroughly. The post move monitor followed up when action was needed.

#	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	SASSLC made progress in some areas of section T, primarily in the continued transition and placement of individuals into the community. There was a new APC, Tania Fak. She had been a transition specialist at SASSLC for the past year and was promoted to the APC position one month prior to the onsite review. There was no one in the APC role from May 2013 until Ms. Fak's appointment. Darlene Morales remained in her position as PMM. There were two open transition specialist positions. One was filled one month prior to the review; the other remained open. These staffing changes competed with the facility's ability to progress in many areas of section T. The number of individuals placed was at an annual rate of about 9%. Approximately 11% of the individuals at the facility were on the active referral list. Below are some specific numbers and monitoring team comments regarding referral and placement numbers and processes.	Noncompliance

	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.	• 11 individuals had been placed in the community since the last onsite review. This compared with 12, 1, 2, 5, 1, 3, and 5 individuals who had been placed at the time of the previous monitoring reviews. o The number was similar to that at the time of the previous review and showed continued referral, transition, and placement activity. • 24 individuals were referred for placement since the last onsite review. This compared with 18, 9, and 8 individuals who were newly referred at the time of the previous reviews. o 4 of these 24 individuals was both referred and placed since the last onsite review. o The re-purposing of home 672 set the occasion for many individuals and their LARs choosing community placement. • 27 individuals were on the active referral list. This compared with 15, 15, 10, 9, 4, and 3 individuals at the time of the previous reviews. o This was by far the largest number of individuals ever to be on the active referral list at SASSLC. o 7 of the 27 individuals were referred for more than 180 days. This compared to 5 and 6 at the time of previous reviews. ▪ 1 of the 7 was ready to move except for the need to locate her original determination of mental retardation document (Individual #72). ▪ 1 of the 7 individuals was referred for more than one year (Individual #22). This compared to 0 at the time of the previous review. The home for this individual, however, was identified. The IDT was waiting on the completion of home renovations and the coordination of nursing and catheterization care for this complicated case. The SASSLC OTPT and nutritionist had done a special assessment. The individual's brother was involved in the transition, too. • 0 individuals were described as having requested placement, but were not referred. This compared with 5, 7, 5, and 7 individuals at the time of the previous reviews. o Of the n.a. individuals who requested placement, but were not referred, n.a. individuals had an LAR who made this decision (not applicable). o Of the remaining n.a. individuals, a lack of consensus review was conducted (not applicable). o Of the 5 individuals listed in the last report, all 5 had since been referred. • The list of individuals not being referred solely due to LAR preference contained 0 names. This compared to 100 and 1 individuals at the time of the previous reviews.	

		- This was not an accurate count and needs to be completed correctly by the facility. The APC reported that valid information was not available. As noted in T1a, T1b1, and T1b3, it may be that the professional members of many individuals' IDTs would have referred the individual. - The referrals of 0 individuals were rescinded since the last review. This compared to 5, 2, 4, 2 and 3 at the time of the previous reviews. - Documentation (ISPA notes) was provided for n.a. of the n.a. individuals regarding the reasons for the rescinding (not applicable). - The referral of 1 individual, however, occurred during the week of the onsite review (Individual #55). Documentation regarding this rescinding will be reviewed at the next onsite review. - A review to determine if changes in the overall referral and transition planning processes at the facility should be conducted for the rescinded referrals. This can be done by the APC and APD staff. If done and if actions were recommended, the monitoring team would look for indication of implementation of actions. 0 individuals returned to the facility after community placement. This compared with 0 individuals at the time of all 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. These data were being obtained for a one-year period after moving. - Of the 22 individuals who moved in the past 12 months (and for whom information was available), 6 were reported to have had one or more untoward events that occurred within the past six months (28%). - It is important for the reader to understand that many individuals who are placed have histories of challenging behavioral, psychiatric, and medical issues. Therefore, it is not unexpected that these issues might occur in the community. - Of these 6, the issues with 6 (100%) were successfully resolved. Individual #195 continued to exhibit behavior problems, but they were reviewed by the SASSLC IDT and appeared to managed appropriately by the provider. - All cases should be reviewed to determine if changes in the overall 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. The monitoring team spoke at length with the APC about ways to do this that would be efficient and useful. If these reviews were done and if any actions were recommended, the monitoring team would look for indication of implementation of these actions.	

		▪ The APC reported that her department did engage in this type of discussion, though they did not yet document it. For example, she reported that a problem behavior exhibited by a nonverbal individual during a provider visit led to them to now ensure that a staff member attended visits with any individual who was nonverbal. ▪ There was a new statewide system and form for reporting these types of events, and for helping the APC to review these events. It was called the Potentially Disrupted Community Transition form. The APC was just beginning to use it. The monitoring team reviewed one example, for Individual #195. Overall, the format helped guide the APC to adequately review the case. It did not, however, address what might be done to improve transition services for individuals at the facility. This may be because it was a description of a meeting with the individual, his community provider, and his advocate. Thus, the discussion of improvements to the referral and placement process were not done because the meeting was for this specific individual. • 0 individuals had died since being placed since the last onsite review. This compared with 0 for all previous reviews. • 1 individual was discharged under alternate discharge procedures (see T4). The APC had created a number of graphs of the APD's activities. These were good to see and helped to summarize the status and trends of referral, transition, and placement activities. Below are 15 graphs the monitoring team suggests be considered by the APC. The check marks indicate those 9 that the APC had created. • √ Number of individuals placed each month or monitoring period • √ 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 • √ 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> There were no additional referral, transition, or placement related activities at SASSLC, such as work groups. <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. Ultimately meeting the requirements for this portion of T1a and for provision T1b3 will require that the APC work closely with the QIDPs and the QIDP coordinator. At SASSLC, both the APC and the QIDP coordinator were newly appointed to their positions. Some facilities have found it beneficial to form a sections F and T workgroup. At this point, the monitoring team believes that the facility should be able to meet the cross-provision requirements, specifically what is in T1a, T1b1, T1b3, and T1b2#1. These are for documenting professional determinations and team decisions, and for planning educational activities at an individual level, in a way that is measurable and individualized. Progress in these areas is noted in sections T, F, I, and S of this report. The monitoring team requested a set of recent ISPs, attachments, and assessments. One was submitted for each of the 8 homes. All 8 were selected for review by the monitoring team (see above under Documents Reviewed). These were from across the SASSLC campus, for individuals with differing levels of needed support, and facilitated by eight different QIDPs. The ISPs were from meetings held June 2013 to July 2013. One of the eight, however, was from April 2013 (prior to the last onsite review) and, therefore, was	

excluded from this report (Individual #203) leaving a total of 7 ISPs for inclusion.

In assessments: Assessments were available for review for all of the 7 ISPs. Of these, all of the assessments for 0 individuals (0%) included an applicable statement and/or recommendation from each of the professionals. On the other hand, most of the assessments for all of the individuals (100%) included a statement/recommendation. Overall, there was an improvement in the number of assessments that contained a statement. The wording of many of the statements, however, was inadequately because the opinion of the professional regarding referral could not always be determined. The implementation of a new standardized statement/requirement from DADS central office (to begin 10/1/13) will likely result in a statement being present in all assessments and the statement being adequately worded to reflect the professional's determination about the most integrated setting for the individual.

Below are some specific data for the set of ISPs:

Discipline	# assessments	# with a statement
Medical	6 of 7	6 of 6
Nursing	7 of 7	7 of 7
Psychiatry	4 of 7	4 of 4
Psychology	5 of 7	5 of 5
Dental	5 of 7	5 of 5
Voc./day	7 of 7	7 of 7
Speech	7 of 7	7 of 7
OTPT	6 of 7	6 of 6
Nutrition	3 of 7	3 of 3

In the written ISPs: Of the 7 ISPs reviewed, 4 (57%) included an independent recommendation from the professionals (as a group) on the team to the individual and LAR. The other 3 said that the IDT followed the LAR's or individual's preference rather than what was required by this item, that is, to give the IDT's overall opinion about referral to the community, separate from the LAR and individual preference.

Of these 7, each professional's opinion was separately given and described in 0 (0%). Note that every ISP included each professional's opinion, but taken directly from the written ISP assessment. There was no indication that each professional presented his or her opinion and/or that these opinions were discussed. This was especially surprising given that there was not agreement across all professionals in most of the ISPs.

Observation of ISP meetings: Of the 2 ISPs observed, 1 (50%) included an independent recommendation from each of the professionals on the team (Individual #241).

Individuals referred: In reviewing the 8 CLDPs, 8 (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 individuals on the active referral list via a weekly email of the status of each referral and a list of individuals who were likely to be referred in the upcoming weeks to help them plan for their discharge assessments. In addition, the APC or PMM made an oral presentation every Wednesday to the morning clinical meeting in which this one page was also shared. An example from 10/23/13 was provided to the monitoring team. Transitions were not yet occurring at a reasonable pace when considering the full set of placements and referrals over the past six months. More recently (i.e., the past two or so months), the pace had improved considerably, most likely due to the appointment of the APC and the filling of one of the two TS positions. 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 a sample of 11 of the 11 individuals placed since the time of the last onsite review, 6 (55%) were placed within 180 days of their referral, 5 (45%) were placed three or so months after 180 days, and 0 (0%) were placed more than one year after referral. o 3 of the 4 most recent placements occurred within 180 days. • Of the 27 individuals on the active referral list for community transition, 7 had exceeded the 180-day timeframe (i.e., 74% were within 180 days). o This compared with 5 and 6 individuals who were referred for more than 180 days during previous monitoring reviews. o Of these 7, 1 individual had exceeded one year. This compared with 0 individuals at the time of the previous review. o The APC predicted that more individuals will exceed the 180 day period over the next few months because of the changes/shortages in staffing in the APD, the high number of recent referrals, and the APC and IDT commitment to only make placements that were well planned and highly likely to succeed. o On the other hand, the APC reported that local providers were eager to work with the facility. They were very open to tours and to serving additional individuals.	

		• There were reasonable activity and actions related to the transition and placement, and no long gaps of time with no activity, for 5 of the 8 (63%) individuals whose CLDPs were reviewed in detail. The three with gaps in activity were the earlier of the 7, that is, the ones done during the time of staffing turnover and change in the APD.	
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 for most integrated setting practices was issued the Friday before this onsite review. The monitoring team will comment at the next compliance review as to whether the state policy adequately addressed all of the items in section T of the Settlement Agreement. All facility-specific policies regarding most integrated setting practices remained the same as at the time of the last review. At SASSLC, this was merely a repeat of the entire state policy. Facility-specific policy will need to be written and implemented based upon the new state policy. 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 obstacles.	<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 8 ISPs and 8 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. <u>Obstacles to Movement</u> Of the 7 ISPs reviewed, 7 should have had obstacles defined (0 were for individuals who were referred). Of these 7 ISPs, 0 (0%) identified obstacles that were related to the reasons for the individual not being referred. Of the 2 annual ISP meetings observed, an adequate list of obstacles to referral or obstacles to transition was identified for 2 (100%).	Noncompliance

		When obstacles are identified in an ISP, the ISP should also include an action plan to address/overcome any obstacles identified. The plans should be individualized, measurable, and include expected timelines. Of the n.a. for which obstacles were identified, there were plans to address obstacles to referral for n.a. (n.a.%). Of the 2 annual ISP meetings observed, a plan to address/overcome the identified obstacles was included for 2 (100%), in that, the LAR for one was going to visit group homes and more individualized transition and community group home visits were going to occur for the other. It may be that IDTs are not specifically identifying what it is that is an obstacle to referral. If they did, perhaps an appropriate action plan would be developed. Consider that many stated that individual choice was an obstacle, even though the obstacle was LAR preference. If so, the actions to address these obstacles should relate to the reason why the individual and/or LAR preferred to not explore community options (rather than merely stating attend provider fair and go on tours). Further, some obstacles were stated to be psychiatric/behavioral or medical problems. It may be that a more specific action plan (rather than PBSP, IHCP, or PNMP) would more readily address the specific aspect of the individual's supports and care that are obstacles. Further, the obstacle might not be these behavioral and medical characteristics of the individual, but rather the inability to identify a provider who could meet the needs of the individual. <u>Preferences of individuals and LARs</u> Of the 7 ISPs, 5 (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). 5 of the 7 individuals could not adequately express a preference. The ISP indicated this, but did not indicate what the IDT had done to make this determination. Further, for the 2 individuals who expressed a preference (for SASSLC), it did not seem that the IDT addressed potential reasons for this choice (e.g., lack of positive experience in the community, failure to explore reasons for fearing the community and if relationship to brother's death a few years prior played a role). Of the 2 annual ISP meetings observed, the individual's preference for where to live was adequately described in 2 (100%), in that both were described as having low understanding; this preference appeared to have been determined in an adequate manner for 2 (100%). Although not relevant to these two ISPs, an individual's low understanding should not necessarily result in a determination that the individual would not benefit from living in a more integrated setting. Of the 7 ISPs, 7 (100%) included an adequate description of the LAR's (or family member's) preference and how that preference was determined by the IDT (6), or indicated that there was no LAR (1).	

		Of the 2 annual ISP meetings observed, there was an appointed LAR for 2. LAR/family member preference was discussed in 2 of these 2 meetings (100%). To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. Ensure ISPs correctly identify obstacles to referral, and that there is an individualized action/plan to address each obstacle.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	Below are the nine activity areas upon which the Monitors, DADS, and DOJ agreed would comprise the criteria required to meet this provision item. The solid and open bullets below provide detail as to what is required. SASSLC was not addressing every one of these activities. <u>1. Individualized plan</u> • There is an individualized plan for each individual (e.g., in the annual ISP) that is o 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. <u>SASSLC status</u>: In reviewing 7 recently completed ISPs: o 0 of the 7 (0%) had an individualized list of activities that related to the reasons for their not being referred. Most referred to generic activities, such as have opportunities to go on tours and attend the provider fair. o 0 of the 7 (0%) were in measurable terms. Most contained statements that would make it difficult to determine if the action had been engaged in, such as "as scheduled" and "as available." o 1 of the 6 (17%) included the LAR, as appropriate, based upon the content of the ISP. o 1 of the 7 (14%) adequately described how/if the previous year's plan was completed. It may be helpful to add some prompts or headers to the ISP shell to help the IDT address each of the above four open bullets. <u>2. Provider fair</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs <u>SASSLC status</u>: A provider fair was held in March 2013 (prior to the previous review) and one was scheduled for 11/16/13. It was being held on a Saturday to make it	Noncompliance

		possibly more likely that more family members could attend. No other activities related to the provider fair or to the requirements of this part of provision T1b2 were addressed. 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: CLOIP-related activities are mentioned in the above item T1b2#3. 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 four people • Individual's response to the tour is assessed (describe methodology and indicators) SASSLC status: Additional attention was paid to tours and the system of tours. Most of the tours, however, were for individuals who were referred for placement, as part of their exploration of community providers. 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, 1 individual went on a visit to a friend in the community and they were now working towards living together. A visit to a friend was also noted in one of the ISPs reviewed (Individual #188). It was good to see SASSLC utilizing this method. 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 not occur. 8. A plan for staff to learn more about community options SASSLC status: Since the last onsite review, educational activities for DSPs did not occur at least once (other than during NEO). Since the last onsite review, educational activities for clinicians did not occur at least once. Since the last onsite review, educational activities for managers and administrators did not occur at least once. Educational activities seemed particularly relevant for SASSLC. For instance, some of the reasons provided in professional assessments indicated that more education about the community was needed. Reasons included need for diabetes management, having Prader Willi Syndrome, being blind, and being nonverbal. 9. Individuals and families who are reluctant have opportunities to learn about success stories SASSLC status: No activities occurred.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all	This provision item required the facility to assess individuals for placement. The facility reported that individuals were assessed during the ISP process, through provision of recommendations in annual summaries and IDT deliberation and consensus. There was a list of all individuals, their preference if known, and whether referred for placement. To meet substantial compliance with this provision item, the facility will need to 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 in a way that included a clear and explicit statement. Even so, there was improvement from the last review.	Noncompliance

	remaining individuals for placement pursuant to such policies, procedures, and practices.	• 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 As also noted in T1a, the reader could not determine if each professional presented and discussed his or her recommendation for referral. • Living options for the individual were thoroughly discussed during the annual ISP meeting and, if appropriate, during the third quarter ISP preparation meeting. o There was a thorough living options discussion during 2 of the 2 ISPs observed (100%) and an adequate description of a thorough discussion was evident in 0 of the 7 ISPs reviewed (0%). o The monitoring team could not determine if a thorough living options discussion occurred during the ISP meeting. There was no description of a living options discussion. A short descriptive paragraph is all that is necessary. o It seemed that a thorough living options discussion should have occurred for most of these ISPs given that there was not agreement across all of the professionals regarding referral. Further, the reasons given by some professionals indicated that more discussion (and education) would be appropriate. For example, reasons to not refer included the need for diabetes management, having Prader Willi Syndrome, being blind, and being nonverbal. • 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 7 reviewed (71%).	
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 8 CLDPs completed since the last review. This was 73% of the CLDPs completed in that period. The CLDPs were in the newer format, which the monitoring team found easy to read. <u>Initiation</u>: N.a. of the n.a. (not available, 0%) CLDPs were initiated right after the referral. The monitoring team looks for this to occur within 14 calendar days of referral. The APC reported that given the APD's lapse in staffing, it did not happen in required timeline of 14 days for most individuals. Going forward, however, they were planning to use a community referral information packet to help prepare for the 14 day meeting and to provide documentation of its occurrence.	Noncompliance

		Timeliness: 5 of the 8 (63%) CLDPs included documentation to show that that ongoing activity was occurring for the individual's placement. For the other three (all were past the 180 day date), the CLDP did not indicate what was done each month to indicate that activities were occurring. IDT member participation: 8 of the 8 (100%) 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). Coordination with LA: 7 of the 8 (88%) 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 8 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. However, each of the CLDPs (100%) included some of these six activities. • Training of community provider staff, including staff to be trained and level of training required. There was improvement in this area, however, as noted below, more detail was needed. o (a) who needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff), ▪ General statements regarding staff of the residential and day provider were included, but more detail was needed, such as if nursing staff, clinicians, or managers were to be included. o (b) 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 ▪ Most CLDPs included some detail on the content of what was to be presented. Most included a sentence or two about method, though in all cases the method of training was didactic only. o (c) a competency demonstration component, when appropriate. ▪ This was not included. Most said that the attendees would have the opportunity to ask questions. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). o This was not included in any of the CLDPs. This seemed particularly important for Individual #97 because his psychiatry notes indicated	Noncompliance

		that the new psychiatrist should be very aware of past problems when medications were changed. Similarly, given Individual #155's previous past failed placements, collaboration with his community psychiatrist and psychologist seemed important. • Assessment of settings by SSLC clinicians (e.g., OTPT, psychology, training and recreation). o This was evident in 2 of the 8 (25%) of the CLDPs. • Collaboration between provider day and residential staff is ensured. o This was not described in any of the CLDPs, but should be assured by the transition specialist. • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community). o This was not described in any of the CLDPs. <u>Day of move activities</u>: 8 of the 8 CLDPs reviewed (100%) clearly identified a set of activities to occur on the day of the move, and 8 of the 8 (100%) indicated the responsible staff member. There should be some indication, however, that every item on the CLDP day of move list did indeed move with the individual. To that end, the APC recently initiated a moving checklist to provide this documentation. It was implemented for the most recent move (Individual #155). <u>CLDP meeting prior to moving</u>: A CLDP meeting occurred for 8 of the 8 individuals (100%). A CLDP meeting was conducted during the onsite review and was observed by the monitoring team, for Individual #350. It was a good, lively meeting, with lots of participation from the individual and most attendees. Although the meeting was long (two hours), the individual was engaged throughout the meeting, and important topics were discussed. All 7 (100%) of the components of a CLDP meeting were demonstrated at this meeting. A number of times, the PMM asked for clarification on what she will need to see as evidence. This was good to see. 1. Attendance by all relevant IDT members, community providers, and LA 2. Individual preparation occurred prior to the CLDP meeting, if appropriate 3. DSP preparation occurred prior to the CLDP meeting, if appropriate to do so 4. Individual participation occurred, or was facilitated, if needed 5. There was active participation by team members 6. All relevant pre-move and post-move (essential/nonessential) supports were discussed and any issues resolved 7. 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 4 of the 8 (50%) CLDPs, the facility identified all facility staff and other staff (e.g., LA, community provider staff) by name and by title for each support. The others only indicated staff title, or made a general statement about the staff of the provider. In 0 (0%) of the CLDPs, the facility identified specific timeframes/specific dates for completion and/or implementation for each support. • Most supports had a template-type insertion of the deadline dates of all three post move monitorings rather than the date the support was to be put in place (or completed) by the provider. The new APC created a new self-monitoring tool to help her staff ensure that this aspect of the CLDPs was completed correctly. The monitoring team recommends that the second item require that the responsible staff name and title be included (not name and/or title).	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.	8 of the 8 CLDPs (100%), included documentation that the plans had been reviewed with the individual and/or the LAR (or indicated that there was no 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. The following review was based on a sample of assessments from 5 of the CLDPs. For 5 of the 5 CLDPs reviewed (100%), all necessary assessments were completed. For 5 of the 5 CLDPs reviewed (100%), all assessments were completed no more than 45 days prior to the date the individual moved to the community (there one or two exceptions for one or two individuals). For 5 of the 5 CLDPs reviewed (100%), all assessments were available to the APC and IDT prior to the final CLDP meeting.	Noncompliance

		Each assessment should meet the following: • A summary of relevant facts of the individual's stays at the facility. o This was done sufficiently in 5 of the 5 (100%) sets of assessments. • Thorough enough to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. o This was done sufficiently in 5 of the 5 (100%) sets of assessments. • 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 This was evident in 0 of the 5 (0%) assessments. The assessor needs to indicate how he or she might see the supports recommended being implemented in the new settings, that is, in the specific home and day program to which the individual was moving. General statements about what the individual would need in the community are not as helpful to the IDT. The medical assessments were neatly organized into a single page, though were almost identical across all individuals. • 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 This was evident in 0 of the 5 (0%) assessments. The comments immediately above apply to this bullet, too. The APC developed a new tool to self-monitor the quality of discharge assessments. It was a two page form, one to track the date of assessments and if they met the 45 day requirement. The second page got at the quality by directly assessing the above four closed bullets. The monitoring team believes that this should assist the APC in obtaining substantial compliance at the time of the next onsite review. To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. The discharge assessments must better address the specific home, day, and employment sites and contexts into which each individual will be moving. This has been mentioned by the monitoring team in the past few monitoring reports and must be improved if substantial compliance is to be maintained.	

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 lists of pre-move and post-move supports were identified in the CLDPs. SASSLC had made some progress in creating comprehensive lists for each individual. 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. ▪ This was demonstrated in 1 of the 8 (13%) CLDPs. Supports that required implementation of PBSP were insufficient because they did not include the important aspects of the plans, such as teaching replacement behaviors and engaging in ways to prevent the problem from occurring. Many of the individuals had complex psychiatric diagnoses, previous failed community placements, and serious behavior disorders. o All safety, medical, healthcare, risk, and supervision needs addressed. ▪ This was demonstrated in 1 of the 8 (13%) CLDPs. Many support and service needs were addressed in the assessments, in training for staff, and in broadly worded CLDP supports. More detail was required about what the provider should do, rather than wording supports, such as "follow GERD procedures." o What was important to the individual was captured in the list. ▪ This was evident in 6 of the 8 (75%) CLDPs. The APC should, however, consider making separate supports when appropriate. In many cases, many leisure and preferred activities were in a single support. o The list thoroughly addressed the individual's need/desire for employment. ▪ This applied to 8 of the 8 CLDPs. The supports listed related to employment were adequate for 7 of the 8 (88%). The best example was for Individual #316. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included. ▪ This was included in 0 of the 8 CLDPs (0%). Having a support that merely says "continue to implement the BSP" was insufficient. Moreover, in some of the CLDP narratives, the importance of positive reinforcement was noted (e.g., Individual #155). 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. ▪ This was seen in 8 of the 8 (100%) CLDPs. This was a strength	Noncompliance

		of this set of CLDPs. The IDTs, APC, and providers really worked to include ongoing skill acquisition training for individuals. Seven of the 8 individuals had three or more skills targeted for formal training. o There were ENE supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. ▪ Important aspects of the BSP, PNMP, etc. should have their own support to highlight their importance and help ensure that the provider carries out these important aspects. This was seen in 0 of the 8 (0%) CLDPs. Examples of what should have been included were the interactional and positive reward components of PBSPs and the most important details of the PNMPs, dining plans, and nursing care plans. One good example was the support for Individual #15 that addressed best ways to communicate with him. ▪ The most recent CLDP (Individual #155) included a support for implementation of the IHCP. This single support included numerous components and would have been better presented if it was split into multiple supports that detailed what it was that needed to be done to address each need. ▪ Similarly, the PNMP post move support for Individual #146 was comprehensive in that it included three important topics: food type, chopped, and calories; mealtime adaptive equipment and eating style; and transfers, mobility gait belt, wheelchair, etc. These, however, which should have been three separate supports. o Topics included in training had a corresponding support for implementation. ▪ This was evident in of 0 of the 8 (0%) CLDPs. • The wording of every support is in appropriate, measurable, and observable terms. o Supports regarding appointments were written adequately. The supports for provision of services and activities, however, 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.	

		- Many, but not all, of the CLDPs included a good paragraph or two describing the deliberations and discussion by the IDT for each area of service and support. This should continue and also should include the rationale for any recommendation in the assessment that was determined to not be necessary to include in the final list of recommendations. The work-related discussion for Individual #316 was a very good example of this. - 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. - Evidence that the PMM should look for was included in all of the CLDPs (100%), however, improvements were needed. - As discussed with the APC and PMM during the onsite review, they should consider three types of evidence for many of the supports: documentation, observation of implementation, and interview of staff. Doing these three activities is a very good way to be confident that the support was being provided. To help with this, the monitoring team again recommends that a checklist or check sheet be created. The diet support for Individual #85 was a good example. - The supports, however, were missing any criteria to give guidance to the PMM. For example, the PNMP support for Individual #146 mentioned above only had evidence to interview staff and see if equipment was present. Evidence should also include direct observation and some sort of daily checklist used by provider staff. To improve, the monitoring team recommends that the APC create a self-assessment for the pre- and post-move support section of the CLDP. She can use the above items to create this checklist for herself and her staff. Below are some comments on the list of supports in each of the CLDPs: - Individual #155: Missing detail on his replacement behaviors. - Individual #83: More was needed to address her likely meal and diet refusals. The PBSP supports did not have enough detail about problem solving and anger management alternatives. She had complicated diagnoses of borderline personality disorder, bi polar disorder, and intermittent explosive disorder. The leisure activities were all in a single support, with no criterion. It did not seem that the supports ensured that she would get to do some her favorite, and clinically important activities, such as baking and reading. Oral hygiene was not included.	

		• Individual #97: He had complicated diagnoses of psychosis, bipolar disorder, and inappropriate sexual behavior. The list of supports only addressed PBSP with no details. Further, the CLDP noted that he had a history of behavioral or psychiatric episodes every three months. This was not explored sufficiently. • Individual #85: There was nothing about keeping him busy. PBSP did not include important details. Exercise and diet were worded as encouraging him to do so, but it was not clear what staff was to do and what they were to document regarding encouraging him to diet and exercise. • Individual #316: Social phobia was described as a serious problem, but no supports to address this from psychiatry or from psychology. He had a serious behavioral history that included incarceration and inappropriate sexual behavior. He needed a low cholesterol diet, but the support list only referred to offering him a diet. Being on time and other social interactional components of his behavior plan were not included. • Individual #133: There were no specific recommendations from medical about what provider staff should do to support his health every day at home. The PBSP support said to use communication, but didn't provide staff with any direction. There were two sets of recreation/leisure supports. The monitoring team could not determine why. He had an individualized support to have private space available. • Individual #146: The PBSP support only listed the target behaviors. There was no detail about the important components of his PBSP. • Individual #15: The PBSP support listed the target problem behaviors as well as a replacement behavior of communication, but provided no detail about what the staff were to do regarding supporting his use of communication. This provision item also requires that: • Essential supports that are identified are in place on the day of the move. o A pre-move site review was reported to be conducted for all individuals (100%). Pre move site reviews were not reviewed by the monitoring team because 0 were submitted. ▪ N.a. of the n.a. (n.a., 0%) indicated that the pre-move supports were in place. o The APC staff should provide detail indicating if all of the aspects detailed in the CLDP regarding training occurred as per the CLDP, such as who, what, how, and documentation of competency. • Each of the nonessential/post-move supports needs to have an implementation date. o Not all post move supports had an implementation date. Many only indicated the deadline dates for post move monitoring.	

		To move in the direction of substantial compliance, the monitoring team recommends that the facility consider the following for focus/priority for the next six months: 1. At this point, the APC and transition specialists should be able to meet all of the criteria for a thorough and adequate list of pre- and post-move supports. Following the above comments regarding the 8 components of a comprehensive list, and the 3 additional characteristics will move the facility towards substantial compliance.	
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.	There was not much activity related to this provision. There was not a written policy or written process for quality assurance to ensure the (a) development and (b) implementation of CLDPs. New statewide tools for section T were still in development. The current set of three tools was not being used. Even so, the APC and her staff were engaging in some quality assurance processes: • QAQI Council presentations (once since last review, in July 2013) • QA report (two packets of info, July 2013 and October 2013) • QAD-SAC 1:1 meetings (June 2013 to September 2013, four times) Data were not reviewed, summarized, and analyzed. Data were included in the facility's QA program, but this was only at the very beginning stages. For instance, the four QAD-SAC 1:1 meeting notes documented that a meeting occurred and that, most likely, the expectations for the QA items were discussed, however, most were not completed or perhaps not even initiated (though understandable given the turnover in the department, and the only recent appointment of Ms. Fak to the APC position). The July 2013 QA data were minimal. The October 2013 data set, however, was much better, including the graphic presentation of the data listed in T1a above. Next steps include the type of analysis and action planning that one would expect to see in an active QA program. DADS central office provided feedback on some of the CLDPs. Information from these feedback reports might also be useful to the APC in her development of a QA program for section T.	Noncompliance
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their	DADS issued an Annual Report: Obstacles to Transition Statewide Summary. This report included an addendum from each of the 13 facilities. This annual report had not yet been updated since the time of the previous monitoring review and, therefore, no new comments are provided here.	Noncompliance

	needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live	The monitoring team was given a document titled "Community Placement Report." It was dated for the six-month period, 4/1/13 through 10/18/13. 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. The facility will need to include this list in order to maintain substantial compliance.	Substantial Compliance

	independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	SASSLC maintained substantial compliance with this provision item. Since the last review, 36 post move monitorings for 16 individuals were completed. This compared to 29 post move monitorings for 11 individuals, and 3 post move monitorings for 3 individuals at the time of the last reviews. The monitoring team reviewed completed documentation for 29 (100%) post move monitorings for 13 different individuals. Of the 29 post move monitorings, all 29 were completed by the post move monitor Darlene Morales. <u>Timeliness of Visits</u>: For the 16 individuals, 36 reviews should have been completed since the previous review. Based upon a chart presented to the monitoring team and by the post move monitoring reports, of the 36 required visits, 36 (100%) were conducted and 36 (100%) were completed on time. Of the 29 post move monitoring forms reviewed by the monitoring team, all 29 (100%) included dates showing that they were completed on time. <u>Locations visited</u>: For the 29 post move monitorings reviewed, 29 (100%) indicated that the PMM visited the locations at which the individual lived and worked/day activity (e.g., day program, employment; no individuals attended public school) were visited. <u>Content of Review Tool</u>: 29 (100%) of the post move monitorings were documented in the proper format, in line with Appendix C of the Settlement Agreement.	Substantial Compliance

		The post move monitoring form had gone through a number of changes since the baseline monitoring review in 2010. Of these 29 forms, 3 were completed on the form used through May 2013, and 26 were completed on the form used from May 2013 through October 2013. None were done on the newest iteration of the form, which was released on October 2013. The newest iteration addressed the concerns raised by the monitoring team regarding the May 2013 form. The post move monitoring report forms were completed correctly and thoroughly, as follows: • The checklist was completed in a cumulative format across successive visits for 17 of the 20 (85%) 45- and 90-day visits (all but Individual #195's and Individual #15's 45-day). • Supports were verified, such as by indication of the evidence examined and the results of this examination, in 28 of the 29 (97%, all but Individual #133 7-day). o The PMM should now provide detail in her report regarding whether she had evidence of all aspects of required training, such as who, what, how, and documentation of competency. o It would be helpful to the reader and IDT if the evidence examined specified was looked at: documentation, observation, and/or interview. • There was adequate justification for findings for each support in 28 of the 29 (97%). • Detail/comment was included in 28 of the 29 (97%) reports for most every support. The PMM did an outstanding job of providing detail in an efficient and easy to read manner a description of the evidence she looked at, the status, and additional interesting information. • LAR/family satisfaction with the placement and the individual's satisfaction were explicitly stated in 29 of 29 (100%). • 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 in 29 of the 29 (100%). The PMM did a very good job of writing these summaries. The monitoring team recommends that the PMM continue to improve upon her post move monitoring reports by attending to the following five comments. • Some items became Yes after previously being scored No, but the checked column was not changed to Yes from the previous report. The PMM should make sure this is always correct (e.g., Individual #344 90 day, Individual #316 45-day).	

		• Not all items scored no had a corresponding notation in the action table towards the end of the report (e.g., Individual #195, Individual #146). In many cases, the PMM's narrative allowed the reader to determine the status of the support, however, the form requires (and the reader would benefit from) putting every support scored no into this table. Also, some actions from earlier reviews were carried forward into the new report. This is OK to do, however, there should be some indication in the table as to which actions were from which reviews so as to not confuse the reader. • Supports that require there be training objectives usually mean that there should be a formal objective, teaching plan, data, review, etc. For some individuals, it was unclear to the monitoring team if the skill was being addressed formally or informally. If the support called for a training objective, but in the opinion of the PMM and provider, an informal plan would now be more appropriate, the PMM should bring this back to the IDT for their opinion before the PMM can accept this. This was seen in one example (Individual #85), though it had not been resolved as of the time of this report. • The monitoring team recommends that the PMM include the names and titles of provider staff who were interviewed to help the reader understand which staff were interviewed during the post move monitoring. This was explicitly done in 3 of the 29 (10%), that is, the three oldest ones, completed on the pre-May 2013 form. However, the monitoring team was able to determine, from the narrative, who was interviewed in the other 26, for a total of 100%. Even so, a list at the beginning of the report would be easy to do and helpful to the reader. <u>General status of individuals</u> Based upon the monitoring team's review of documents and discussion with the APC and PMM, of the 16 individuals who received post move monitoring, 16 (100%) transitioned very well and appeared to be having good lives. One of the 16, had some behavioral challenges (Individual #195), but collaborative work between the provider, PMM, APC, and SASSLC IDT resulted in successful modification of supports and his continued placement in the community. This was quite an improvement from previous onsite reviews, especially compared to the most recent review in April 2013. This was likely due to more thoughtful work with providers in their preparation for individuals as well as continued thorough post move monitoring. At the time of the previous review, IDTs were considering making provider changes for a number of individuals. At this time, there was no consideration to do so for any individuals. The APC and PMM presented a number of very successful and unique cases, including improvements in the residential supports for Individual #245, discussed in detail in the previous report. Examples included group homes, specialized adult foster care, and	

		living with family members. 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 10 of the 29 post move monitorings (34%), additional follow-up, assertive action, and activities were required of the post move monitor. These were for 6 of the 16 individuals (38%). Most of the problems were of a moderate level, such as initiation of day programming, documentation of inservicing, increase in behavior problems, and challenges with a parent. There was appropriate follow-up and correction for 10 of these 10 (100%) visits for 6 of the 6 individuals (100%). Follow-up was done in a timely and thorough manner, a good improvement from the last onsite review. <u>ISPA meetings after post move monitoring visits</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 7 out of 8 (88%) of post move monitorings for which an ISPA was appropriate to have been held. This was another good improvement from the last onsite review. However, for the others, there was no documentation of notification of the IDT that post move monitoring had occurred. The monitoring team recommends that the PMM notify the IDT after each post move monitoring, even if it is to report that the individual was doing well, that there no concerns, and that in her opinion a meeting was not needed.	
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 one post move monitoring at the home of Individual #85 for the 90-day review. 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 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 provider was Just Like Home. The owner and a staff member were present. The home was clean and simply furnished. The individual was happy and verbal about his satisfaction. The PMM interviewed the staff member about the individual's diagnosis, dining plan, and behavior problems. Overall, this appeared to be a good placement for the individual. The monitoring team and the PMM discussed some ways for her continue to improve post move monitoring: • Helping the provider to address the individual's apparent low level of involvement in preparing dinner, doing laundry, etc. • Conducting the interview of the staff member more in private, if possible, but without compromising the supervision of individual. • Conducting a portion of the individual interview in private, when possible. • Helping IDTs to develop pre/post move support lists that include adequate detail and required evidence, so that she can better monitor, such as o Developing checklists to document implementation of many different types of supports (e.g., parts of the PBSP and PNMP, in home leisure activities, preferred foods). o Ensuring that all of the bulleted information for medical providers was indeed presented to the medical provider (e.g., via the consult form) o Specifying what is required when a pre/post move support refers to a training objective.	
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations	This item does not receive a rating.	

T4	**Alternate Discharges –**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible	There was one individual whose discharge required this provision's discharge and transfer requirements. <u>Compliance with CMS-required Discharge Planning Procedures</u>: Based on a review of the discharge summary completed for Individual #131, it did 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. A review was conducted to determine whether or not the Facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ In 1 out of 1 records reviewed (100%), good cause was identified in the discharge summaries. • 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) for 1 out of 1 individuals (100%), reasonable time was given to prepare. • The facility developed a final summary of the individual's developmental, behavioral, social, health and nutritional status, and the information was adequate for 1 out of 1 individuals (100%). • For 1 out of 1 individuals (100%), the facility provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving facility. • Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the report for 1 out of 1 individuals (100%) adequately described the key supports that the individual would need in the new setting.	Substantial Compliance

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) o SASSLC Policy: Consent and Authorization for Treatment and Services revised 9/19/13 o SASSLC Policy: Rights and Restrictive Practices revised 10/11/12 o SASSLC Policy: Human Rights Committee revised 10/11/12 o SASSLC Rights Assessment form o SASSLC Need or Advocate/Guardianship Priority Summary and Referral o SASSLC Section U Monitoring Tool o Need for Guardianship IDT Training Curriculum o Prioritized Need for Guardianship List o SASSLC Self-Assessment and Provision Action Information for section U o SASSLC Section U Presentation Book o ISP, ISP Addendums, Assessments, PSIs, SAPs, Risk Rating Forms with Action Plans: • Individual #198, Individual #225, Individual #35, Individual #188, Individual #340, Individual #151, Individual #164, Individual #75, Individual #47, Individual #203, Individual #142, Individual #292, Individual #330, and Individual #137 o Draft ISPs and Assessments for Individual #241 and Individual #55 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 QIDPs in homes and day programs o Gevona Hicks, Human Rights Officer o Joan O'Connor, ADOP o Rhonda Sloan, QIDP Coordinator Observations Conducted: o Observations at residences and day programs o Incident Management Review Team Meeting 10/21/13 o Morning Unit Meeting 10/22/13 o QA/QI Meeting 10/22/13 o Morning Clinical Review Team Meeting 10/21/13 o Annual IDT Meeting for Individual #241 and Individual #55 o Rights Assessment Meeting for Individual #111 o Pre-ISP Meeting for Individual #282 o ISPA regarding falls for Individual #47

	Facility Self-Assessment: SASSLC submitted its self-assessment updated on 10/7/13. The section U audit process had been revised to review changes made in determining individual's capacity to give informed consent. 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. Activities engaged in to conduct the self-assessment for U1 and U2 included: • Observation monitoring by program auditors of rights assessment discussions for newly trained IDTs. • Review of written ISPs and rights assessments from meetings observed. The facility self-rated U1 and U2 as not in compliance. Findings from the facility self-assessment were similar to findings of the monitoring team for the two provisions of section U. The monitoring team agreed with the facility's noncompliance ratings for U1 and U2 and commends the facility for continuing to assess progress through the self-assessment process.
	Summary of Monitor's Assessment: Progress was made towards compliance with section U requirements. • Facility policies regarding consent for treatment and rights and restrictive practices were updated. • Section U corrective action plans were implemented July 2013. • The Need for Advocate/Guardianship Priority Summary and Referral form was revised. • The SASSLC Provision U Monitoring Tool was revised • One IDT from each of the three residential units had received training on the need for guardianship discussion. 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 based on an adequate assessment process. 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.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	On 3/7/12, DADS State Office issued Policy #019: Guardianship. A second policy on consent remained in the development phase. The state is encouraged to finalize this policy because it should assist the facilities in moving forward with regard to the Implementation of the Section U Settlement Agreement requirements. The facility had revised the SASSLC Rights Assessment tool to assess each individual's capacity to give informed consent. IDTs were responsible for reviewing assessment information and determining if a referral for guardianship was appropriate. One IDT from each of the three residential units had received training on the need-for-guardianship discussion. The rights assessment tool was being completed by core IDT members in a meeting scheduled prior to the annual ISP meeting. The IDT then completed the Need for Advocate/Guardian Priority Summary and Referral form. A priority for guardianship rating was assigned based on information gathered and agreed upon by the IDT. The monitoring team observed an IDT rights assessment meeting for Individual #111. The IDT reviewed his rights restrictions and ability to provide consent with guidance from the HRO. It was a new process, but one that should lead to an adequate assessment for determining the need for guardianship. The HRO was working closely with families, community guardianship providers, and the court to facilitate the guardianship process when IDTs determined a need for guardianship. Two annual ISP meetings were observed, for Individual #241 and Individual #55. IDTs were holding better discussions regarding each individual's ability to make informed decisions. Teams stopped short of developing possible training opportunities to improve decision making skills, even at the most basic level (e.g., simple choice making). The facility was developing a new priority for guardianship list based on the new rights assessment process. Four individuals had been through the assessment process and assigned a priority for guardianship. This was good to see. A sample of ISPs was reviewed to determine if IDTs were adequately addressing each individual's ability to give informed consent. It was not yet evident that an adequate discussion was routinely taking place at annual ISP meetings. It will be important for QIDPs to document recommendations from the assessment process and ensure that outcomes are developed to address any barriers to each individual's ability to make decisions when deemed applicable.	Noncompliance

#	Provision	Assessment of Status	Compliance
		To move forward, the facility will need to: 1. Ensure an adequate assessment process is used to determine each individual's need for guardianship. 2. Ensure that the facility's priority list for guardianship is accurate based on information gathered at annual IDT meetings.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	New guardianship had not been obtained for any individuals at the facility in the past six months. The Human Rights Officer continued working with many current guardians to renew guardianship on an annual basis. The facility had 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, through the self-advocacy group at the facility Compliance with U2 will be contingent on ensuring that all individuals have been assessed using the newly developed 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.	Noncompliance

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: • Acknowledgement Form Procedure, 300.10 (or is it V.4?), updated 5/20/13 • Master record procedure, 300.10, (or is it V.5?) updated 6/4/13 • Recordkeeping practices, V.1, updated 8/20/13 • Physician master signature list, V.4 (or is it V.6?), 8/18/13 • Monthly record review, V.7, 10/14/13 • Medical travel packets, V.8, 8/20/13 • Active records checkout procedure, V.9, 8/20/13 • 300.10 Consumer record policy (discontinued?) • 300.45 Protection and management of client records (discontinued?) o SASSLC organizational chart, undated, but likely September 2013 o SASSLC policy lists, 4/1/13 o List of typical meetings that occurred at SASSLC, undated but likely September 2013 o SASSLC Self-Assessment, 10/8/13 o SASSLC Action Plans, 10/8/13 o SASSLC Provision Action Information, 10/4/13 (but there was no information since the last onsite review included for section T) o SASSLC Most Integrated Setting Practices Settlement Agreement Presentation Book o Presentation materials from opening remarks made to the monitoring team, 10/21/13 o List of all staff responsible for management of unified records o Description of changes since the last onsite review, solely about the management of ISPs o List of other binders or books used by staff to record data (data notebooks in day programs) o Description of the SASSLC shared drive, (not provided) o Tables of contents for the active records (7/11/13), individual notebooks (7/10/13), and master records (undated, likely July 2013) o Checklist for new admissions to ensure unified record was created o Description of special project regarding ISP documents and a blank tracking form o List of Medicare cards obtained, September 2013 o List of medical consultations, used to do audits, for July 2013 audits o Documentation of staff training in 673E and 673W o List of all state and facility policies, 10/14/13 o Policy review committee meeting log, 9/27/13 o Description of the unified record audit process o Blank tools used by the URC (table of contents tool and statewide tool), undated, likely July 2013

	o List of individuals whose unified record was audited by the URC, April 2013 to September 2013 (five per month) o Completed audits for 10 individuals, July 2013 and August 2013 • Active record and individual notebook • Master record • Statewide self-monitoring tool (these were not provided for any of the 10 audits) • Additional comments for each audit o Emails requesting error correction for all 10 of the audits, with the completed audit attached o Copy of the completed audit that the URC used to track/record completion status of errors for 10 o Emails to department heads regarding some specific items still not completed, four, July 2013 and October 2013 o QAD-SAC 1:1 meeting notes, June 2013-September 2013 o QA report for section V, August 2013 report • Graphs o Active records and/or individual notebooks of: • Individual #90, Individual #45, Individual #59, Individual #128, Individual #297, Individual #188, Individual #183, Individual #89, Individual #3, Individual #111, Individual #142, Individual #261, Individual #226, Individual #118, Individual #274 o Master records of: • Individual #180, Individual #305, Individual #263 <u>Interviews and Meetings Held</u>: o Noemi Cardenas, URC o Janet Prince-Page, Coordinator of Unified Records o Dave Ptomey, Juan Villalobos, Annette Longoria, Unit Directors o Josephine Tarin, Gloria Huron, Home Record Clerks o Rose Maria Maya, Eva Gonzalez, Paul Villareal, Janet Pena, Kathy Caza, DSPs <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 were identical to the previous report, with the exception of updated data. The monitoring team again recommends that the self-assessment contents line up directly with the contents of the monitoring 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, existence of policies, training on policies, components of the V3 audit,

	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: The recordkeeping department at SASSLC maintained the status of where it was at the last review. A number of facility-specific policies were written or updated. Eighteen of 18 (100%) individuals' records reviewed included an active record, individual notebook, and master record. In the active record, progress/activities noted in the previous report maintained. Some new processes were put into place. The simple tasks of properly and legibly signing and dating entries continued to be a problem. Missing documents continued to be a problem. The monitoring team's review of active records showed approximately 10 of these types of errors per active record. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. Overall, the content of the individual notebooks was appropriate and complete, however, PBSPs were missing from some and, in many cases, data were not recorded in a timely manner or there were many blanks in the current day or in days earlier in the week. In the master records, a project to obtain missing Medicare cards resulted in obtaining missing cards for approximately 100 individuals through September 2013. The URC completed five quality assurance review audits in each of the previous six months. The tools used for these audits needs to be updated and made more valid, as has been done at many of the other facilities. In particular, the combination of the statewide tool and the TOC tool was needed. The URC clearly marked items that needed correction and notified relevant staff who needed to make corrections. Many items were scored yes, even though the comment reported on there being problems with the documents. The monitoring team recommends that the URC make improvements to her data system by considering the monitoring team's comments in the previous monitoring report. V4 was not a focus of the recordkeeping department in the last six months, thus, no work was done and the facility was in substantial compliance with none of the six items (0%).

#	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.	The recordkeeping department at SASSLC maintained the status of where it was at the last review. It appeared that the URC, Noemi Cardenas, who had returned to her position at the time of the previous review (after close to a year away), was still putting into place the procedures and processes that were necessary if SASSLC was to obtain substantial with all four provisions of section V. That being said, the URC and the home record clerks were working hard and the monitoring team expects that more progress will be seen at the time of the next onsite review. State policy remained the same since the last review. A number of facility-specific policies, however, were written or updated (as suggested in previous monitoring reports). Most of these were documenting, in policy, procedures that were already in place (e.g., active records checkout). Updating and writing new policies was a good idea and will set the occasion for more facility-wide compliance with recordkeeping practice standards. The monitoring team, however, found inconsistencies in the numbering and titling of the policies. The URC should review these and make any changes if needed. For example, the numbers on the facility's policy list did not match the numbers on some of the documents given to the monitoring team (see the list above, documents reviewed). For future reviews, the monitoring team requests that the recordkeeping department not send duplicate copies of the same document or copies of all new policies for the entire facility, only new recordkeeping policies are necessary to be submitted for this section. Eighteen of 18 (100%) individuals' records reviewed included an active record, individual notebook, and master record. The table of contents and maintenance guidelines for all three components of the unified record were updated in July 2013. <u>Active records</u> The status of the active records maintained from the time of the last review, 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 homes across the SASSLC campus. Comments on the active records: • Progress/activities noted in the previous report maintained. • Some new processes were put into place that should help to improve the active records to the point of being in substantial compliance. Their formal implementation was recent and effects were not yet evident. o A new policy created a physician signature sheet to make it easier for the reader of the active record to know who wrote the entry. o A new policy sought to ensure that SAPs were written and that they	Noncompliance

#	Provision	Assessment of Status	Compliance
		made their way into the active record in a timely manner. • The ISP document management process described in the previous report continued to be implemented, with some modifications. A detailed spreadsheet now documented the status of the ISP and SAP documents for every individual. Home record clerks said that they filed whatever they were given, with special priority given to ISP documents and medical documents. It was impossible for them to determine what documents were missing or out of date and seek out missing or new documents. This seemed valid, given their workloads. • The URC conducted inservicing for some homes. It seemed that more of this will be needed. Aspects still in need of improvement. • Although legibility of entries had improved, the simple tasks of properly and legibly signing and dating entries continued to be a problem as found by the monitoring team and by the URC audits. The monitoring team was unable to read many signatures, and many did not have time entries, however, the content of the entries were understandable and legible. Unfortunately, the recordkeeping department was not counting this and, therefore, did not really know if this was improving, getting worse, or maintaining. • Missing/misfiled documents continued to be a problem. Examples found by the monitoring included the following: o Individual #90: some consents were from 2010, and there were no ISP reviews for her ISP held in May 2013. o Individual #45: annual medical assessment was more than 18 months old, the last quarterly medical review was more than a year ago, quarterly psychiatry documentation was more than six months old, and the MOSES, DISCUS, and QDRRs were beyond their time standards. o Individual #59: most recent preventive care flow sheet entry was 2011, vital signs were kept through April 2013 and not again until September 2013, and the most recent MAR was August 2013. o Individual #128: there was no PSI, July 2013 was the last ISP review, and his guardianship paperwork was expired. o Individual #297: the most recent preventive care flow sheet entry was 2011. o Individual #183: the most recent ISP review was August 2013, and his active record contained the psychological assessment for Individual #85, misfiled here.	

#	Provision	Assessment of Status	Compliance
		The monitoring team's review of active records showed approximately 10 errors per active record. The URC's quality assurance audits described in section V3 had similar findings, however, her data were presented only as a percentage of all items correct, rather than showing the actual number of errors found (see V3 below). The facility might consider new ways of improving the quality of the active records. For instance, some SSLCs have had home record clerks conduct abbreviated/modified active record reviews of one of their peers' active records once per month. <u>Individual notebooks</u> Individual notebooks continued to be used for all individuals and as per state policies. An individual notebook existed for each individual. All individual notebooks contained the ISP (most were current), however, none contained the IRRF and IHCP. Staff interviewed by the monitoring team appeared comfortable with, and knowledgeable of, the individual notebooks. For instance, Janet Pena, Paul Villareal, Kathy Caza, Rose Maria Maya, and Eva Gonzalez described the purpose of the individual notebooks and said that they were easy to manage and use. Overall, the content of the individual notebooks was appropriate and complete, however, PBSPs were missing from some, and in many cases, data were not recorded in a timely manner or there were many blanks in the current day's data or in days earlier in the week (e.g., Individual #111, Individual #142, Individual #261, Individual #118). As noted in section K and in V4, PBSP data were recorded up to date in only 14% of the sample observed by the monitoring team. Two exceptions were the individual notebook for Individual #274, in which the behavior data were recorded right up to the hour observed by the monitoring team, and the monitoring team's observation of the 1:1 staff for Individual #16 recording 15-minute interval data right on time during the evening in his home. Two problems were noted in the previous report: availability of the individual notebooks and appropriate content of individual notebooks. SASSLC took some actions to address both. For example: • Carts were being used in the day programs and homes, so that the individual notebooks could be in the living rooms and activity rooms rather than locked in the offices. This was observed across the facility, in particular, in home 672. • An individual notebook transport data sheet was being used to raise the likelihood that the individual notebooks would be at the day program sites by requiring staff to sign off on their arrival at day program. The monitoring team observed that individual notebooks were regularly at the day programs.	

#	Provision	Assessment of Status	Compliance
		• At the morning home management team meetings, led by the unit directors, each home manager/supervisor brought in one individual notebook and reviewed its content, quality, and status with the group each day. • At the time of the last review, the URC was going to begin conducting random checks to see if active records were available and if individual notebooks were available. She reported that she did this twice, but did not have the time to do it regularly. This was a good idea and the facility might consider other ways of accomplishing this, perhaps by having the home record clerks do a daily check of the active records and individual notebooks on their own homes. <u>Other binders/logs</u>: Behavior data sheets were maintained at some of the day programs. These data ended up in the psychology data system. This seemed to be a reasonable system. <u>Master records</u> A master record existed for every individual at SASSLC and all were in the new format. Overall, the master records were in good shape. The audit checklist being used by the URC was now in line with the newest format for the master records. There was some progress in resolving what to do about items that should be in the master record, but were not. For instance, a project to obtain missing Medicare cards resulted in obtaining missing cards for approximately 100 individuals through September 2013. The new master records policy directed the recordkeeping department to make notes in the master record table of contents as to what was done to obtain any documents that were missing. <u>Shared drive</u> 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.	

#	Provision	Assessment of Status	Compliance
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 continued to have an active policy review committee. It met every Thursday and a tracking log was kept that updated that status of new and/or revised policies. As noted throughout this report, many new policies were put into place. Even so, SASSLC had not progressed towards substantial compliance with this provision. Therefore, the monitoring team repeats the comments made in the previous report: 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 Appendix D. The quality assurance	The facility and URC were back on track since the last review and completed five quality assurance review audits in each of the previous six months. The review consisted of these components: • TOC tool for all three components of the unified record • State tool • URC's notes	Noncompliance

#	Provision	Assessment of Status	Compliance
	procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The URC was not re-auditing a unified record if it had been audited in the previous 12 months, as suggested in the previous monitoring report. Moreover, she did not audit any individual's record who had his or her annual ISP in the previous three months. In this way, she would be assured the ability to review at least one-quarter's worth of documents, such as SAPs, IPNs, etc. This was a very good idea. As noted in previous reports, it was past the time that the tools used for these audits was updated and made more valid, as has been done at many of the other facilities. In particular, the combination of the statewide tool and the TOC tool was needed. The reviews were done in the same manner described in previous reports. Her completion of the TOC forms was done succinctly and consistently. The reviews appeared to be done in a thorough manner (even given the need for the tools to be updated). The URC reported, in the comments column, the number of observation note entries assessed and the number of those that had problems. Calculating and reporting on a percentage of these would be useful to the recordkeeping department and the QAQI Council. Many items were scored yes, even though the comment reported on there being problems with the documents. The monitoring team sees this as a validity and integrity problem that should be addressed. The medical consultation listing was again being used, however, missing medical consultation paperwork was not being counted as an error; it should be. The typical number of errors found in a table of contents review was around 10 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. Data, however, were not managed as per number of errors. The data should be managed in this manner (see below). Completed statewide tools for the 10 audits were not given to the monitoring team, making it impossible to determine the documented adequacy of that part of the audits. Further, the items on the statewide tool related to many of the items in Appendix D of the Settlement Agreement. Results of her statewide tool data were merely presented in a graph; no follow-up was done and the monitoring team could not determine where there may have been problems.	

#	Provision	Assessment of Status	Compliance
		Once completed, the URC color-coded the table of 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. She used a checkmark to indicate corrected or wrote a short note the status. Other items had an x mark or no mark. The monitoring team could not determine the status of these other items. If errors were not corrected, she further followed-up with emails to department heads. The QA department conducted six audits every month. Two were to compare inter observer agreement and the other four were for other individuals. The data from these other four were not used at all (as far as the monitoring team could determine). Further, inter observer agreement was only obtained for the statewide tool, not on the more important TOC tool. The QA department and URC should re-evaluate the use of the QA department's system (and resources) in the conduct of interobserver agreement in order to make it more sensible. The data system created by the URC remained the same as at the time of the previous reports. It was good to see a long running data presentation in the QA reports for this section, however, there were numerous problems with the data. This was discussed at length in the previous report in a series of five closed bullets with sub-bullets below them. The URC (and the reader) is referred back to the previous report for this information. The monitoring team recommends that the URC make improvements to her data system by considering the monitoring team's comments in the previous monitoring report.	
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 URC reported that V4 was not a focus of the recordkeeping department in the last six months, thus, no work was done to address the requirements of this provision. During the onsite review, the monitoring team reviewed V4 with the URC, including sharing some suggestions for how to address V4 by the time of the next onsite review. The facility was in substantial compliance with none of the six items (0%). Below, the six areas of this provision item are presented, with some comments regarding	Noncompliance

#	Provision	Assessment of Status	Compliance
		SASSLC's status on each. 1. Records are accessible to staff, clinicians, and others The monitoring team observed that: • Records were accessible to the medical staff. • Records were accessible to the psychiatrist during clinic. • The record for Individual #314 was accessible on the home, however, an important acute care plan was not found in the record. The individual had a recent serious injury of a chemical burn to her neck from gastric drainage from her gastrostomy tube • The active records were available to the clinicians (OT, PT, SLP, and the PNMT). Most of the IPNs were handwritten and completed at the time of the contact. This was an appropriate system for providing key information/access to other team members. • DSPs used individual notebooks. They were more accessible than found in the last review, however, some individual notebooks continued to remain behind locked doors. • 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 16 (89%) of 18 individual notebooks in the sample, however IHCPs were not available to staff in any of the records reviewed. 2. Data are filed in the record timely and accurately For this item (#2), the monitoring team looks to see if the documents in the active record are up to date. This differs from the item immediately below (#3) for which the monitoring team looks to see if current data sheets are being completed expediently and correctly (e.g., behavior data sheets, seizure logs, PNMP logs). 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: • Dental evaluation forms were titled initial evaluation even when it was an annual evaluation. • A number of record notes were prefaced with "late entry." • Psychiatry documents appeared to be filed timely and accurately. • Habilitation therapy documents appeared to be filed timely and accurately. • The facility had begun gathering data on the submission of documents for the active records. A list provided by facility reported that only 41 of 171 (24%)	

#	Provision	Assessment of Status	Compliance
		ISPs developed in the past year were filed within 30 days after the annual ISP was held. <u>3. Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> The monitoring team observed that: • Only 14% of PBSP data sheets reviewed had data recorded in a timely fashion. • There were omissions of documentation in the bowel management and trigger sheet records. • Data for direct habilitation therapies were generally reported via IPNs. Monthly reviews were consistently completed in a timely manner and contained a report of actual clinical data as it related to established objectives of intervention with appropriate analysis. • QIDP monthly reviews indicated that data on progress towards ISP outcomes was often unavailable at the time of review. <u>4. IPNs indicate the use of the record in making these decisions (not only that there are entries made)</u> The monitoring team observed that • There was clearly a review of the active record in the PNMT, OT/PT, and SLP assessments. • According to some RNs and LVNs, the active record was used in making care, treatment, and training decisions, however, the majority of nursing IPN entries were driven from a complaint by the individual or from a person supporting the individual. The IPN entry focused on the complaint, and rarely focused on the entry contained in the historical data or baseline data pertinent to the assessment. • Psychiatry clinic staff were noted to utilize other information with regard to making treatment decisions (e.g., psychology evaluations, data graphs, MOSES, DISCUS, nursing information, and other clinical data). • Some records had electronic MOSES/DISCUS evaluations that did not have prescriber review. • Some APLs in records were not signed. • There were numerous illegible medical staff IPN entries, making it difficult for other IDT members to read. • Some IPNs by the clinical pharmacist were titled “Neuro.” It was not clear if these were recommendations from the neurologist or from the pharmacist. They seemed to be from neurology clinic (based on the date and that they needed the signature of the MD). The documentation should clearly state the source of the recommendation. For instance, if this was from pharmacy, it should have been a “pharmacy” note.	

#	Provision	Assessment of Status	Compliance
		5. Staff surveyed/asked indicate how the unified record is used as per this provision item The monitoring team found • Medical staff talked about the need and benefits of an electronic medical record. • Some clinic appointments were cancelled because seizure records were not available or not sent. • Questions were presented by the monitoring team to inquire in what situations RNs and LVNs would refer to the individual's record. The majority of responses were inconsistent in how the individual's health record was used to make decisions about care and services • Staff were not interviewed. The "V4 interviews" were discontinued at SASSLC. 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 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. The monitoring team found the following: • The QIDP provided IDT members with a draft ISP and IHCP at the annual team meetings for Individual #241 and Individual #55. The active record was available at the meeting and was used by the team when additional information was needed. • The unified record was present at ISP meetings. It was accessed when the monitoring team asked questions that one or more IDT members could not answer. • The pre-ISP meeting was observed for Individual #282. The QIDP used information in the active record to update IDT members to determine which assessments were needed prior to the annual meeting and to review progress towards outcomes. • There was use of the unified record during psychiatric clinic meetings. • The personal records were available during the PNMT meeting observed for reference and documentation as required.	

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
ART	Administrative Review Team
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
COS	Change of Status
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
DPN	Dental Progress Note
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
DSP	Direct Support Professional
DUE	Drug Utilization Evaluation
DVT	Deep Vein Thrombosis
DX	Diagnosis
E & T	Evaluation and treatment
e.g.	exempli gratia (For Example)
EC	Enteric Coated
EC	Environmental Control
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
GA	General Anesthesia
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
HCV	Hepatitis C Virus
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 Case Analysis
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
ICN	Infection Control Nurse
ICO	Infection Control Officer
ICP	Infection Control Preventionist
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
IPMP	Integrated Pest Management Plan
IPN	Integrated Progress Note
IPSD	Integrated Psychosocial Diagnostic Formulation
IRR	Integrated Risk Rating
IRRF	Integrated Risk Rating Form
IRT	Incident Review Team
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
LTBI	Latent TB Infection
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
MIT	Mealtime Improvement Team
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
MTC	Meal Time Coordinator
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
PNE	Pneumonia
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
QIDP	Qualified Intellectual Disabilities Professional
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
SIT	Skin Integrity Team
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
TLSO	Thoracic Lumbar Sacral Orthotic
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
VAP	Vascular Access Port
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