United States v. State of Texas

Monitoring Team Report

San Antonio Supported Living Center

Dates of On-Site Review: February 8-12, 2010

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Introduction

I. Background - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him or her every six months, and detailing his or her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of the San Antonio State Supported Living Center.

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this baseline review of San Antonio SSLC, the following Monitoring Team members had primary

responsibility for reviewing the following areas: Teri Towe reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, as well as quality assurance, and integrated protections, services, treatments and supports; Russell Livingston reviewed psychiatric care and services, and medical care; Karen Green McGowan reviewed nursing care, dental services, and pharmacy services and safe medication practices; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Carly Crawford reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Alan Harchik reviewed serving individuals in the most integrated setting, consent, and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 SA.

II. 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 February 8-12, 2010, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes,

community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. 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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. 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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility,

this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the facility has with regard to compliance with the particular section;

(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;

(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;

(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is in the State's discretion, however, to adopt a recommendation or use other mechanisms to implement and achieve compliance with the terms of the SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual as Individual #1, Individual #2, and so on. The Monitors are using this

methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

First, the monitoring team wishes to acknowledge the outstanding cooperation and responsiveness of all staff members at all levels at SASSLC during the on-site tour. A review, such as this, is impossible to conduct without the willingness of management, clinicians, and direct care staff to provide the monitoring team with a variety of information. This required many SASSLC staff to re-arrange their schedules, tour team members around the facility, include team members in meetings, participate in interviews, provide documents, and allow themselves to be observed conducting their typical job activities. The monitoring team also acknowledges the willingness of many individuals to talk about their lives at SASSLC and to be observed in their daily day, work, and home activities. The facility director, Ralph Henry, helped set the tone early, specifically inviting the monitoring team to learn everything possible about SASSLC. Further, he instructed all of his staff to be open and to answer all questions posed to them by team members. This collaborative approach was right in line with the way the parties intended for the monitoring process to occur.

As a result, a great deal of information was obtained during this tour as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations were conducted, and interviews were held. Specific information regarding more than 100 individuals is included in this report. It is the hope of the monitoring team that the information and recommendations contained in this report are both credible and helpful to the facility.

Second, the monitoring team found management, clinical, and direct care staff eager to learn and to improve upon what they do each day to support the individuals at SASSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong on-site tour. Although it is difficult to provide much technical assistance during a baseline tour, team members found opportunities to share ideas and make suggestions. Their comments were well received. The team hopes to continue to provide suggestions and recommendations and has done so throughout this report.

Third, although team members found numerous problems in the systems of care and service delivery across the facility (as detailed in this report), they also found that staff members really cared about the individuals who lived at SASSLC. The monitoring team found a workforce that was proud of what they did each day and that cared about the individuals whom they supported. The senior management at SASSLC took the time to celebrate the successes of staff, individuals, and their overall program. They found the time to do so, even in a fairly large facility that supported 283 individuals and approximately 825 FTEs of employees.

Fourth, below some general themes found by the monitoring team are discussed.

Restraint

- The reduction in the use of physical restraint to deal with behavioral or psychiatric emergencies was one of the successes celebrated by SASSLC. Indeed, no restraints had been implemented in many months. This was a result of active planning by management; a result of focusing on the avoidance of escalation of behavioral crises, improving access to activities, and keeping a lot of attention and focus on this topic. The monitoring team was pleased and impressed by this accomplishment.

Engagement

- Another area of focus for the facility was on what management referred to as "active treatment." For the most part, it was a focus on providing engaging activities for the individuals and staff. This required the implementation of activity schedules, provision of a variety of materials, hiring of specialized staff to focus upon activities, and the training of management and direct care staff. The monitoring team saw numerous examples of effective ways of engaging individuals, such as splitting up into smaller groups, rotating attention, and ensuring the availability of materials. On the other hand, SASSLC needs to ensure that engagement activities are individualized and actually engaging for the individuals. Moreover, a system to measure engagement levels and provide feedback and suggestions for managers and staff was needed.

Staffing

- A recurrent theme was a need to ensure levels of staffing at each home that allowed direct care staff to properly supervise and attend to the needs of the individuals in their care. This appeared to be especially problematic in the homes for the individuals who had more serious medical and physical support needs. Frequent "pulling" of regular staff to cover for staff who were not on duty competed with the facility's goal of providing proper support, supervision, care, and safety. This need was not only told to monitoring team members by direct care staff and residential managers, but by family members who were at the facility during the on-site tour, nursing staff, physicians, and the individuals themselves. During a group meeting with about two dozen individuals, participants commented that they didn't like when staffing gets pulled down to the minimum or when staff get reassigned. One residential manager described an example of the challenge that occurs when a home has three staff on duty and two are required for one individual's lift and transfer for hygiene, toileting, or dressing. The result is unsupervised or under-supervised individuals. Indeed, monitoring team members often observed two, and sometimes three, non-ambulatory individuals in their bedrooms with no staff present. Although it is not unusual for individuals to be alone in their bedrooms from time to time, especially if they do not require line of sight supervision, the monitoring team was struck by the number of individuals, the number of bedrooms, and the amount of time that individuals with profound disabilities were alone. For example, the monitoring team

observed hallways of four or five bedrooms with individuals with profound disabilities alone with no staff in sight. Another consequence of staff shortages is that management staff must then assist with direct care service and cannot conduct thorough or frequent staff training sessions.

Integration of Services

- As noted throughout the report, the provision of supports and services in an integrated manner was not occurring at SASSLC in a manner sufficient to meet the requirements of the Settlement Agreement. Fortunately, management and clinical staff were unanimous in their desire to have services occur in a more integrated manner.

Training

- The facility had recently taken on the task of conducting its own staff training activities. Previously, staff training was conducted by the adjoining state hospital training department. The state had detailed required core and specialty trainings to be completed by various categories of staff, depending upon their job responsibilities. The facility is likely to handle these trainings successfully. More challenging, however, will be ensuring that actual competency-based training is conducted, documented, and monitored for those areas required by the Settlement Agreement (e.g., in sections C, D, F, K, O, and P), noted in DADS and facility policies, and done on-the-job by clinical staff (e.g., PBSPs, PNMPs, skill acquisition plans).

At-Risk Individuals

- The facility failed to properly and thoroughly identify individuals who were at risk for injury due to a variety of medical and health-related conditions. Although policies existed, there was little correspondence between the risk level assigned by the facility and the observations of monitoring team members.

Immediate Attention

- Throughout the report to follow, many details and examples are provided that identify positive practices that were occurring at the facility as well as a variety of areas that were in need of attention and improvement. Some of these areas required more immediate attention to ensure that individuals were not at any risk of harm. Some of these areas of service were as follows:
    - ensuring proper staffing levels
    - timely completion of all investigations
    - the assignment of proper risk levels to individuals
    - provision of dental services
    - proper positioning during meal times
    - presentation of proper food textures, size, and pacing

- ensuring that all required supports are in place prior to transition to the community and during all post-move monitoring visits

The above comments in this summary were meant to highlight some of the more salient aspects of this baseline review of SASSLC. The monitoring team hopes that the comments throughout this report are useful to the facility as it works towards meeting the many requirements of the Settlement Agreement.

The monitoring team looks forward to continuing to work with DADS, DOJ, and SASSLC.

Thank you for the opportunity to present this report.

V. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management o DADS Policy #001: Use of Restraint o San Antonio State Supported Living Center Policy: Use of Restraint 300-29 dated 10/8/09 o DADS Health Care Guidelines, dated May 2009 o Texas Administrative Code Title 40, Part 1, Subchapter H, Rule Section 5.354 General Provisions, Use of Restraint in Mental Retardation Facilities o San Antonio State School Behavior Therapy Manual 300-18 dated 10/5/05 o SASSLC Plan of Improvement o Restraint Checklist Form 4012008R o Administration of Chemical Restraint Form o Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint Form o Imminent Danger Restraint Checklist (Documentation of chemical restraints 9/09-10/09) o List of all restraints applied at SASSLC 7/1/09-1/13/10 o Graph of physical restraints over the last three years o Graph of chemical restraints over the last five years o Psychology POI Monthly Report from Sept 09 to Jan 10 o Facility reports reporting the use of poly-pharmacy from Jan 09 to Aug 09 o SASSLC Restraint Trending/Analysis Report FY10 1st quarter o Restraint Reduction Committee Notes 9/10/09 o Incident Management Meeting Minutes for the following time periods: • 7/13/09-7/17/09 • 9/1/09-9/4/09 • 10/19/09-10/23/09 • 1/4/10-1/8/10 o Review of staff training transcripts for the four residential direct care staff who were interviewed o Sample of PSPs including: • Individual #113 6/16/09 • Individual #211 8/7/09 • Individual #45 3/13/09 • Individual #148 1/15/10 • Individual #145 11/6/09 • Individual #15 8/4/09 • Individual #302 2/12/09

	• Individual #24 7/15/09 • Individual #341 9/28/09 • Individual #68 9/21/09 • Individual #254undated • Individual #227 10/23/09 • Individual #41 12/1/09 • Individual #313 10/16/09 • Individual #91 3/16/09 • Individual #40 12/4/09 o HRC Review of PBSP for: • Individual #276 • Individual #261 • Individual #315 • Individual #218 <u>Interviews and Meetings Held</u>: o Ralph Henry, Director o Daisy Ellison, Director of Psychology o Four residential direct care staff • Home 672W • Home 766 • Home 665 • Home 671 o Informal interviews with various staff in homes and day programs throughout campus <u>Observations Conducted</u>: o All day programs on campus o Residential homes: 665, 670, 671, 672, 673, 674, 766 o Human Rights Committee Meeting 2/11/10 o Incident Management Team Meetings 2/10/10 and 2/11/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: This facility policy #300-29 included all mandates from the state policy regarding the Use of Restraints (#001) with stricter guidelines incorporated into some parts of the policy. For the remainder of comments in Section C of this report, any reference to policy, unless otherwise stated, will refer to SASSLC procedure #300-29: Use of Restraints. In addition, the San Antonio State School Behavior Therapy Manual #300-18,

	dated 10/5/05 also outlined procedures to be followed for the use of restraints as behavioral intervention. It was evident throughout the monitoring visit that SASSLC had made it a priority to ensure that restraints used for behavioral intervention would only be used as a last resort measure. The facility had already prohibited the use of mechanical restraint for behavior intervention and had not used a physical restraint for crisis intervention on any individual at the facility for over 300 days. Restraint data indicated that the facility had reduced the use of physical restraints for crisis intervention from 291 incidents in FY08 to 38 incidents of restraint in FY09. Furthermore, the number of chemical restraints had decreased from 96 in FY08 to 47 in FY09. Data collected for the six months prior to the monitoring visit indicated that there had been 13 incidents of chemical restraints for behavior intervention and 10 protective restraints applied. The last documented incident of chemical restraint was 10/23/09. These numbers would indicate that there has not been a significant increase in chemical restraints to replace the use physical restraints. The data analysis report indicated protective restraints utilized included helmets and wristlets/anklets. Interviews with staff of various levels and attendance at clinical meetings consistently spoke to the commitment to reduce restraint use at San Antonio State Supported Living Center. All staff interviewed were able to articulate this commitment and explain how they were going to accomplish this goal. They talked about increasing antecedent control, having better understanding of the variable or variables affecting restraint use, and focusing on prevention of the behaviors that provoke restraint. In the Behavior Therapy Committee meeting, where the psychology staff reviewed new and updated behavior support plans, the director of psychology repeatedly challenged staff to identify how the PBSP could be modified to reduce an individual's prescribed medications. Finally, the data clearly showed that this commitment and effort had translated to a substantial reduction in restraint use. Currently, there were only two PBSPs that authorized the use of restraint. Both were plans that specified the use protective equipment when self-injurious behavior reached unsafe levels. Additionally, in both cases the time in protective equipment had been decreasing. Similarly emergency use of chemical, physical, and mechanical restraint has been zero for the last three months. Several strategies were credited with the ability of the facility to reduce the use of restraints. According to the facility director, an increased focus on active treatment and a concentrated effort to encourage a "team approach" to providing supports were significant factors in reducing restraint usage. Restraint Reduction Committee notes also indicated an increased effort to train all staff on implementing positive behavior supports. The facility's commitment to this effort in reducing restraints was impressive. There was, however, an additional concern noted in the area of restraint reduction. The concern was that several direct care staff indicated that the use of restraints was prohibited at the facility. Although it was clearly presented and documented by senior management that restraint was allowed as a last resort to maintain safety, this perception among some direct care staff could result in staff using methods that were prohibited by the facility, or result in the unreported use of restraint if staff felt that their or others' safety

	was at risk and they could not use authorized restraint.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Assessment of this item required review of policies and an examination of implementation of those policies. State and facility policies existed to address the provisions of the Settlement Agreement regarding restraints. The state policy was labeled "Use of Restraints," numbered 001, and dated 8/31/09. It included five addenda guidelines and forms. The facility had adopted most of the state policy to use as the facility policy, with a few revisions and clarifications to sections of the policy. The use of prone restraint was prohibited by the policy. In addition, the use of mechanical restraints other than approved protective restraints had been discontinued by the facility. There was no evidence that prone or mechanical restraints other than protective restraints were in use at the facility. Staff who were interviewed were aware of the mandates prohibiting the use of prone and mechanical restraints. Some direct care staff, during informal discussions with monitoring team members during tours of the residences and day activities, said that restraint was not allowed at the facility. This information was presented to the facility director. He indicated that he and the senior management team would clarify with all staff that restraint was not prohibited and that it was allowed to be used when needed as per their training. Policies mandated that restraints may only be used if the individual posed an immediate and serious risk of harm to him/herself or others in item II.C.3, and after a graduated range of less restrictive measures in item II.B. Item II.C.2 stated that restraints would not be used for punishment, for the convenience of staff, or in the absence of or as an alternative to treatment in item. The policy outlined when and how restraints were to be used and described procedures that staff must follow regarding monitoring and documentation of restraint use. These policies were in line with the contents of this settlement agreement item. Staff were required to complete initial training and were retrained annually on the use of restraints. This was supported by documentation in the staff training records reviewed and discussions with staff interviewed during the review. An action plan developed in conjunction with the 1st quarter FY10 data analysis trending report included the recommendation to delete restraint from behavior programs. This recommendation further noted that the number of behavior plans with approved restraint interventions has been reduced from 70 to 2. Efforts were underway to fade the use of these restraints in these remaining plans, as well.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Policy item I.1 mandated that restraints be terminated as soon as the individual was no longer a danger to himself, herself, or others. SASSLC's policy on release from restraint specified shorter maximum time limits for each type of restraint than the state policy. The policy stated that PMAB basket holds must be released within 30 seconds. Horizontal restraints longer than five minutes were prohibited unless there was a physician's order to extend the restraint longer. Contingent mechanical restraints were limited to 30 minutes. If the individual was not calm after 15 minutes, he or she had to be released, or a physician's order had to be obtained in order to extend the restraint. An individual in protective restraints treatment must be released after 50 minutes for a period of at least 10 minutes. (The state policy mandated release for five minutes after each 55-minute period.)	
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.	Prevention and Management of Aggressive Behavior (PMAB) was used at all facilities across the state and was the specific training program identified in the state and facility policy. Section L of the policy described the types of restraints that were allowed to be used and listed restraint types that were specifically prohibited. There was no evidence that any prohibited restraints had been used during the period reviewed. Physical restraints allowed included: a. PMAB horizontal or follow down restraint, b. PMAB basket hold for no more than 30 seconds, and c. holding a person's hands, arms, or legs. Mechanical restraints allowed by PMAB included: a. arm splints or elbow immobilizers, b. arm or leg pads, c. belts, helmets, mittens, d. wristlets, e. binders, and f. jumpsuits or leotards. The policy further described each of these restraints. There was no evidence that any other physical or mechanical restraint had been used by the facility in the six-month period reviewed. Section III.B of the policy addressed staff training mandates regarding the use of restraints. Policies required that, before working with individuals, all staff responsible for applying restraint techniques have to successfully complete competency-based training on approved verbal intervention and redirection techniques, approved restraint techniques, and adequate supervision to any individual in restraint.	

#	Provision	Assessment of Status	Compliance
		Training transcripts that were reviewed for this report documented that staff received training RES0105 Restraint: Prevention and Rules for Use of Restraints at MR Facilities, and Competency Based PMAB training upon initial hiring and were retrained at least annually. Informal interviews with staff confirmed a basic knowledge of policies regarding restraint, including prohibited restraints and required documentation and follow-up. Although in several cases, staff stated that all restraints were prohibited. This was brought to the attention of facility management during the on-site tour. Facility management stated that restraints were not prohibited. Facility management noted the efforts that had gone in to teaching staff how to avoid restraint, but that staff should know that restraint could be used when required, such as in an emergency situation. Facility management told the monitoring team that they would ensure this was clarified with all staff at SASSLC. When staff were questioned about what they do if an individual begins engaging in aggressive behavior, direct care staff consistently talked about antecedent approaches or redirection approaches to managing the behavior. Staff also consistently stated that they felt well trained and comfortable with strategies contained in specific PBSPs for deescalating aggressive behaviors. Staff reported that they were comfortable in seeking additional information from psychology staff assigned to their work area and, furthermore, staff indicated that psychology support staff were readily available and helpful when they needed additional support or information on implementing plans. Homes with the highest number of behavioral incidents had a psychology support staff person assigned to work at each of those homes with an office located at the home. It was observed during the on-site review that psychology staff were on the floor, available, and involved with individuals and their direct care staff. Homes with lower behavioral intervention needs shared psychology support staff with other homes, but direct support staff still indicated that they had support readily available to them. During night shifts, when psychology staff was not on duty at each home, support staff indicated that campus coordinators made rounds frequently and responded quickly to provide back up support if a behavioral crisis occurred. The corrective action plan developed in conjunction with the 1st quarter FY10 data analysis report on restraint use included the following action step: A new monitoring form was being used. The form was to assess staffs' knowledge of precursor and antecedent behavior interventions, interventions for target behaviors, observation of staff implementing PBSPs, monitoring PBSPs and role-playing. The facility is to be commended for continuing to explore ways to increase staff competency in providing positive behavior supports.	
C4	Commencing within six months of	The policy section I.a stated that restraints may only be used for crisis intervention or	

#	Provision	Assessment of Status	Compliance
	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.	medical reasons. There was no indication that restraints had been used at the facility other than for crisis intervention or medical reasons. Section II stated that at least annually, or when significant changes occurred to the extent and nature of the identified conditions and factors, the PST must ensure that a physician, advanced practice nurse, or physician assistant reviews and updates, as necessary, the identified conditions, factors, and limitations on specific techniques or mechanical devices for restraint. PSPs did not indicate the review of mechanical restraint use by medical staff, or the conditions and limitations of their usage. A specific review of medical restraints was not conducted during this baseline review though it was noted that medical restraints, particularly during dental procedures were used for a high number of individuals reviewed. Out of 17 PSPs reviewed, seven of these indicated that the individual was restrained for dental procedures (Individual #45, Individual #302, Individual #113, Individual #68, Individual #227, Individual #24, and Individual #40). The corrective action plan developed in conjunction with the 1st quarter FY10 data analysis report on restraint use included the following action step: "The next area of focus will be in the area of medical and dental sedation and restraint. Psychology Assistants will be training on desensitization training and other areas of need. A new goal is to have at least 10 percent of the persons served involved in training that will focus on reduction and elimination of dental and/or medical sedation and restraint." Hopefully, the facility will be as successful in reducing the number of dental and medical restraints. A Human Rights Committee (HRC) meeting was observed during the on-site monitoring visit. Medical restraints were reviewed and the committee asked about any methods that had been attempted to eliminate the use of restraints for the individual. The committee, however, did not have enough information at the meeting to know what had or had not been tried. Specifically, the committee had questions regarding the information submitted and the members requested additional information before making a recommendation. They did this because there was not anyone present at the meeting to answer some of their questions QMRPs were not a part of the meeting and, thus, very little additional information was available other than the information contained in a few documents provided to the team. One way of addressing this would be to have the QMRPs attend HRC meetings to present information for the individuals that they support. This would help the team make informed decisions regarding restraints and other rights restrictions, however, the monitoring acknowledges the already busy schedules of the QMRPs as discussed in section S below. During upcoming monitoring visits, the used of medical restraints and procedures to reduce or eliminate their use will be reviewed.	

#	Provision	Assessment of Status	Compliance
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Policy sections F and G mandated monitoring of restraints with a face-to-face assessment of individuals within 15 minutes of the application of any restraint. Staff were required to complete a Face-to-Face Assessment, Debriefing, and Review checklist for each incident of restraint applied for crisis intervention. There were no restraints used in the six months prior to the review period and, thus, there no restraint monitoring forms were completed. Policy section H.3 addressed monitoring of individuals following restraints applied away from the facility with provisions of this agreement. Mandates met this provision of the Settlement Agreement. There were no documented instances of restraints used away from the facility.	
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.	The facility had a Restraint Checklist and Face-to-Face Assessment, Debriefing, and Review checklist for use when restraint was applied for crisis intervention. This form included a check for restraint related injuries. Again, there were no incidents of restraint to be documented, so this process could not be reviewed. Facility policy C.11 addressed safety and supervision during restraint. This policy met the standards of this provision.	

#	Provision	Assessment of Status	Compliance
	Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.		
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:	Policy J.5 addressed this section of the Settlement Agreement requiring the PST to review restraints and address factors that may be contributing to the exhibited behaviors requiring the use of restraints. Although data and trending were available on the use of restraints, there was no recent occurrence of an individual receiving more than three restraints in any rolling 30-day period. The adequacy of the assessment process for any individuals who have been placed in restraint more than three times in any rolling 30-day period will be reviewed during upcoming monitoring visits. The adequacy of Behavioral Assessment, Positive Behavioral Support Plans, and Crisis Intervention Plans is addressed elsewhere in this report.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	See note C7 above.	
	(b) review possibly contributing environmental conditions;	See note C7 above.	
	(c) review or perform structural assessments of the behavior provoking restraints;	See note C7 above.	
	(d) review or perform functional assessments of the behavior	See note C7 above.	

#	Pro	Assessment of Status	Compliance
	provoking restraints;		
	(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;	See note C7 above.	
	(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	See note C7 above.	
	(g) as necessary, assess and revise the PBSP.	See note C7 above.	
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	This requirement was addressed in the agency policy, but implementation could not be verified because there were no incidents of documented restraint.	

#	Provision	Assessment of Status	Compliance
	days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.		

Recommendations:

1. Continue to focus on developing desensitization programs for individuals currently using medical and dental restraints.

2. Consider ways for the Human Rights Committee to have complete and thorough information. One way might be for QMRPs to present information at the Human Rights Committee meeting for the individuals whom they support.

3. Ensure that a physician, advanced practice nurse, or physician assistant reviews and updates, as necessary, the identified conditions, factors, and limitations on specific techniques or mechanical devices used for restraint for each individual who has an approved restraint in use.

4. Ensure staff know that restraint can be used in an emergency situation, that is, that restraint is not prohibited.

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:** o State Policy #002.1: Protection from Harm – Abuse, Neglect and Incident Management o Unusual Incident Report Coding and Reporting Matrix o SASSLC Procedure # 300-20: Protection From Harm, Abuse, Neglect and Incident Management o List of all injuries 7/1/09-1/31/10 o Log of DFPS Investigations 9/9/09 – 12/31/09 o Log of all ANE Investigations 7/1/09 – 1/31/10 o List of 10 Individuals with most injuries 7/1/09-1/31/10 o List of all fractures and sutures 7/1/09-12/31/09 o List of all individuals with injuries 7/1/09-12/31/09 o List of all incidents by individual 7/1/09 – 12/31/09 o Sample of PSPs (see list in Section C) o Sample DADS memorandum dated 9/8/06 regarding self reporting and attached form requiring employees to disclose all arrests, indictments and convictions. o Campus Coordinator Log February 9, 2010 o Review of staff training transcripts for four residential direct support staff: • Home 672W • Home 766 • Home 665 • Home 671 o Incident Management Meeting Minutes for the following time periods • 7/13/09-7/17/09 • 9/1/09-9/4/09 • 10/19/09-10/23/09 • 1/4/10-1/8/10 o Sample of Closed DFPS Investigative Reports from 8/09-1/10 (16 total) • #3309515 8/31/09 Neglect Unconfirmed • #33428991 9/24/09 Physical Abuse Unconfirmed • #33447410 9/25/09 Neglect Unconfirmed • #33400129 9/22/09 Neglect Unconfirmed • #33537753 9/29/09 Neglect Unconfirmed • #33906451 10/26/09 Neglect Confirmed • #33968629 11/02/09 Physical Abuse Unconfirmed • #33980231 11/2/09 Abuse Referred back to facility • #34293909 11/29/09 Physical Abuse Unconfirmed • #34380309 12/4/09 Sexual Abuse Unconfirmed • #34482069 12/10/09 Neglect Unconfirmed

	• #34518230 12/13/09 Neglect Confirmed • #34580349 12/17/09 Physical Abuse Unconfirmed • #34648249 12/21/09 Physical Abuse Confirmed • #34674109 12/23/09 Neglect Unconfirmed • #35677249 12/23/09 Neglect Confirmed • #34695609 12/27/09 Physical Abuse Unconfirmed • #34855469 1/11/10 Abuse Unconfirmed o Sample of unusual incidents investigated by the facility • #415293 9/12/09 Serious Injury-Consumer to Consumer Aggression • #10-004 9/20/09 Serious Injury-Consumer to Consumer Aggression • #10-005 9/23/2009 Consumer to Consumer Aggression • #00543 9/25/09 Alleged Ingestion of Medication • #10-022 12/3/09 Serious Injury – Undetermined Cause • #10-020 12/6/09 Death by natural causes o Employee criminal background checks for four residential direct care staff: • Home 672W • Home 766 • Home 665 • Home 671 <u>Interviews and Meetings Held</u>: o Four residential direct care staff • Home 672W • Home 766 • Home 665 • Home 671 o Laurence Alqueseva, QE Program Auditor o Letecia Jalomo, ANE Coordinator o Michelle Rodriguez, Facility Investigator <u>Observations Conducted</u>: o All day programs on campus o Residential homes: 665, 670, 671, 672, 673, 674, 766 o Human Right Committee Meeting 2/11/10 o Incident Management Team Meetings 2/10/10 and 2/11/10 o Morning Meeting for Homes 671 and 672
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.

	Summary of Monitor's Assessment: SASSLC had policies in place to address identifying, reporting, and investigating incidents of abuse, neglect, and exploitation. All staff interviewed were familiar with the policies and had received training consistent with facility policies. Information regarding identifying and reporting abuse and neglect was posted in each building in the facility. There was a system in place for completing internal investigations and referring investigations to DFPS and DADS regulatory for review. The facility policy mandated that all serious injuries of unknown cause were to be referred to DFPS for investigation. Policies did not address the reporting of non-serious injuries of unknown cause for investigation. It was not clear how it was determined when, or how, non-serious injuries were to be investigated at the facility. According to a log provided to the monitoring team by the facility, there were 119 investigations completed for abuse and neglect at the facility between July 2, 2009 and January 18, 2010. The 119 incidents included 215 allegations of abuse or neglect. Only 17 of these were substantiated and confirmed as cases of abuse and neglect. The others were either unconfirmed, inconclusive, or referred back to the facility by DFPS as administrative issues. A majority of the cases reviewed were for injuries of unknown cause where there was no known perpetrator and/or no significant evidence to support abuse or neglect. It appeared that there was no hesitation by the facility to report to outside authorities as required. In the 17 confirmed cases, employees received some type of disciplinary action in three of those cases. There were several cases of the 17 where disciplinary action was still pending even though the allegation had occurred more than 30 days prior. The current policy stated that the facility director or Adult Protective Services supervisor can grant a written extension for an investigation because of extraordinary circumstances. A review of DFPS investigations revealed a trend of lengthy investigations where approval for extensions were requested and some cases took as long as 45 days to complete. In many cases, multiple extensions were requested to extend the investigations due to employee holidays, staff on leave, and failure to schedule interviews. It appeared that in the most recent investigations there has been greater effort at completing investigations in a timely manner.

#	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.	Assessment of this item required review of policies and an examination of implementation of those policies. The policy was labeled "Protection from Harm-Abuse, Neglect, and Incident Management." It was numbered 002.1, and was dated 11/6/09. It included a number of addenda and forms, such as regarding unusual incidents, high profile incidents, and staff reporting. This was the state policy and was adopted, in whole, by the facility. The facility policy was titled and numbered SASSLC Procedure #300-20: Protection From Harm, Abuse, Neglect and Incident Management. Further reference to policy in this section of the report will refer to the facility policy #300-20. The policy clearly indicated that abuse and neglect of individuals would not be tolerated and required staff to report any abuse or neglect of individuals. All staff were required to report suspected abuse, neglect, and exploitation. There were posters regarding this mandate posted in each facility visited and all staff interviewed were able to relay this information.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that	The policy specified reporting requirements for all serious incidents and was in line with this provision. The facility utilized a standardized reporting form for all serious injuries and incidents. In the sample reviewed, the facility reported all serious incidents to the facility director and to DFPS if warranted. It was documented that most incidents were reported to the facility director or AOD within one hour, however, it was noted that some incidents were not reported within the required timeline. Incident #10-006 occurred at 9:30 pm and was reported to the facility AOD at 11:05pm, one hour and 35 minutes after the incident occurred. In DFPS case #34518230, the incident occurred on 12/11/09 at 7:15 pm and DFPS was not notified until 12/13/09 at 4:09 pm; DFPS case # 33093515 occurred on 8/30/09 at 10:30 pm and DFPS was not notified until 8/31/09 at 1:17pm; and DFPS case # 33537753 occurred on 9/29/09 at 8:00 pm and DFPS was not notified until 10:12pm.	

#	Provision	Assessment of Status	Compliance
	official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	These three cases all involved serious injury with allegations of neglect. Policies mandated that all incidences of suspected abuse, neglect, or exploitation were to be reported to DFPS within one hour.	
	(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 policy mandated immediate action and reporting of all allegations of abuse, neglect, and exploitation, and any serious injuries. Initial staff inservice training included training on recognizing and reporting incidents of abuse and neglect (Course ABU0100) that was to be provided upon initial hire and annually for tenured staff. Staff interviews confirmed that staff were aware of the mandate to immediately protect the victim from further harm. Further, facility staff appeared to take immediate and appropriate action to protect individuals involved. Observation of facility Incident Management Meetings confirmed that participants discussed each incident and made recommendations to further protect the individual if warranted by increasing staffing ratios or requesting other additional supports as needed. For example, in case #10-005, consumer-to-consumer aggression, the level of supervision for the aggressor was immediately increased to 1:1 supervision. In case #10-022, serious injury of undetermined cause, the level of supervision was increased to 1:1 supervision, the nurse developed an acute care plan and campus coordinators began monitoring the home at an increased level. Immediate corrective action was stated in the report for each investigation reviewed. In all cases reviewed, a nurse completed an immediate assessment of the individual and recorded findings on a standardized Client Injury Report Form. The policy addressed the reassigning of alleged perpetrators. It was evident that alleged perpetrators were routinely reassigned until investigations were completed. A review of Incident Management Meeting minutes indicated that employees remained on reassignment until investigations were completed. A log of all investigations since July 2009 indicated that staff were not routinely disciplined immediately when allegations of abuse or neglect were confirmed. Out of 17 confirmed allegations, there was a known perpetrator in 12 of the cases. There were only three instances where staff received some form of disciplinary procedure. In eight cases, disciplinary action was still listed as pending.	

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
The following is a summary of action taken in regards to the 17 confirmed allegations:
<table>
<tr><th>Case Number</th><th>Date</th><th>Allegation</th><th>Perpetrator</th><th>Disciplinary Action</th></tr>
<tr><td>1481</td><td>7/8/09</td><td>Neglect</td><td>Unknown</td><td>None</td></tr>
<tr><td>1488</td><td>7/4/09</td><td>Neglect</td><td>Unknown</td><td>None</td></tr>
<tr><td>1498</td><td>7/16/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
<tr><td>1505</td><td>7/27/09</td><td>Neglect</td><td>Known</td><td>Written Reprimand</td></tr>
<tr><td>1506a</td><td>7/27/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
<tr><td>1506b</td><td>7/27/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
<tr><td>1578</td><td>9/17/09</td><td>Abuse</td><td>Known</td><td>Pending</td></tr>
<tr><td>1593</td><td>9/28/09</td><td>Neglect</td><td>Unknown</td><td>None</td></tr>
<tr><td>1606</td><td>10/2/09</td><td>Neglect</td><td>Unknown</td><td>None</td></tr>
<tr><td>1618a</td><td>10/26/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
<tr><td>1618b</td><td>10/26/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
<tr><td>1621</td><td>10/27/09</td><td>Neglect</td><td>Known</td><td>Resigned</td></tr>
<tr><td>1623a</td><td>10/28/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
<tr><td>1623b</td><td>10/28/09</td><td>Neglect</td><td>Known</td><td>Dismissed</td></tr>
<tr><td>1630</td><td>9/12/09</td><td>Abuse</td><td>Known</td><td>Suspended</td></tr>
<tr><td>1657</td><td>12/13/09</td><td>Neglect</td><td>Unknown</td><td>None</td></tr>
<tr><td>1663</td><td>12/23/09</td><td>Neglect</td><td>Known</td><td>Pending</td></tr>
</table>
It was not clear why disciplinary action was delayed in cases where disciplinary action was listed as pending. In regards to case #1618, the investigation was completed on 11/23/09, but disciplinary action was still pending at the time of the on-site monitoring visit. The facility needs to develop a system for taking quick action in resolving investigations and following through with recommendations. This issue will be reviewed in greater detail at upcoming monitoring visits.
</td><td></td></tr>
<tr><td></td><td>(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.</td><td>The facility provided initial training and annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect and exploitation. Documentation of training was kept by the facility and a small sample was reviewed. Training transcripts for the employees interviewed showed that of the four employees, all had received initial training on abuse and neglect. One of the four employees, however, had not received retraining annually.

During interviews, all employees were able to give accurate examples of abuse and neglect and verbalized their responsibility for reporting such incidents. A larger sample</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		of training records will be reviewed for reviewing this provision item during future monitoring visits.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	The policy addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. Facility policy required employees to sign form 1020 (implemented July 2009) acknowledging their responsibility to report abuse, neglect, and exploitation. A sample of staff personnel records was not reviewed during this initial review to verify the existence of these signed statements, however, this will be verified during future reviews. In all facility buildings toured during the review, posters stating the obligations of mandatory reporters were posted in common areas.	
	(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.	The policy stated that a training and resource guide on recognizing and reporting abuse and neglect will be provided by the facility to all individuals and their LARs at admission and annually. The state developed a brochure (resource guide) with information on recognizing abuse and neglect and information for reporting suspected abuse and neglect. Some, but not all, PSPs included documentation that this brochure was shared with the individual and his or her LAR (if applicable) at annual PST meetings. Clear reporting information was also posted in each building in the facility.	
	(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.	All facility buildings toured had posters with a statement of individuals' rights called "You Have the Right" posted in common areas. These posters included information on reporting violation of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read.	

#	Provision	Assessment of Status	Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	Policies addressed referring investigations to local law enforcement officials when a criminal act had occurred. The policy did not give criteria for such referrals beyond the statement that "any suspicion of criminal activity" be reported. Of the sample of 18 investigations reviewed, four were referred to local law enforcement agencies by DFPS. It was not clear what action was taken, if any, by the law enforcement agency. This provision item will be further reviewed during upcoming monitoring visits.	
	(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.	Policies prohibited retaliatory action for reports of an allegation of abuse or neglect. The policy specified how to report retaliatory action and stated that employees engaging in retaliatory action were subject to employee disciplinary procedures. All staff interviewed stated that they were not hesitant to report suspected abuse, neglect, or mistreatment, and were able to state to whom incidents of abuse, neglect, and mistreatment should be reported.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There did not appear to be an audit process in place to determine whether or not significant injuries were reported for investigation. A review of documentation of serious injuries supported that they were routinely reported for investigation, and this was confirmed by looking at individual reports. A log of serious injuries was provided to the monitoring team prior to the review, but it did not indicate which injuries were reported for investigation. The log documented a total of 28 serious injuries including fractures and injuries requiring sutures or staples in the period between 7/09 and 1/09. According to the Facility Investigator, all serious injuries were investigated by either the facility investigator or the campus coordinators and then referred to DFPS or DADS as required.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and		

#	Provision	Assessment of Status	Compliance
	implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The facility policy addressed the conduct of investigations and qualifications of investigators. The policy stated that all investigators who were responsible for completing all or part of the Unusual Incident Report must complete the course, Comprehensive Investigator Training (CIT0100) within one month of employment or assignment as an investigator, and prior to completing an Unusual Incident Report. Additionally, the Incident Management Coordinator and Primary Investigator(s) must complete the Labor Relations Alternative's (LRA) Fundamentals of Investigations training (INV0100) within six months of employment The Facility Investigator stated that she had completed CIT and LRA training along with the campus coordinators and QMRPs. When interviewed, the facility investigator was knowledgeable about the investigation process and requirements. Having several trained investigators on campus ensured that investigations could begin promptly when the primary facility investigator was not available.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The policy referred to cooperation with DFPS and law enforcement agencies in conducting investigations. Interview with the facility investigator, and review of a sample of completed investigations indicated investigations were a cooperative effort with DFPS investigators. The facility investigator described incident types and the process for reporting to DFPS and DADS.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	Four investigations out of the sample of 18 investigations reviewed were reported to law enforcement; documentation indicated the date and time of report. Policies stated that a referral will be made to law enforcement when the incident involved criminal conduct. The facility investigator stated that the facility had a good working relationship with local law enforcement agencies and worked cooperatively with them.	
	(d) Provide for the safeguarding of evidence.	The policy described procedures for safeguarding evidence in the event of a serious incident. DFPS investigations were not completed in a timely manner leading to questions of whether or not investigators were able to gather all evidence while it was still available.	

#	Provision	Assessment of Status	Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The policy addressed timelines for investigations. The policy required that investigations commence within 24 hours, but allowed for investigations to be completed within 14 days (10 days after June 1, 2010). The policy did not meet requirements of this provision item. DFPS investigations commenced within 24 hours of notification for all incidents reviewed, but were not completed within 10 days. The policy allowed for the facility director to approve an extension of the investigation in extraordinary circumstances. Of the 17 investigations completed by DFPS, only one (the most recent one) was completed within 10 days. Five of the others took more than 30 days to complete. The sample of internal investigations reviewed indicated that investigations completed by the facility all commenced within 24 hours of the incident and were generally completed within 10 days. Only one of the five cases in the sample was not completed within 10 days. Case #10-002 was not completed until 27 days after the incident. There was no indication in the report as to why this occurred. All investigations reviewed included a summary of the investigation, findings, and recommendations for corrective action.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a	The policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. All items listed in this provision item were included in each of the investigations reviewed both by the facility and by DFPS. Investigation files were consistently compiled in a clear and easy to follow format.	

#	Provision	Assessment of Status	Compliance
	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.		
	(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.	The policy required that a summary of the investigation be sent to DADS regulatory within five working days of the incident and a final DFPS report be completed within 14 working days for review by DADS regulatory. The facility director reviewed final internal investigations. Internal investigation reports were submitted to the facility director and DADS for review when completed. Of the five unusual incident investigations reviewed, three were submitted for review within seven days. In case #415293, the incident occurred on 9/12/09, the facility director dated his review as 9/16/09. It was submitted to DADS for review on 9/18/09. The fourth case (#10-022) was not reviewed by the facility director until 27 days after the incident.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Each written report of unusual incidents was written in a clear and consistent manner. Reports included an in depth summary of investigative procedures, relevant history, personal information about the individual, a list of immediate corrective actions to be taken, and an analysis of findings and recommendations for remedial action to be taken.	
	(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.	For incident files reviewed at the facility, there was some evidence that prompt action was taken to correct the situation and/or prevent reoccurrence when indicated necessary by the investigation. For example, during the review, it was observed that immediate action was taken to increase staffing levels for individuals with injuries. Physical therapy reviews were completed following fall incidents if indicated and PBSPs were reviewed for injuries caused by incidents of aggression between individuals. Actions were reviewed and documented during morning incident management meetings and information was shared at shift change meetings in the residences.	

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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.	A review of investigation records from the past year confirmed that files were maintained and were easily accessible for review. Logs were compiled by incidents involving particular individuals. Trends were not provided to the monitoring team regarding incidents involving particular staff. This will be reviewed further in upcoming monitoring visits.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. It was not evident that the facility used these data in any type of overall trending report to assist in quality enhancement activities. Trends for particular individuals were addressed by PSTs and individual corrective action plans were developed for those individuals. The monitoring team will review the efficacy of corrective action steps implemented by teams further in upcoming reviews.	
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	Criminal background checks were reviewed for the four direct care staff interviewed. Background checks were in place for all four employees. These appeared to be routine for newly hired staff. Employees were also required to complete a form disclosing all arrests, indictments, and convictions immediately upon employment. A sample of this form was reviewed. The degree to which volunteers were subject to the same screening was not reviewed at this time. Additional review of this system for both employees and volunteers will occur during future monitoring visits.	

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	the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.		

Recommendations:

1. The Protection from Harm policy should be revised to offer clear guidance to staff on when non-serious injuries should be reported to DFPS and other regulatory authorities.

2. The facility needs to implement a system for ensuring that all employees complete annual retraining on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation.

3. Every effort should be made to complete all investigations in a timely manner and follow up on recommendations in a reasonable timeline. The facility needs to set forth clear policies on when an extension can be granted to extend an investigation beyond 10 days.

4. Implement an audit process to determine whether or not significant injuries were reported for investigation.

5. Data gathered on incident and injury trends should be analyzed and a summary of findings should be used to develop specific objectives in the facility's quality improvement plan.

6. Implement quicker resolution when staff discipline is required following confirmed cases of abuse or neglect.

7. Ensure all individuals and their LARs receive the annually required information regarding abuse and neglect.

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:** o DADS Policy #003: Quality Enhancement, dated 11/13/09 o SASSLC Policy #200-1: Quality Enhancement o SASSLC Policy: 300-39: Recordkeeping Practices o SASSLC Plan of Improvement o Quality System Oversight (QSO) Scoring Guide for Person Directed Planning Process dated 12/09 o Quarterly Trend Analysis report for 4th Quarter 2009 o Blank auditor observational tools for four areas noted below o Various emails and notes regarding issues found during QE activities o Corrective Action Plan for Injuries 1st Quarter FY10 o Action Plan/Plan of Improvement: Aggression 10/09 o Personal Support Plan Meeting Monitoring Checklist o Physical Management Plan Monitoring Tool (SOP 300-43) o Home Management Team Checklist o Habilitation Therapies – Meal Observation Sheet o Sample of completed unusual incidents reports o Log of ER visits from 1/1/09 – 12/31/09 o Log of all injuries by individual 7/09-1/10 o Log of fractures and sutures 7/09-1/10 o List of 10 individuals with the highest number of injuries (requested document VI.4.d) o Log of Individuals assessed by SASSLC at Risk Level 1 (High) o Incident Management Meeting Minutes for the following time periods: • 7/13/09-7/17/09 • 9/1/09-9/4/09 • 10/19/09-10/23/09 • 1/4/10-1/8/10 <u>Interviews and Meetings Held</u>: o Larrie Collier, Director of Quality Enhancement o Informal interviews with various care staff, QMRPS, nursing, and psychology support staff in homes and day programs throughout campus o Laurence Alqueseva, QE Program Auditor o Letecia Jalomo, ANE Coordinator o Michelle Rodriguez, Facility Investigator <u>Observations Conducted</u>: o All day programs on campus o Residential homes: 665, 670, 671, 672, 673, 674, 766 o Incident Management Team Meetings 2/10/10 and 2/11/10

	o Morning Meeting for Homes 671 and 672
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: It was evident that the Quality Enhancement department was in the beginning stages of developing a system to monitor the facility's progress towards complying with provisions of the Settlement Agreement. Many of the quality enhancement activities at SASSLC were still in the initial stages of development. At the time of the on-site tour, the facility had a fragmented quality assurance system in place to address specific issues within the facility. For example, the facility had several monitoring tools in place, but the information appeared only to be used to address recommendations specific to single issues rather than addressing system issues that might have a broader impact on reducing or eliminating these problems. The Incident Management Team, led by the facility director, met daily to review unusual incidents, allegations, significant medical issues, and rights restrictions. The meetings included a brief discussion of incidents and specific recommendations were made to address issues. Any follow-up action completed for prior issues was reviewed by the team. Habilitation and residential units met daily to review any new or outstanding issues, including changes in status and supports provided to particular individuals. These meetings included direct care staff, home supervisors, QMRPs, psychology staff, and nursing staff. Smaller "huddle" meetings were also held at each shift change to share information among staff. Staff assignments were made for follow-up when recommendations were made regarding specific issues. It was evident that a system had been put into place to facilitate frequent communication among staff at all levels. This was an effective means of assuring that issues were tracked and followed up on until resolved. The facility was just beginning to address the quality of planning and implementing comprehensive services and supports for individuals. See section F below for additional comments on the development of quality enhancement systems to evaluate Person Directed Planning.

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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	The state policy regarding quality assurance was fully adopted by the facility. The policy was titled, "Quality Enhancement." It was numbered 003 and dated 11/13/09. The policy called for a quality assurance system that, if implemented, would meet the requirements of this provision of the Settlement Agreement. The policy had a number of addenda and forms that were to be used for the QE plan, corrective action plans, tracking of these plans, and operation of the performance improvement council.	

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	receiving services and supports.	SASSLC was at the initial stages of putting this policy into place. A director of quality enhancement had been appointed and there were three or four staff assigned to this department, including two auditors and one nurse. The facility had a system in place to track data regarding the following three areas: • Unusual incidents • Abuse neglect cases and allegations • Restraints A quarterly trend analysis report of these three areas was reviewed. The report included data and information on only the above three areas. Overall, the report may provide a good basis for the further development of a comprehensive and quality QA/QE program and report. Some comments regarding this report and the facility's QA/QE program follow below. First, the report included a great deal of data on the above three areas. The first part of the report presented data in bar graphs comparing previous quarters and looking at data across homes, days of the week, and types of incidents and allegations. A single simple line graph showing successive quarters of data is recommended rather than the bar graphs and line graphs that included three years of data superimposed over one another. This will make it easier to observe and understand trends. Second, the second part of the report demonstrated some of the initial steps of quality improvement actions based upon data. This part of the report included some narrative summation of the data presented earlier in the report, but more importantly, presented some possible rationales for trends and some recommendations for improvement. For example, a campaign to promote safety was initiated in response to increased incidents, and using campus coordinators to help with behavioral crises was initiated as a way to continue to maintain a reduction in use of restraint. Third, data from a variety of additional areas of the facility's operations must be included. A number of these areas were listed in the policy (e.g., section III on page 10). Moreover, a number of provisions of the Settlement Agreement called for the development and implementation of a quality assurance process. These areas should also be included in the facility's QA/QE program. Fourth, a typical outcome measure usually assessed and tracked at facilities, such as SASSLC (and most agencies and companies) is the satisfaction of individuals, their families and LARS, staff, and affiliated providers (e.g., local hospital, community physicians, community employers). These groups are surveyed to assess their	

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		satisfaction across a range of areas, some broad, some very specific. The SASSLC QA/QE program should include a measurement of these types of satisfaction. Fifth, the QE department should be very thoughtful in its development of data collection, tools, and reports. The monitoring team recommends that the QA/QE system ensure that the system is developed to collect and present data that are (a) valid, (b) relevant and used by the facility, and (c) reliable. Further, the QA/QE system should itself be subject to review, feedback, and assessment. The SASSLC QE director and staff would benefit from have opportunities for training and coordination with central office DADS staff and with the QE staff from other facilities. Sixth, a review of the quarterly trend analysis report showed that data were trended by individual and program area and the information was used to develop corrective action plans for individuals, but a broader look at addressing system issues was not always evident (though some positive examples were noted, as indicated above). Seventh, also in development, according to the director of the department, were the following activities required by the policy on quality enhancement. The monitoring team is looking forward to learning about these components of the facility's QA/QE system at a future on-site tour. • Continuous improvement process • Performance improvement measures • Performance improvement reports Other QA/QE activities were occurring and deserve mention. For example, the QE department had observational recording tools for monitoring in the following areas. • PSP meetings • Active treatment • Dining • Home management team meetings It was good to see that the facility was beginning to look at these important areas from a quality perspective and that the department was utilizing direct observational methodology (rather than relying solely on documentation or solely on staff verbal reports). Observational tools and checklists were developed for all four of the above areas. These tools were implemented primarily by the two auditors. Overall, the forms captured a lot of good information about the processes that were being observed, but more work needed to be done on them. For example, implementation appeared to be sporadic and random, there was no assessing of inter-rater agreement, it was unclear as to how the information was used to give feedback to staff and managers, and there was	

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		no indication of how these measures fit in with an overall QE program at the facility. More specifically, the PSP meeting observational tool was dated November 2007 and still said "draft" on it. It should also be assessed for face validity, that is, whether the tool was measuring what it was supposed to be measuring. The active treatment observational tool looked at important aspects of engagement and active treatment, but it was unclear as to whether observations were for a consistent and predetermined period of time, when an observation should start and end, and what happened to the data once recorded. Similar questions about implementation also applied to the dining and home management team meeting tools. The monitoring team was pleased to see the initiation of these additional observational measures and looks forward to their development and refinement. In addition, the facility was able to provide the monitoring team with other data in the form of logs such as emergency room visits, hospitalizations, and individuals at high risk in particular areas. It was good to see that these data were being tracked, but there was no evidence that this information was analyzed or used to identify issues to be addressed in quality assurance activities.	
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.	As noted in the above section E1, the facility had begun to examine some data from some areas of facility operation. The quality assurance process at SASSLC was not yet developed and as a consequence there was not an organized manner of data analysis or the development and implementation of corrective action plans. The monitoring team requested corrective action plans and received a number of plans for individuals. In addition, there were a variety of copies of various emails, forms, notes, and lists regarding some of things observed by the QA/QE auditors when they implemented the observational tools discussed above in section E1. These documents were difficult to follow and it was unclear as to how these related to an overall corrective action and follow-up system. Topics included PNMP monitoring, and level of staffing and supervision. There were also copies of emails, including one from the director of QA/QE to unit directors called "Quarterly injury trends," a document called "Request to post training," some data for home 671, and lists of injury reports. Although these documents indicated that there was some communication going on between the QA/QE department and unit directors, it seemed disorganized and sporadic. Though not part of the QA/QE system, PSTs met in interim meetings to address problems and formulate a plan of action following any unusual incident or when trends were identified through data collected. PSP addendums addressing specific issues identified were in place assigning action to individual team members. Specific examples of PSP addendums to address issues that were identified included the following:	

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		• Individual #254 was identified as having a trend of aggression toward other individuals served. The team met on 10/18/09 following the compilation of the quarterly report for June, July, and August 2009 to discuss the trend. The three incidents noted occurred 6/3/09, 6/10/09, and 8/26/09. The team identified 14 episodes of aggression in June 2009, two in July, and three in August. It was not clear why these additional episodes were not included in the trend report. The team stated an anticipated outcome and developed action steps to address the issue. Not all action steps indicated who would be responsible for implementation or gave a specific timeline. • The team met to discuss Individual #66's injuries for September, October, and November 2009. Injuries reviewed included five minor injuries, including three scratches. The team concluded that there was a trend for scratches due to inadequate nail care. An action plan addressing nail care was developed, but implementation was not assigned to specific staff and there were no dates for completion. Corrective action plans addressing trends were developed for individuals when trends were identified in regards to injuries. These corrective action plans assigned a responsible person, due date, and evidence/documentation to be submitted for corrective action to be taken. Corrective action was developed by the team and submitted as an addendum to the PSP. The system for monitoring the effectiveness of these plans will be reviewed further during future monitoring visits. Again, the facility had begun some QA/QE processes, specifically in regards to injuries and incidents. Administrative staff from each program area and discipline met daily to review incidents at the facility and address problems. Staff were assigned follow-up and each item remained on the daily agenda to be discussed until action steps were completed. The facility had a Plan of Improvement (POI) that listed action steps facility staff were to take to meet the many provisions of the Settlement Agreement. This document and process can be part of a comprehensive QA/QE plan, but is not, by itself, a plan that can meet this provision of the Settlement Agreement. Moreover, the action steps of the POI should be evaluated to determine if the action steps are the correct actions for the facility. Facility and state staff might consider aligning the POI action steps with the content of the monitoring team's evaluative checklist tools.	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	The facility developed a communication system throughout the facility that should ensure that all team members were aware of their responsibilities in implementing plans. This will be reviewed further during upcoming monitoring visits.	
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.	For injuries and incidents, corrective action plans were monitored at morning incident management meetings and information stayed on the agenda until outcomes were met. If the problem still existed, additional action was recommended by committee members, as evidenced in the review of meeting minutes. A system for monitoring implementation of corrective action plans had not been fully developed at the time of the baseline review. This will be reviewed further during upcoming monitoring visits.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	There was no indication that individual corrective action plans were reviewed for efficacy or modified when needed. Most of the corrective action plans reviewed were developed from information in the last quarterly trend report, data from the next quarter should be used to measure the effectiveness of corrective action plans. This will be reviewed further during upcoming monitoring visits.	

Recommendations:

1. Establish a system to analyze data collected by the facility and use the information to develop quality enhancement priorities. Ensure data collection systems are both valid and reliable.

2. Develop a comprehensive QA/QE program.
   - Ensure inclusion of all relevant aspects of facility operation, state policy, and Settlement Agreement provisions.
   - Incorporate and include those other measures that are already being measured, or that the facility determines important to measure.
   - Include the components required by the policy, such as continuous improvement process, performance improvement measures, and performance improvement reports.
   - The POI may be a part of the QA/QE program, but should not be considered the facility's QA/QE plan.
   - Consider modifying the POI to align with the monitoring teams' evaluative checklist tools.

3. Implement corrective action plans for systems and facility-wide needs, not only for individuals.

4. Simplify data collection in trend analysis reports. A single line graph is recommended.

5. Develop a satisfaction measure for individuals, staff, family members and LARs, and affiliated agencies and providers.

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 Person Directed Planning Guide (Procedure 300-9, Rev. 7/15/09) o Personal Support Plan Guide (Procedure 300-9B, Implemented 8/1/2009) o Personal Support Plan Meeting Monitoring Checklist o Quality System Oversight (QSO) Scoring Guide for Person Directed Planning Process dated 12/09 o Review of staff training transcripts for four residential direct care staff o Sample of PSPs including: • Individual #113 6/16/09 • Individual #211 8/7/09 • Individual #45 3/13/09 • Individual #148 1/15/10 • Individual #145 11/6/09 • Individual #15 8/4/09 • Individual #302 2/12/09 • Individual #24 7/15/09 • Individual #341 9/28/09 • Individual #68 9/21/09 • Individual #254undated • Individual #227 10/23/09 • Individual #41 12/1/09 • Individual #313 10/16/09 • Individual #91 3/16/09 • Individual #40 12/4/09 o HRC Review of PBSP for: • Individual #276, Individual #261, Individual #315, Individual #218 <u>Interviews and Meetings Held</u>: o Ralph Henry, Director o Daisy Ellison, Director of Psychology o Lawrence Alqueseva, QE Program Auditor o Director of Vocational Services o Paul Valerio, Pre-Vocational Coordinator o Mary Ventara, Home Supervisor 766 o Meeting with the facilities Qualified Mental Retardation Professionals (QMRPs) o Interviews with five residential direct care staff • Home 672W

	• Home 766 • Home 665 • Home 671 • Home 672 o Informal interviews with various care staff, QMRPS, nursing staff, and psychology support staff in homes and day programs throughout campus <u>Observations Conducted</u>: o All day programs on campus o Residential homes: 665, 670, 671, 672, 673, 674, 766 o Human Right Committee Meeting 2/11/10 o Incident Management Team Meetings 2/10/10 and 2/11/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility was only in the beginning stages of addressing this provision of the Settlement Agreement and therefore most of the items in this provision were either not developed or not yet implemented thoroughly enough to allow for monitoring. Further, the state was in the process of writing a policy to address this provision. The facility was awaiting this policy and further direction from the state. Nevertheless, the facility implemented limited procedures in regards to Person Directed Planning (procedure 300-9) and Personal Support Plan development (procedure 300-9B). These procedures outlined some basic mandates regarding Personal Support Teams (PSTs) and Personal Support Plans (PSPs), but did not offer clear guidelines in developing person centered plans and did not meet the requirements of this section of the Settlement Agreement. A sample of 16 PSPs reviewed during the monitoring visit confirmed that there was an evolving process in developing person centered plans. The implementation dates on these 16 PSPs ranged from 2/09 to 1/10. The more recent plans clearly showed an effort to move towards developing plans based on the individual's needed supports, interests, preferences and long-term goals. Even so, plans still did not offer direct care staff clear information and guidance for providing integrated supports and meaningful programming. As noted below, the quality of plans reviewed varied greatly. Some plans offered no guidance for providing supports while others were fairly descriptive in the range of supports that the individual was receiving. Since not all plans had signature sheets attached, the monitoring team was not able to determine if some of the variances could be attributed to the difference in QMRPs, though that may be the case. There was a concentrated effort at the facility to provide active treatment to individuals. The monitoring

	team witnessed these efforts throughout the day and evening at every site visited. Each home had a daily active treatment schedule available and staff specifically assigned to implementing active treatment. It was noted, however, that a large number of individuals were either sleeping or not engaged in the program. There was an obvious effort to assure communication between staff, which would certainly improve the cohesiveness of supports provided to each individual. Staff met in what was referred to as "the huddle" between shifts to share information about any changes in supports or unusual incidents. Staff spent a few minutes reviewing any significant information and then used a couple of minutes to share agency philosophy and teach a "sign for the day." These meetings included direct care staff, campus coordinators, QMRPs, nursing, and psychology staff.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The DADS policy for this section had not been developed at the time of this on-site review. Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan. At the facility, interdisciplinary teams were called Personal Support Teams (PSTs).	
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.	PST meetings were facilitated by the QMRP assigned to each individual. Informal interviews with QMRPs during the review process revealed that they were generally aware of the range of supports and services being offered to the individuals whom they supported. The monitoring team did not focus on the adequacy of monitoring and revising treatments, services, and supports during this baseline review. When the monitoring team has had the opportunity to evaluate the adequacy of the process for assessing individuals and developing supports, we will comment further on this. The monitoring team's understanding was that DADS was in the process of revising a policy regarding Person Directed Planning.	
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	The QMRPs were responsible for coordinating the development and implementation of the PSP. The QMRPs indicated that the team met quarterly to review PSP progress. Of the 16 PSPs reviewed for this sample, only three had signature sheets attached verifying which team members participated in the development of the PSP. All PSP and PSP addendums should include a list of who participated in developing the plan. If key	

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	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.	members cannot be present to meet with the team, the PSP should reflect any efforts to obtain input from the team member prior to the PST meeting. The following is a summary of findings regarding team member participation found in the three PSPs that included a signature sheet. • Individual #211's PSP signature sheet indicated that he attended his meeting and the plan was developed by a team that included residential direct care staff, Vocational Manager, SLP, home supervisor, QMRP, and psychologist. He did not have an LAR. There were no key team members not in attendance. • Individual #148's PSP signature sheet did not indicate involvement from his LAR or QMRP in developing his plan. The body of the plan stated that the QMRP did attend the meeting and attempts were made to contact his mother regarding the meeting, but no response was received. • Individual #24's PSP signature sheet included signatures of her LAR, QMRP, and other key team members, but did not indicate whether or not she was present at her PST meeting or if direct care staff participated in planning. Direct care staff interviewed confirmed that they attended team meetings and were given the opportunity for input into the plan both at the meeting and outside of the meeting by ongoing discussion with the QMRP regarding supports and services. All of the direct care staff interviewed reported that if a service or support was not adequately addressing an individual's need, they could discuss it with the QMRP or other team members and that those team members would address the issue and call the team together if needed.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	It was expected that the new state policy will provide direction to the facility regarding this provision item (e.g., the type and frequency of assessments). The policy should include all of the required assessments noted in provisions throughout the Settlement Agreement. Information from assessments should be included in the PSP body and used to develop supports based on the individual's preferences and needs. As noted in a number of other sections in this report, the monitoring team found the quality of some assessments to be an area of needed improvement. In order for adequate protections, supports, and services to be included in individual's PSPs, it is essential that adequate assessments be completed that identify the individual's preferences, strengths and supports needed. This provision of the Settlement agreement will continue to be reviewed during upcoming monitoring visits.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines	A majority of the PSPs reviewed did not include a summary of services and supports that the individual was receiving. PSPs should clearly address all of the supports that an individual will receive, including a description of the residential, day, medical, and	

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	the protections, services, and supports to be provided to the individual.	therapy services, along with a schedule of when these services will be provided, where they will be provided, and what types of supports the individual will need throughout the day. • For example, Individual #211's PSP did not include his primary diagnosis, any relevant medical information, or risks that would guide staff in ensuring the safe delivery of services. His plan did not include a description of his preferences, interests, likes, and dislikes. It did not offer a description of what services he will receive, when supports will be provided, who will provide those support, and in what setting. It was noted during the review that Individual #211 was nonverbal and communicated with sign language and gestures, but this was not reflected anywhere in his plan. His plan should include a clear description of how he communicated. Furthermore, action steps in his plan included the use of verbal prompts. Action steps should be individualized to include strategies that staff can consistently use to support Individual #211 to achieve his desired outcomes. It was noted in Individual #211's PSP that a functional skills assessment was in the QMRP file, but a summary of this assessment was not included in the PSP. Unless support staff had access to assessments or at least a summary of findings from each assessment, this information was not beneficial in guiding supports to him and other individuals. His OT/PT section required inner lip plate, chair with armrest OR regular dining equipment. His plan should have clearly stated if adaptive equipment was needed and in what situations. The dental section stated, "will continue with cleaning," but did not indicate how often he should return to the dentist for cleaning and follow-up. The physical/medical section did not indicate any medical problems or diagnoses. The nutrition section indicated chopped diet, but did not give further direction on size, limits, or risks. The rights section just stated present and reviewed by the PST and HRC, but did not indicate which rights, if any, were restricted. The PSP should include a description of any restriction to rights, a justification of the restriction, and a plan to reduce or remove restrictions, if reasonable. • Individual #24's PSP, in contrast to many reviewed, contained a summary of protections, services, and supports. Her plan included a description and schedule of the supports that she received and a justification for most supports. Her health summary included current assessments, results, and recommendations. There was also a list of adaptive equipment that she used and current medications along with the reason prescribed for each medication. There was no systematic procedure for ensuring that assessment results were incorporated into the development and implementation of the PSP. PSP meetings, however, were convened to discuss changes and incidents as they occurred.	

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		When comprehensive policies are in place to address PSP development, the facility needs to be sure that QMRPs receive updated training on developing plans and a system is put into place for monitoring plans to ensure all treatments and supports for each individual are addressed each PSP.	
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).	Again, addressing this item will require direction from the state's forthcoming policy. PSPs reviewed did not focus on long range planning for living or working in the community. There appeared to be discussion by the team regarding living options at each PST annual meeting, but the discussion was limited to confirming that the individual liked where he or she was living. All PSPs reviewed addressed community living options by stating that the individual was content and happy with his or her current living option and not interested in exploring living in the community. Many of the PSPs reflected that the individual did not understand other living options, but none addressed this other than to say that the team shared the brochure "Making Informed Choices" with the individual. Below are summaries from three of the PSPs reviewed regarding the discussion of living options. These were typical of all the PSPs reviewed. PSPs should include a plan for exposing individuals to other residential options if the PST determines that the individual does not have enough information to make an informed choice regarding residential placement. • Individual #113's PSP included this summary in his Living Options Discussion Record: "Individual #113's verbal skills are very limited and he communicates almost exclusively via body language and facial expressions. Individual #113 was asked if he would like to live at this current home or if he would like to live someplace else. The team interpreted his expression as "pleasure" with his current environment preference. Team agreed that Individual #113 appears comfortable on [home] at this time." • Individual #40's PSP included this summary of discussion regarding community living options: "Information about living options, adult foster care, community group homes and other state schools were given to Individual #40 in plain, simple language. However, she did not appear to comprehend the information. Individual #40 only speaks uses certain phrases, and, therefore, was unable to voice her preference of living options. However, she appears comfortable and content in her current environment, as evidenced by her relaxed demeanor, how often she smiles and "talks" with others and herself and her interest in visiting staff and other individuals in her home." • Individual #227's PSP discussion of living options was summarized in these statements: "Although the team agrees that Individual #227 does not have the cognitive ability to understand the information that could be provided related to	

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		placement options, Individual #227 has expressed through his smiles and contentment that he is happy here at [SASSLC]." • Individual #41's PSP noted that he prefers to continue to live at SASSLC, but did include a fairly comprehensive discussion of supports that he would need if he moved into the community. His plan dated 12/01/09 was one of the more recently developed plans reviewed. As plans are updated at the facility, it is hoped that this type of discussion around community placement will be included in all plans. Very few PSPs included a description of the individual's current day program. There was generally not consideration of community-based day programs or supported employment by the team. Although, trips were planned in the community each week, active treatment did not focus on functional learning in the community and outcomes in individual PSPs did not focus on training in the community. Observation at the vocational program on campus indicated that there were many individuals who had valuable job skills that would transfer well into a more integrated setting. The facility had a vocational program that offered work to many individuals. Staff were very inventive in creating adaptive equipment when needed to help individuals perform task related to contract work available. For example, Individual #92 was able to complete a job sorting plastic fittings with his feet. Staff had engineered a jig and communication system that he could be operated with his feet. His communication board was programmed with functional work phrases that allowed him to ask for support when needed. Other adaptive equipment was observed to be in use in the vocational and prevocational program to promote greater independence in completing task for many individuals served. Individual #148's PSP was one of the few in the review sample that discussed employment. It noted that he has received vocational training and was able to work with low supervision. He worked 16 hours for the year and earned $6.36 at the facility's sheltered workshop. PSTs should discuss supported employment opportunities in the community that pay at least minimum wage for individuals currently working at the sheltered workshop. There were few individuals engaged in supported employment in the community and more efforts need to be made by the facility to give additional individuals these opportunities. Clearly, the facility had the skills to be able to do so. For example, two of the individuals working in the community were interviewed during the monitoring visit, Individual #162 and Individual #160. Both were very excited about working off campus	

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		and told the monitoring team that they got the support that they needed from staff to do their jobs. The facility had a Human Right Committee (HRC) in place to review any restriction of rights for the individual. Observation of an HRC meeting during the monitoring visit revealed that the committee generally looked at alternatives to interventions to reduce restrictions of rights. All restrictions submitted to the committee were approved, but the committee did ask that teams look at implementing plans to reduce these restrictions when possible. Whether or not the team followed up on recommendations by the committee, however, was not evident. HRC notes should document the team's attempts to reduce or eliminate the restriction of rights when recommended by the HRC. Informal interviews with staff in various homes throughout the facility revealed that staff were aware of the rights of individuals whom they supported and there was an understanding that they were responsible for safeguarding each individual's rights. The monitoring team observed many instances throughout the review of individuals being offered choices in how they preferred to spend their day. It was noted that individuals were not all required to go to the day program between specific hours of the day. Many individuals stayed at their home in the morning and were offered alternate activities if they chose not to go to the prevocational or vocational program. They then had the option to go to work later in the day when they were ready to work. The same was true after lunch break. Individuals were able to return to work at their own pace. Interviews with the home supervisor, and observation, at Home 672 indicated that individuals living in that particular home had opportunities to make choices that individuals living in the community routinely experienced. This was particularly evident at mealtime. Rather than everyone eating at the same time, each individual wandered down to the dining room to have dinner when he was ready to eat. They were able to choose what they wanted for breakfast and help prepare their own meal. This practice, however, was not observed in other homes at the facility. In conversations with the home supervisor, as well as, other direct care staff at Home 672, it was evident that they used routines throughout the day and evening as opportunities to attempt to teach independence and offer choices. It was noted during the week of the review that, in general, staff at the facility treated individuals whom they supported with dignity and respect. In Homes 665 and 674, for example, individuals were asked if they would like to give the tour to members of the monitoring team. This was a respectful gesture that supported the idea that the home belonged to the individuals living there. In both cases, individuals giving the tour	

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		knocked before going into others' rooms and respected the privacy of their housemates. This indicated that they see this respect for others modeled by staff in the home.	
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:	This provision will be reviewed in greater detail by the monitoring team following the development of facility policies to address PSP development and implementation.	
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;	PSPs included a table with a list of what was most important to the person. This list was to be used for outcome development. This list of things important to the person, however, was not individualized in some cases. For example, Individual #15, Individual #113, and Individual #148's PSPs all listed leisure time, learning independence, personal safety, and personal health as the things that were most important to the person. Teams should use this area of the PSP to list specific things that are important for the individual and then include supports that the person needs to maintain or increase the occurrence of those things in his or her life. PSPs reviewed typically had an outcome to participate in some community activity, but plans did not state functional learning that would take place while the individual was in the community. The focus appeared to be on community participation in specific events rather than integration into the community. Opportunities for community integration at the facility will be reviewed further during future monitoring visits.	
	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 Personal Support Plan Guide (Procedure 300-9B) addressed this provision item in section 4 (Desired Outcome). Plans were not consistent in addressing supports needed to achieve outcomes, and barriers to living in the most integrated setting were not addressed in most of the PSPs reviewed (see F1e above). • Individual #302's PSP included actions steps for implementing his outcomes, but no strategies were in place to give staff guidance in implementing action steps. One of his outcomes was to maintain good health. Action steps implemented to achieve this outcome included, "Individual #302 will have no more than four infections during the next 12 months." There were no strategies in place to	

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	the most integrated setting appropriate to his/her needs;	address how this would be achieved. He had an outcome to enjoy his leisure time with the action step to purchase items from the Dollar Store at least quarterly. The action step did not indicate what Individual #302 would need to do to successfully complete this goal (e.g., choose the item, pay the cashier for the item). • Individual #68's PSP listed the following action step: "Individual #68 will be offered staff assistance with calling her father at least once per week through 9/2010." The plan did not include what types of supports Individual #68 would need and what criteria would determine successful completion of this action step. • Individual #15's PSP included the action step, "Individual #15 will be offered at least 1 on-campus and at least 1 off-campus activity per month." No additional information was offered that would help staff determine when this outcome would be considered complete. From reading the action step, it would appear that staff only had to offer the activity. The action step should be expanded to include specific criteria for determining successful completion, such as the type of participation required on his part, and the types of supports that could be provided. Action steps should include information that would direct staff in how to implement the action step consistently and to determine what level of participation by the individual was needed to successfully complete each step. With the exception of a few speech goals, most of the supports and services by OT, PT, and speech and language were in the form of service objectives, with a primary focus that specific equipment would be available. There were very few training objectives developed by therapies. The direct interventions that were provided did not appear in the PSP (e.g., Individual #323, Individual #31, and Individual #92).	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Again, achievement of this provision item varied widely in PSPs reviewed. The facility needs to put into place specific procedures for developing PSPs that integrate all protections, services, and supports that the person needs. PSPs were developed with an apparent goal to capture each individual's needs, goals, preferences, and abilities in one document as described by each treating discipline, but there was little evidence of true integration of all services into one comprehensive plan. Plans need to include not only a list of services and supports that the person is receiving but a description of how and when those supports will be implemented and monitored.	
	4. Identifies the methods for implementation, time frames	Plans did designate staff responsible for implementation of the objectives by discipline, but lacked specific methods for implementing outcomes or, in most cases, target dates for	

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	for completion, and the staff responsible;	completion of outcomes. If target dates were assigned, they generally reflected an annual date based on the PSP year, rather than each individual's rate of learning.	
	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	Action plans in the PSPs reviewed were based on learning within the facility, often in the classroom setting rather than where the skill might naturally be utilized. Many of the action steps in PSPs reviewed did not support functional learning. For example: • Individual #40 had an action step to identify coins, but there were no additional steps to make this a functional goal for her to use money skills in the facility or community. • Individual #68 had an action step to participate in on/off campus leisure activities with no guidance on functional learning that should be occurring during participation. • Individual #45 had action steps to attend on campus activities, take wheelchair walks, and rock in a rocking chair. These action steps could have been expanded to provide her with learning opportunities in gaining independence, making choices, or other acquiring other skills, but without offering guidance and strategies, staff could not consistently support her to acquire new skills while involved in these activities. Plans did not address implementing functional learning in the community. Action steps related to community outcomes were generally just a statement that the person would have the opportunity to do an activity in the community. They did not specify how the person would participate in the community, what type of learning would occur and what supports would be needed.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	Plans reviewed specified a method for data collection and the frequency of data collection, but did not guide staff as to what type of information should be collected. Some, but not all action plans designated who would review and monitor implementation and progress towards outcomes. Plans should specify the data that staff will record for each action step. Data collection should indicate the individual's level of participation, supports needed, and response to the activity.	
F2b	Commencing within six months of the Effective Date hereof and with	The facility did not have a process to ensure coordination of all components of the PSP. Direction from the state and the new policy will need to focus on guidance to the facility	

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	full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	in meeting this item.	
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.	Policies and procedures were not in place regarding this section. The PSPs did not provide clear information that would guide direct care staff in providing necessary supports. See specific details and examples in F2a above.	
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.	The facility's current policy and procedures (300-9 and 300-9B) did not require monthly reviews of services and supports. The policy mandated quarterly review by the PST. It was not evident that quarterly reviews were effective for monitoring and updating plans when progress was not noted. The facility will need to develop a policy that requires monitoring of PSP implementation and criteria for reviewing data and modifying plans as needed. Efficacy of all support plans should be evaluated by team members with a system that includes input from direct care staff responsible for implementation, and oversight and monitoring by plan developers. Monthly progress notes were completed by therapists for direct intervention (e.g., OT, PT, speech), but as stated above, there was limited integration of these services in the PSP in the form of measurable goals.	
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	As noted above, staff responsible for developing plans will need to be trained on new policies relating to PSP development. Staff responsible for implementing the PSP should have competency-based training initially and when plans are revised, however, there was no system in place to ensure that this occurred and there was no documentation in place to show that staff had been trained on individual plans initially or when they were updated/modified. This provision of the Settlement Agreement will continue to be reviewed in upcoming	

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	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.	monitoring visits to determine the adequacy of training in providing team members with the skills to develop and implement comprehensive, effective plans for individuals.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Of the 16 PSPs reviewed, one (Individual #254) was not dated. The other 15 were current. Policies had not yet been developed to address this requirement. Only one individual in the sample was admitted into the facility in the past year. His PSP was developed within 30 days of admission as required. The current policy mandated that on the day of admission, the PST needed to meet with the individual to determine services needed and methods of delivery. It further stated that the team will determine a date within 30 days to review the comprehensive functional assessment and develop a Personal Support Plan. The monitoring team will review further for compliance of this provision during upcoming reviews.	
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.	As noted above, Quality Enhancement activities with regards to PSPs were in the initial stages of development and implementation. The QE auditor told the monitoring team that the facility had monitors in place to look at PSPs. Additionally, a copy of the Quality System Oversight (QSO) Scoring Guide for Person Directed Planning Process dated 12/09 was provided to the monitoring team. Apparently, this tool was being piloted at SASSLC. It will be used to evaluate the quality of services provided to the individual as defined within the domains of Comprehensive Functional Assessments, Personal Support Teams, Integrated Personal Support Plans, Habilitation, Training, Education, and Skill Acquisition, and Unified Integrated Records as defined in the Settlement Agreement. This was meant to be a comprehensive review guide with specific instructions for reviewing	

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		services to individuals. A review of the document indicated that there was an attempt for it to provide a thorough review of these areas. The monitoring team, however, had questions about (a) observer/recorder training to ensure he or she knows how to score each of these items, (b) inter-rater agreement, and (c) validity of the tool (i.e., is it really measuring the topics it purports to be measuring). It looked like a lot of work went into developing this tool, but before it is fully implemented, the facility and DADS should test some of these factors. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.	

Recommendations:

1. Develop policies for this provision that clearly address person directed planning focusing on integrating of all services and supports into a plan that includes clear strategies for implementation.
2. Conduct comprehensive assessments as noted above in section F1c.
3. Continue team building efforts at the facility to foster an attitude that encourages and supports integrated services
4. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.
5. Develop a system to monitor the PSP, the implementation of services and supports, and the timely modification of plans when services and supports are not effective.
6. Include strategies for decreasing and eliminating restriction of rights for each individual.
7. Continue to build the supported employment program to offer more individuals the opportunity to work in the community.
8. Provide competency-based training for staff regarding all aspects of the PSP process and implementation of goals and objectives.
9. Include a discussion of comprehensive supports and services that would be needed for community placement in all plans.
10. Develop and implement a quality assurance process for assessing whether PSPs are developed consistent with this provision.

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:** • General discussions held with facility director, Ralph Henry, and department management, clinical, administrative, and direct care staff throughout the week of the on-site tour. • Various meetings attended by monitoring team members as indicated throughout this report. • Review of SASSLC's Plan of Improvement, most recent received, dated August 2009.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement. As noted elsewhere in this report, meaningful integration of clinical services was not evident in most areas at the facility. Some detail is provided below in section G1.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	A plan was not in place to address this item. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision. Discussions with staff at various levels of management, clinical services, and direct care indicated that meaningful integration of clinical services was not evident. On the other hand, there was unanimity in a desire to work towards and achieve an integration of clinical services, including more communication, acceptance of input and opinion from all clinical disciplines, and notification of treatment changes to all relevant clinicians. Information learned by the monitoring team during the on-site tour is listed below and may be helpful to the facility as it works toward meaningful integrated clinical services. • The medical director signed off on all psychiatrist notes indicating some communication and within-department oversight. • Physicians reported frequent collaborative conversations with other physicians and medical staff, also indicating some within-department integration. • The medical director spoke about the continued development of an integrated	

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		progress note. • Physicians were often not notified about PST meetings. • QMRPs worked well with medical, habilitation, and vocational services. These clinicians were responsive to requests and did so in a timely manner. • QMRPs did not always have a psychologist to whom they could go to for support, especially in cases where, in the QMRP's opinion, a PBSP was not adequate for implementation by staff. More communication was needed between QMRPs and psychologists. • Data for target behaviors were not regularly or adequately provided to the psychiatrists (see section K4 below) and, therefore, the psychiatrists were not able to make treatment and medication decisions based upon data. • There was a lack of coordination across disciplines regarding addressing the need for pre-treatment sedation. • While psychologists identified replacement behaviors (see section S1 below), they did not consistently develop, monitor, or revise the plans. • QMRPs reported that they were responsible for developing and monitoring all skill acquisition plans, but other specialist clinicians were probably better suited to manage these plans (e.g., psychologist for medical and dental desensitization plans, SLPs for communication plans, OTs for self-care plans). • Sometimes requests for equipment appeared difficult to meet, such as a request for a nighttime enuresis monitor at one of the homes. • The facility's plan of improvement provided very little guidance to the clinical staff and to the medical director regarding how to implement, document, and monitor the facility's performance regarding this provision.	
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.	A plan was not in place to address this item. As noted in section L2 below, however, numerous specialist physicians provided consultation, primarily regarding specific individuals at the facility. The state and facility were in the process of developing a policy to guide the facility in meeting the requirements of this Settlement Agreement provision.	

Recommendations:

1. Develop and implement policy.

2. Develop a system to assess whether or not integration of clinical services is occurring. This will require creating measurable actions and outcomes.

3. Consider assigning the monitoring of integration of clinical services to the QA/QE department at the facility.

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:** • General discussions held with facility director, Ralph Henry, and department management, clinical, administrative, and direct care staff throughout the week of the on-site tour. • Various meetings attended by monitoring team members as indicated throughout this report. • Documents reviewed by all members of the monitoring team and listed in all of the sections of this report, including assessments, treatment plans, reviews, and medical and nursing records. • Review of SASSLC's Plan of Improvement, most recent received, dated August 2009.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State policy was not developed or implemented at the time of the on-site tour to address this provision of the Settlement Agreement Nevertheless, across the facility, there was great desire for there to be coordinated clinical treatment, and to have that treatment contain more than just the minimum generally accepted professional standards of care as set forth in this provision. The facility, however, lacked direction in how to obtain this outcome. This was due in part to (a) the recency of attention to this provision, (b) some confusion as to who was responsible for each component and the monitoring of each component, and (c) a plan of improvement that did not provide guidance or direction regarding specific actions to be taken.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals'	A plan was not in place to address this item. Some actions, however, were being initiated. For example, the psychology department had very recently begun conducting psychological assessments. Comprehensive assessments were not in place as noted above in section F1c. Nursing assessments, as noted in section M below, lacked sensitivity to adequately identify and address health care problems in a number of areas of health status.	

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	needs.		
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.	As indicated below in sections J2 and J6 of this report, there were numerous problems with the manner and thoroughness with which assessments were conducted and diagnoses were assigned.	
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.	Clinical interventions were not consistently appropriate nor were they based on assessment results (see sections K5 and K9 below), or modified in response to clinical indicators (see section S3 below).	
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.	A plan was not in place to address this across the variety of clinical disciplines at the facility. The facility did not have a way of determining if appropriate clinical indicators of efficacy of treatments were being used.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A plan was not in place to address this item.	
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.	A plan was not in place to address this item. Even so, each clinician, as noted throughout this report, attempted to incorporate some clinical indicators into his or her treatment decisions. There was, however, no systematic manner in which this was conducted across the facility, nor any guidance from the facility regarding how this should be done, documented, and monitored.	

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H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H.	

Recommendations:

1. Develop and implement policy.
2. Develop a system to assess whether or not minimum common elements of clinical care are being provided to individuals. This will require defining minimum common elements of clinical care, creating measurable actions, and monitoring measurable outcomes.
3. Consider assigning the monitoring of the provision of minimum common elements of clinical care to the QA/QE department at the facility.
4. Review the caseload and workload of the medical director to determine how much additional support is needed.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #006: At Risk Individuals o DADS Risk Assessment Tools, dated 8/31/09 o Health Status Team Recommendation/Health Care Provider Statement o SASSLC Procedure #300-22: At Risk Individuals, dated 10/5/09 o Corrective Action Plan for Injuries 1st Quarter FY10 o Action Plan/Plan of Improvement: Aggression 10/09 o Request to Post Training: Injury Trend Investigation 1/8/2010 o Log of ER visits from 1/1/09 – 12/31/09 o List of all injuries by individual 7/09-1/10 o List of fractures and sutures 7/09-1/10 o List of 10 individuals with the highest number of injuries o List of Individuals assessed by SASSLC at Risk Level 1 (High) in the following areas: • Seizures • Challenging Behaviors • Dehydration • Osteoporosis • Skin Integrity • Weight • Hypothermia • Respiratory • Medical Concerns • GI Concerns • Constipation • Cardiac • Urinary Tract Infection • Polypharmacy • Injury • Diabetes • Choking o Sample of PSPs including: • Individual #113 6/16/09 • Individual #211 8/7/09 • Individual #45 3/13/09 • Individual #148 1/15/10

	• Individual #145 11/6/09 • Individual #15 8/4/09 • Individual #302 2/12/09 • Individual #24 7/15/09 • Individual #341 9/28/09 • Individual #68 9/21/09 • Individual #254undated • Individual #227 10/23/09 • Individual #41 12/1/09 • Individual #313 10/16/09 • Individual #91 3/16/09 • Individual #40 12/4/09 • Individual #95, Individual #155, Individual #218, Individual #103, Individual #205, Individual #304, Individual #64, Individual #40, Individual #335, Individual #241 o Incident Management Meeting Minutes for the following time periods • 7/13/09-7/17/09 • 9/1/09-9/4/09 • 10/19/09-10/23/09 • 1/4/10-1/8/10 o A Sample of unusual incident reports (see section D) o PSP addendum to address injuries for: • Individual #87 10/5/09 • Individual #274 10/5/09 • Individual #11 7/30/09 • Individual #254 10/8/09 • Individual #342 9/29/09 • Individual #17 9/29/09 • Individual #225 10/5/09 • Individual #211 9/29/09 • Individual #94 10/5/09 • Individual #129 10/7/09 • Individual #333 10/9/09 • Individual #66 1/7/10 • Individual #312 1/7/10 • Individual #317 1/7/10 • Individual #253 1/7/10 • Individual #36 1/7/10 • Individual #167 1/7/10 o Incident Trend Analysis Report for FY09 and 1st Quarter of FY10 o Injury Trend Analysis Report for 1st Quarter of FY10

	o Records of individuals (see listing in section J of this report) Interviews and Meetings Held: o Four residential direct care staff • Home 672W • Home 766 • Home 665 • Home 671 o Laurence Alqueseva, QE Program Auditor o Letecia Jalomo, ANE Coordinator o Michelle Rodriguez, Facility Investigator Observations Conducted: o All day programs on campus o Residential homes: 665, 670, 671, 672, 673, 674, 766 o Human Right Committee Meeting 2/11/10 o Incident Management Team Meetings 2/10/10 and 2/11/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: State Policy #006: At Risk Individuals had been developed by the state to address assessing risks for individuals. SASSLC had adopted this policy in whole. It was procedure #300-22 titled, At Risk Individuals, implemented 10/5/09. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. Further reference in this section of the report to policy will refer to SASSLC: At Risk Individuals Policy. Although, risk assessments were requested at the time of the monitoring visit for each individual listed above for whom a PSP was reviewed, the documents provided to the monitoring team did not include the standardized risk assessments included in the state policy. PSPs, however, contained a risk tracking record section in each PSP reviewed. There was not a consistent process evident for reviewing and updating risk. Not all PSPs included a risk assessment level rating as mandated in the policy. In conversations with staff, however, it was not clear that most were aware of the risk level of each individual or what they needed to do differently because the individual was identified as being at risk. The monitoring team recommends that the facility clarify the purpose of the identification of at-risk individuals. All individuals served at SASSLC were admitted to the facility because they were considered to be at high

	risk for health and/or behavioral issues. Risk assessments should be more than a perfunctory review of risk factors for each individual. Comprehensive risk reviews that consider and address factors that contribute to each risk area need to be completed and all staff need to be aware and trained on identifying crisis indicators. Accurately identifying risk indicators and implementing preventative plans should be a primary focus for the facility to ensure the safety of each individual.

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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.	A state and facility policy existed to address this provision of the Settlement Agreement. The state policy was labeled "At-Risk Individuals," numbered 006, and dated 10/5/09. It included a number of addenda and forms. This was the state policy and was adopted, in whole, by the facility and labeled procedure #300-22, "At Risk Individuals," implemented 10/5/09. The policy mandated a risk review at least every six months for each individual by a Health Status Team (HST). The policy identified who should participate on the team and assigned specific responsibilities to team members. It was not evident that standardized risk assessments mandated by the state policy were routinely in use by the facility. Though risk assessments were requested by the monitoring team, only one was produced that used the standardized form. There were major issues at the facility regarding the assignment of risk. One was related to whether individuals were properly identified as being at risk. This is discussed below. The other was regarding how an individual's risk level might be determined. This second issue is discussed below in section I2. Determining risk levels were done in a manner that allowed very vulnerable individuals to not be properly identified as being at risk, in part because of the assumption that if a plan, no matter how inadequate, was developed to address the risk, risk no longer existed. Below are examples of risk assignments and risk incidents. • Respiratory: There were 45 individuals admitted to acute care settings with a pneumonia diagnosis. Seventeen of these 45 were identified as aspiration pneumonia. There were no individuals identified at SASSLC as being high-risk in this area. • Cardiac: Only one individual, Individual #185, was identified at being at high cardiac risk, but five others were admitted to acute care for cardiac issues. • Constipation: No individual was identified as being at risk for constipation, but Individual #18 was discharged from acute care in the last 12 months with constipation as the second reason for hospitalization, Individual #243 was discharged with a diagnosis of abdominal distension and fecal impaction two	

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		times, Individual #6 had a bowel resection due to abdominal distension and absent bowel sounds, Individual #36 was discharged with fecal impaction, and Individual #265 had a discharge diagnosis of fecal impaction. • Dehydration: No individuals were listed as being at risk for dehydration, but there were at least five individuals for whom dehydration was one of the discharge diagnoses. • Skin breakdown: Only three individuals were listed as being at risk for skin breakdown, but more than 20 had experienced skin breakdown in the last 12 months. • Polypharmacy: Only 11 persons were listed at risk for polypharmacy. The facility administered 140,000 doses of oral medication per month which amounted to nearly 500 doses of medication per individual per month. In the nursing sample of individuals listed in Section M of this report, the majority were identified as experiencing polypharmacy by the quarterly drug regimen reviews. • Osteoporosis: Individual #18 was the only individual listed as being at risk for osteoporosis, although a significant number of the sample was being treated for this condition. Eight individuals who were not on the osteoporosis list had fractures in the last 12 months. Only one individual was on that list. • Injuries: Only four individuals were listed as being at high risk for injury although 37 individuals were seen in the emergency room to treat injuries in the last 12 months. One individual was hospitalized due to injuries. Moreover, 11 individuals were listed as having the highest frequency of all injuries. These individuals accounted for 227 (i.e., nearly 21 per individual) injuries and only one of the individuals appeared on the high-risk list for injuries. • Seizures: Five persons were listed at risk for seizures, but there were 16 hospitalizations for seizure-related issues, and three of these individuals were not on the high-risk list. Further, there were 29 emergency room visits for seizure-related issues, but only one individual was on the high-risk list. Six of the 15 non-listed individuals had between two and five emergency room visits each due to seizure activity. • GI Concerns: No one was identified in the facility as having GI concerns. Twelve individuals, however, were hospitalized for GI issues, and 14 individuals were transported to the ER and discharged with GI issues. • Urinary Tract Infections: The facility indicated that there were five individuals at high risk for UTIs. Eighteen individuals were hospitalized with UTI issues, of whom only four were on that list. Another nine had 13 emergency room visits with UTI as the reason for admission, with seven of those individuals not on the high-risk list. • Hypothermia: No individuals were listed at high risk, but six individuals were	

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		hospitalized with hypothermia as part of their discharge diagnoses and there were three emergency room visits where hypothermia was also among their discharge diagnoses. On a positive note, the facility used trending information on injuries to develop a corrective action plan that included identifying individuals with three or more injuries and developing a corrective action plan for each individual sustaining three or more injuries during 1st quarter FY 10. There were PSP addendums in place indicating that teams had met and developed action steps to be addressed in the corrective action plans. The corrective action steps assigned a responsible person and date to begin implementation. Action steps specific to each individual were developed to attempt to reduce injuries for the each individual. It was not evident, however, that the facility monitored and updated plans as needed.	
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 policy stated that the Health Status Team (HST), chaired by the Primary Care Provider, would ensure a preventative approach to the health and safety of persons served by assigning each individual a risk level/rating. High Risk (level 1) would apply to an acute or unstable condition that would require increased intensity of intervention to achieve an optimal health outcome. Furthermore, it stated that individuals discharged from the hospital should have their risk level reviewed by the physician. The policy mandated that once a high risk condition was identified, the PST would meet within five working days to formulate a plan. The plan must be implemented within 14 days and incorporated into the individual's PSP. The PST was required to meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition was stabilized and the risk level was reduced. The current policy allowed for a risk level to be deemed medium risk (level 2) if the individual had adequate supports that were actively monitored for any assigned risk category. Review of support plans did not support that adequate preventative measures or plans were in place or that adequate monitoring of implementation was occurring. Thus, the monitoring team could not support the practice of lowering individual's risk level from high to medium just because a plan was in place to address the issue. Until the facility develops an effective plan of monitoring and revising supports as needed, it is recommended that risk levels are assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. PSPs did not include documentation that teams met to reevaluate risk levels following ER visits and hospitalizations for medical incidents typically associated with increased risk factors. Please see the detail provided above in section I1. Following hospital visits,	

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		according to policy #006, the PST should have convened within five days and reassess risk level, to ensure safe monitoring of individuals. Some examples and detail are provided below. • Individual #45 was identified as being at risk for constipation, though the PSP does not indicate at what level. Since no individuals were identified as being at high risk for constipation at the facility, she was considered a medium or low risk. She took medication for constipation and additionally, was given enemas twice, and suppositories 33 times over the PSP review year. An abdominal x-ray showed markedly large quantities of stool. This would indicate that her constipation was not under control and she should have been considered to be at high risk. • Individual #341 had 14 episodes of constipation and several constipation medication changes over the past year. By assigning a high risk level, direct care staff and nursing staff would be more aware of the need to monitor individuals at risk for signs and symptoms of constipation. • According to the list of individuals designated as high risk at the facility, no individuals were considered to be at high risk for aspiration or choking at the facility, even though observation of mealtimes, and a review of mealtime plans, indicated that numerous individuals were on mealtime plans with restricted consistency due to the risk for choking. • Individual #341 had been treated for pneumonia twice over the past year, both incidents appeared to be related to swallowing issues, but she was not considered high risk for aspiration. Again, assigning a high risk score to individuals with a history of aspiration or choking would alert team members to be particularly aware of following preventative measures to ensure the individuals health and safety. Furthermore, a designation of high-risk puts into place additional safeguards and reviews as indicated in the policy regarding At-Risk Individuals.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment,	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. PSPs reviewed included strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Home supervisors interviewed reported that they were notified of changes in plans by therapist and implementation of changes began immediately. All staff were notified of changes in meetings held at each shift change. There was a communication system in place to share changes in risk levels and alert staff to monitor individuals at risk, but again, risk was not accurately identified so that this	

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	including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	system could be effective at minimizing risk.	

Recommendations:

1. Implement and follow the written policy regarding assignment of risk level.

2. Develop a system to accurately identify any individuals whose health or safety is at risk. Risk levels should be evaluated considering the level of support needed in each risk area.

3. Establish written policies regarding the types of incidents that would require immediate review of the individual's risk assessment including unusual incidents, hospitalizations, and ER visits.

4. All staff should receive individual specific training on each safety and health care risk identified for the individual(s) they are assigned to support.

5. All health issues should be addressed in PSPs and direct care staff should be aware of health issues that pose a risk to individuals and know how to monitor those health issues and when to seek medical support.

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:** <u>Documents Reviewed</u>: o Curriculum vitae of both psychiatrists, Dr. Thomas Mings and Dr. Elizabeth Mitchell. o The following documents from the records of the individuals listed below: • Demographic data sheet, diagnostics (DG 1-A), social history assessment, psychological assessment, ICAP scoring sheet, active medical problem list, annual medical summary, medical evaluation, seizure record, vital signs record, neurologic signs graphic record, growth record, glucose monitor log, all consultations, annual psychiatric summary, psychotropic medication evaluation, quarterly medication review, all lab reports, EKG, EEG, physical exam, immunization record, adult preventative care flow sheet, most recent hospitalization, all medication treatment, diet, physicians orders, nursing progress records, suicide/homicide nursing assessment, physical therapy, vocational, nutritional assessment, nursing assessment, health risk assessment tools, personal goal meeting, action plans, functional assessment and BSP, Consent for PBSP or psychoactive meds, all SPOs and progress notes for current PSP, the past four 90-day reviews, all incident/injury reports, and most recent update. • Psychological update (most recent) • Most recent annual medical summary, physician orders for the last 12 months • MOSES and DISCUS scales since July 2009 • Interdisciplinary progress notes from 9/09 to most recent • Medication administration records from 9/09 to most recent • All psychiatric progress notes and neurology consultations from 1/09 to most recent • Radiology reports from 1/09 to most recent, most recent EKG • Initial psychiatric evaluation, and comprehensive psychiatric evaluation • Most recent PSP and any addendums from July/09 to most recent • All restraint reports from 7/09 to most recent, all injury reports from 9/09 to most recent • All consents for treatment with psychotropic medications from 7/09 to most recent. o Record reviews of: • Individual #1 Individual #347, Individual #240, Individual #133, Individual #113, Individual #3, Individual #209, Individual #342, Individual #43, Individual #264, Individual #225, Individual #111, Individual #214, Individual #191, Individual #86, Individual #279, Individual #5, Individual #277, Individual #211, Individual #166, Individual #129, Individual #250, Individual #75, Individual #155, Individual #13. <u>Interviews and Meetings Held</u>: o Two interviews with Dr. Thomas Mings o One interview with Dr. Elizabeth Mitchell

	o Interview with Daisy Ellison, MA, Director of Psychology <u>Observations Conducted</u>: o Attendance at Dr. Mings' clinic o Attendance at Dr. Mitchell's clinic o All residences and day activity sites at least once during the on-site tour
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Both Dr. Mings and Dr. Mitchell had training and experience commensurate with capably performing their duties. They each demonstrated, in their clinics witnessed by the monitoring team, and also in direct interviews with the monitoring team, good awareness of current, generally accepted professional standards of care. Departures noted by the monitoring team from said standards were likely a function, in part, of inadequate psychiatry staffing hours. There were multiple compromises in professional standards of care, presumably in the service of trying to get the work done with inadequate time. For example, the facility obtained informed consent for all present and future psychotropic trials at the facility when an individual was first admitted, but the psychiatrists, upon prescribing a new medication, did not seek a new consent, and instead merely asked the psychologists or nurses to inform guardians or LARs of the new treatment. In another example, instead of reviewing data collected about target behaviors using a graphic showing daily data, with phase lines indicating other factors bearing on targeted problem behaviors, the psychiatrists in their medication review visits relied on data points showing a 30-day aggregate of behavior, without the use of phase lines.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Both psychiatrists were board certified in adult psychiatry. Dr Mitchell had additional board certification in child and adolescent psychiatry. Dr. Mings, at the facility since 6/1/09, had previous experience as a consultant to the facility from 1989 to 1994. The bulk of Dr. Mitchell's practice over many years involved treating individuals with developmental disabilities. An important component of professional practice for psychiatrists is the availability of peers for review and consultation. A peer review and consultation forum did not exist at SASSLC, but is recommended as the facility moves forward advancing its psychiatric	

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		services.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	While both psychiatrists demonstrated thoughtful clinical judgment during their respective clinics, and while the annual psychiatric summary and the psychiatry progress notes contained some further evidence of thoughtful evaluation and diagnosis, there ultimately was not means to confirm, from the existing data set, that this criterion was being met in a uniform or comprehensive fashion. The psychiatrists' diagnostic process in the clinics attended included record review and mental status exam. The psychiatrists' available time allowed approximately seven and a half minutes per week per individual. Taking into account all other clinical responsibilities, this suggested that there was not enough time to properly attend to psychiatric care as delineated in this provision. This was likely the primary factor leading to inadequate documentation of initial diagnostic evaluations. The inadequate documentation, in turn, made it difficult for the monitoring team to gauge whether their diagnostic process was otherwise conducted in a clinically justifiable manner.	
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.	Both psychiatrists demonstrated commitment to reasonable usage of behavioral treatment in advance of psychotropics. For example, Individual #335 was being weaned off of Ativan, while at the same time the psychiatrist was hoping that behavioral management of anxiety would be sufficient. Presumably due to time constraints rather than directly observing the quality and fidelity of behavioral interventions, the psychiatrists relied on very brief summary descriptions by clinical staff of these interventions. This was problematic because of the questionable accurateness of the staff reports. For example, in the case of Individual #119, the psychiatrist accepted, at face value, a statement from staff that her "sleeping seems to be fine" without referencing any documented evidence of sleep patterns. In the case of Individual #204, while psychopharmacologic intervention was directed at diminishing intense crying and yelling, the team was not tracking these behaviors. Instead, they were noting occurrences of the behaviors under "hyperactivity" and "compulsive behaviors," descriptors of behavior that were far too general and vague. This was not optimal because good clinical decision-making is contingent on integrating subtle detail. Moreover, it would improve clinical decision-making by the psychiatrists if they were to observe a sampling of the process of data collection. As a result, they would be more informed about the way data were collected. Individuals on psychotropics had a documented psychiatric diagnosis, but as referenced in J2 above, documented formulations that demonstrated support for diagnoses were not present in the medical record.	

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		The monitoring team found no instances where psychotropic medications were used for the convenience of staff or as punishment. Moreover, medications were used for pre-treatment sedation rather than for behavior control.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment 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 pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	On record review, some individuals' PSPs included strategies to minimize or eliminate the need for pre-treatment sedation. In the case of Individual #133, for example, his PSP included a plan to relax listening to soft music for progressively longer periods of time. The plan included the teaching technique of explaining to him that this objective was important in helping acquire relaxation techniques for his visits to the dentist. There was no definitive indication of whether this intervention was useful for him. There were instances where pre-treatment sedation was recommended, without the PSP including strategies for minimizing or eliminating the need for this pre-treatment sedation, and without evidence of coordination between psychiatric and medical services. The medical record of Individual #191, for example, demonstrated this finding. As a result, Individual #191 was potentially receiving sedating medication unnecessarily. Without coordination, the potential exists that the sedating medication could adversely affect his psychiatric status in a way that could have been avoided were the psychiatrist involved in the decision-making. Dr. Mings highlighted multiple concerns about pre-treatment sedation. He suggested that there was a lack of standardization and guidelines, and said that it was not clear who "owns it" (i.e., medical staff or psychiatry staff). He also indicated that the plans to minimize or eliminate the need were likely ineffective. This suggests that the psychiatrists should be involved in such plans, and the PST could be the venue for relevant team members thinking together about such plans. Overall, SASSLC was not meeting this provision item because plans did not always exist, they were not regularly monitored for progress and revised as needed, treatment was not coordinated in an integrated manner with other disciplines at the facility, and it was unclear how side effects were monitored.	
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	Psychiatry staffing added up to one full-time equivalent. It seemed reasonable to estimate that one quarter of the psychiatrists' time was accounted for by meetings, documentation requirements, and administrative responsibilities. If so, the psychiatrist's remaining time allowed for only approximately seven and a half minutes per individual served, per week. Dr. Mings indicated that he had direct contact with individuals in his clinics, for five to 15 minutes every three months. Dr. Mitchell indicated, for example, that much as she valued the information that she might accrue from visiting the residences, she generally did not have time for a walk-through, to do direct observation,	

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	necessary for implementation of this section of the Agreement.	or to talk with the individuals and staff in the residences and day activity areas. The facility was in the process of recruiting another psychiatrist, and had recently hired a psychiatric assistant. It is expected that this will help somewhat with some of the logistics and administrative activities in the department, but in the monitoring team's opinion, is unlikely to have a meaningful impact on the day to day ability of the psychiatrists to devote to direct service to individuals and PSTs. It is also expected that the new policy regarding psychiatry services will provide direction regarding the required number of psychiatrist FTEs.	
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.	The existing procedures to address psychiatric assessment were limited by the psychiatrists' time constraints. The psychiatric annual summary generally included name, date of birth, all five DSM-IV Axes, target symptoms, current medications, and a paragraph each for annual summary and medication discussion. Other data that, by generally accepted professional standards of care is typically included in a psychiatrist's assessment of an individual, were present in the psychological assessment, completed by the psychologists, or in the medical evaluation completed by the internists. Even so, across these reports, not all aspects of history were obtained, and there was no evidence of comprehensive case formulation, including a comprehensive bio-psychosocial formulation. Nevertheless, the psychiatric assessments did not follow the format and requirements of Appendix B of the Settlement Agreement. It is expected that the formulation and implementation of a new policy regarding psychiatric services will provide the facility and its psychiatrists with guidance in this area.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment	Subsequent to the on-site tour, the facility reported that a Reiss Screen had been administered to all but 15 of the individuals at SASSLC, however, the monitoring team had not found any evidence of its usage while at the facility, either in any record or at the clinics. Therefore, this will be reviewed again during the next monitoring tour. There were no other standard screens conducted at the facility, other than a mental status exam. Further, the psychiatrists only saw individuals who were referred to them by the PST.	

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	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.		
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.	While the facility did not have a written policy describing a systemic approach to achieve this goal, there was observed evidence of effort on the part of staff from multiple disciplines to achieve integrated care. This was evident in the case discussions in Drs. Mitchell and Mings' respective clinics. For example, when Individual #149 was reviewed in Dr. Mitchell's clinic, because of the integration of multiple disciplines' data sets, the team was able to tie Individual #149's recent medication noncompliance to the observation that there was a new nurse who departed from the usual medication administration in that she did not crush her medications. On the other hand, there were also problems pertaining to this goal. For example, the Director of Psychology described efforts to engage in dialogue with psychiatry about reduction of polypharmacy while wanting to respect the professional expertise of the psychiatrist and not "step on the doctors' toes." When asked, she endorsed that this was emblematic of a more global dynamic regarding the need for better communication between psychiatry and psychology. When reviewing the case of Individual #337, who had very apparent signs of tardive dyskinesia, both the DISCUS and the MOSES, filled out by an RN noted "no TD." Dr. Mitchell initially signed off on this without comment; when the error was brought to her attention, she corrected it immediately. This latter example illustrated a lapse in integration amongst disciplines, as well as highlighting the inadequacy of parsing out elements of care to other disciplines that, by generally accepted professional standards of care, should be tended to by psychiatry. Dr. Mings estimated that he received behavioral data of sufficient detail and quality that it can meaningfully inform his clinical decision-making half of the time. The remainder of the time, he sees it as the psychologists reporting behavioral impressions rather than a review of data. During Dr. Mitchell's clinic, when the monitoring team commented on the prevalence of individuals appearing sedated or asleep during the day in the residences, she expressed	

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		surprise, saying that she doesn't have time to go to the residences. She went on to say that when individuals were somnolent during her medication visits with them, she asked the staff if that was common for the individual in question, and that staff routinely reported that it was typically not a problem. Integration of pharmacological treatments is an important area for focus by the facility.	
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.	On the whole, this provision item had not been attained, that is, there was no evidence of the type of integration of psychiatry into any proposed PBSP. Moreover, the implementation of psychiatric pharmacologic treatment appeared to occur in a parallel fashion to the implementation of PBSPs and their development by psychology and implementation by direct care staff. Further, there was little mention of psychiatry in the PSP document, only a listing of medications and some diagnoses. Elements that approached this goal were present in a piecemeal fashion. For example, in the psychiatric clinics in particular, both Drs. Mings and Mitchell brought up in case discussions their respective commitment to holding off on further medication intervention when it appeared to them that a change in the behavioral treatment plan might achieve relief of the symptom/behavior in question. For example, in the case of Individual #82, Dr. Mitchell described a recent attempt to wean her off of Zyprexa, hoping that a combination of behavioral treatment and more conservative use of medication would sufficiently address aggression and hyperactivity. While there was no evidence that the PST was addressing this goal in a comprehensive fashion, the Human Rights Committee, which convened about all treatment changes, did appear to specifically ask whether a given intervention was least intrusive (though there was less focus on whether the intervention was the most positive possible).	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful	The existing mechanism for obtaining informed consent (which consisted of a description of potential risks, benefits, and alternatives given or presented to a legal guardian) failed to ensure that this provision was being adequately addressed. A single page form was presented to legal guardians upon admission to the facility, indicating that upon signing, the guardian had given, for the duration of the individual's stay at the facility, consent for all behavioral and psychotropic treatments. Thereafter, the nurse or psychologist was to inform guardians after the fact of a change in psychotropic treatment. There was no evidence that the psychiatrists sought or obtained confirmation that the guardian had, in fact, been informed, nor whether the guardian might have had	

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	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.	questions. Additionally, apart from the question of engaging guardians in the process, there was no documentary evidence of the PSP addressing the questions raised in this provision item regarding the weighing of harmful effects and the possible comparative effectiveness of alternative strategies.	
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.	The facility had been completing the monitoring component of this goal. A tracking instrument that contained data from September 2009 until January 2010 demonstrated no reduction in either polypharmacy criteria. While reports by individual were being furnished to the psychiatrists on a monthly basis, there was no systematized evidence that this had resulted in ensuring that the use of medications was clinically justified. Overall, 101 out of the approximately 200 individuals followed by psychiatry at the facility, met one or both of the polypharmacy criteria. Twenty-one of those individuals were on five psychotropic medications, while seven individuals were on six different psychotropic medications. Twenty individuals were on two or more antipsychotic medications. Dr. Mings pointed out that the tracking was somewhat flawed because it failed to distinguish when these medications might have been used for non-psychiatric purposes (e.g., anticonvulsants for seizures, rather than to stabilize mood). It is possible that an electronic record may be of use to the facility as it moves forward in monitoring and managing these types of data. The use of multiple medications for an individual does not automatically constitute inappropriate treatment. In some cases, an individual can be optimally served with a treatment plan that meets the criteria for polypharmacy. Establishing that a given individual's psychopharmacologic treatment plan is inappropriate generally requires hours of case review. Given the absence of an integrated approach to treatment planning as discussed throughout this report, it is possible, if not likely, that at least some individuals were receiving multiple medications due to the absence of a comprehensive integrated approach. In the case of Individual #10, for example, the only behavior being tracked was hyperactivity. She was taking Ativan and Prozac, neither of which treats hyperactivity. The monitoring team, in an effort to establish a measure which can provide some data	

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		bearing on the question of whether the considerable percentage of individuals asleep at the facility ultimately represented a problem, elected to do a walk-through of the facility between 9 a.m. and 11:30 a.m. on 2/17/10, recording whether individuals were awake or asleep at the time of contact. In the residences, 43 out of 127, or 33.8% of individuals observed were asleep. In the Developmental Center, 30 out of 142, or 21.1% of individuals observed were asleep. As an aggregate, 27.1% of 269 individuals seen were asleep at the time of observation. While there may have been other contributory factors, such as organic impairment in arousal, or inadequate environmental stimulation, this high percentage suggested that sedation, as a medication side effect, could be a contributory cause. This was particularly noteworthy at SASSLC where active treatment, engagement, and participation were a focus of senior management for many months. Certainly, this should be explored further by the facility, perhaps as a facility-wide project, involving multiple disciplines and departments.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The MOSES, to assess presence or absence of tardive dyskinesia, and the DISCUS, to assess more global side effects of psychotropic medication were in use, but could not be found in all records reviewed. These assessments were being performed by nursing; the psychiatrists reviewed the nurses' completed assessment document during their clinics. As noted in J8, there were instances where it appeared that the form had been filled out with very substantial errors. At a minimum, the psychiatrists should be implementing the scale to assess for tardive dyskinesia, whether it's the DISCUS or the AIMS. Direct psychiatrist involvement in these assessments should improve their capacity to notice medication side effects.	
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 treatment plans did not exist at the facility. The psychiatric clinic progress notes included a section describing the behaviors targeted by the administration of each medication. While the same note included a "comments/assessments/formulations" section, it was often filled out in a cursory fashion with comments such as "stable" or "grabbing staff, episodic, will watch, no side effects or sedation noted" (from the record of Individual #347). There was no evidence of this goal being otherwise addressed.	

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	psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.		
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.	This provision was not being met at SASSLC in a way that met generally accepted professional standards of care. Comments regarding consent are above in section J10 and, therefore, are not repeated here.	
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.	This provision of the Settlement Agreement was not being addressed thoroughly or in any meaningful way at SASSLC. First, neither psychiatry nor neurology participated in the PST or PSP process. Dr. Mings stated that he attended all neurology clinics, but that they only occurred once each month and during these clinics only four individuals were reviewed per month. Moreover, the means by which the psychiatrists learned of changes in dosages of medications used for neurologic purposes was through nursing, after the changes had been made, another indication of the absence of coordination between the neurologist and psychiatrists.	

Recommendations:

1. A comprehensive policy and practice manual should be established regarding psychiatric care at the facility. This will likely be undertaken as a statewide task, wherein multiple facility psychiatrists will participate in its development. Such a manual should clarify policies, practices, and responsibilities that do not "belong to" psychiatry, but nonetheless bear on coordination of care with other disciplines.

2. A significant number of the deficits noted above issued from inadequate psychiatric time and resources. The facility was seeking another full-time psychiatrist. Without this change, it is unlikely there will be progress on provisions J2 and J4 to J15.

3. Psychiatrists should complete and document an initial psychiatric assessment as per Appendix B. While it was reasonable for the psychiatrists to draw some of the interview and historical data from the initial psychological assessment, they should be collecting and documenting their findings about most areas in much greater detail. Perhaps more importantly, these data should then provide the ground for the psychiatrist to document a comprehensive bio-psychosocial formulation (conspicuous in it absence and at variance with generally accepted standards of professional care).

4. Psychiatrists should participate fully in the PST.

5. Psychiatry should be represented at the HRC.

6. Psychiatry should be conducting the informed consent process directly with guardians. This process should be documented appropriately.

7. Psychiatry should be directly conducting and documenting the MOSES and DISCUS.

8. The facility should track aggregate evidence of potential inappropriate use of medications. This was another item that the state may best address with a standard approach across facilities.

9. Behavioral data should be presented to psychiatry using a graph of daily data points, and including phase lines to indicate the occurrence of any circumstance bearing on the behaviors being tracked. Integrated work between psychiatry and psychology will be required to determine the specific type of information that is most relevant for each individual.

10. Psychiatrists should engage in regular, even daily, observations of individuals, and their interactions with staff in the residences and in the Developmental Center.

11. Psychiatrists should participate in peer supervision on a monthly basis. This should last approximately two hours, allowing time for both discussions about clinical questions or problems, as well as more in-depth presentations of complex cases, best practices, and literature review. Though not ideal, this could take place by phone or web conferencing, perhaps with psychiatrists from other SSLCs. Membership should not be more than six psychiatrists so that each has twice a year to present in-depth, and the membership should be a stable group, not rotating.

12. The facility should consider the adoption of the usage of an electronic medical record; this will result in increased coherence, better means of tracking compliance with policy, and significant savings of time when persons from any clinical discipline are trying to sort through a question that requires them to reference multiple data sets about an individual. Until then, there should be a section of the record dedicated to

psychiatric progress notes. According to Dr. Mings, this had been in place, but there had recently been a push for universal integrated charting. The problem this creates is that during clinics, the psychiatrist then uses precious time flipping through the record to try and review the sequence of visits. It is possible that the new state policy regarding recordkeeping practices might address this need.

13. All prescribing physicians should consult each other about any planned changes in the medication regimen of individuals, in advance of making said change.

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS Policy #008, Psychological and Behavioral Services, dated 11/13/09 o SSLC Psychiatrist & Psychologist Position & Employment Data (11/9/09) o Psychology director's academic credentials o Psychology meeting minutes o Behavior Therapy Committee meeting minutes o Competency check for Behavior Support Plans format o Structural and Functional Assessment Report format o Person-guided Functional Assessment format o Various emails included in the documents regarding quality assurance o List of individuals with PBSPs o List of individuals by home o PBSPs for: • Individual #272, Individual #205, Individual #47, Individual #64, Individual #141, Individual #59, Individual #95, Individual #211, Individual #155, Individual #252, Individual #94, Individual #218, Individual #145, Individual #199, Individual #66, Individual #135, Individual #315, Individual #261, Individual #233, Individual #276, Individual #150, Individual #216, Individual #163, Individual #221, Individual #103 o Psychological Assessments for: • Individual #325, Individual #234, Individual #152, Individual #72 o Functional Assessments for: • Individual #276, Individual #218, Individual #261, Individual #65, Individual #66, Individual #163, Individual #72, Individual #204, Individual #234, Individual #257, Individual #122, Individual #86, Individual #349, Individual #40, Individual #224, Individual #152, Individual #315 o Training Logs for: • Individual #42, Individual #148, Individual #88, Individual #348, Individual #13, Individual #2, Individual #185, Individual #318 <u>Interviews and Meetings Held</u>: o Daisy Ellison, MA, Director of Psychology o Discussions with Psychology Department Staff: • Steven Boncek, MA.; Charles Obi, MA,; Gary Sarli, MA.; Mark Boozer, MA. o Discussions with a variety of staff from clinical, administrative, and direct care <u>Observations Conducted</u>:

	○ Psychology Department meeting ○ Behavior Therapy Committee meeting ○ Psychiatry Clinic ○ Observations occurred in every day program and home. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example: • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in recreation and leisure activities, • Providing training (e.g., skill acquisition programs), and • Implementation of behavior support plans
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Psychology staff at SASSLC utilized many components of an effective applied behavior analysis approach. These included a through structured functional assessment and behavior support plan format, and a strong focus on the identification (and prevention) of antecedents to undesirable or dangerous behavior. In general, however, the psychology staff lacked the advanced training and experience in applied behavior analysis necessary to use this methodology most effectively. Examples of areas that required improvement included data collection and presentation, and the functional use of data-based clinical decisions. That is, although complete functional assessments and positive behavior support plans existed for every individual served at SASSLC, it was not clear from reviewing the plans, interviewing staff, and observing the implementation of those plans, that PBSPs were consistently functional and effective. Additionally the program lacked critical behavioral systems to assess data and treatment integrity. The monitoring team believes that continuing advanced training in applied behavior analysis and the establishment of opportunities to discuss behavioral challenges and share expertise among other psychologists, both within and outside the department, will be critical components if the psychology department is to achieve the settlement provisions articulated in this section. The facility recently began conducting psychological assessments (December of 2009). The new format appeared to be complete, however, only a few assessments were available for this review. These will be more thoroughly reviewed during subsequent monitoring visits.

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K1	Commencing within six months of the Effective Date hereof and with	PBSPs were developed by professionals with a Master's degree and varying levels of experience and familiarity with applied behavior analysis. At the time of the on-site tour,	

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	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.	none of the psychologists in the facility were Board Certified Behavior Analysts (BCBAs), however, four of the eight psychologists had begun taking classes to become eligible to take the BCBA exam. The attainment of a BCBA is important because it represents an objective measure of competence in applied behavior analysis. Additionally, the course sequence necessary to sit for the national exam presents practical and important information on topics, such as data collection, graphic presentation and interpretation of data, functional assessment, and behavioral interventions that the monitoring team believes would be very beneficial in enhancing the behavioral skills of the current psychology staff. At the time of the on-site tour, there was no plan/policy for ensuring that all staff who wrote PBSPs to obtain and maintain board certification in applied behavior analysis. Although the current PBSPs at SASSLC appeared to effectively identify and address antecedent conditions that provoked undesirable or dangerous behaviors, the monitoring team believes that the current psychology staff's competence in applied behavior analysis did not meet the requirements of this provision item.	
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 employed a Director of Psychology. The director had a Master's degree in psychology and had worked at the facility for 22 years. She had been the director of psychology for 10 years. The director was currently enrolled in course work towards the BCBA certification. Observations of meetings and interactions with psychology staff suggested that she served as an excellent manager and mentor for the psychology staff. Although she was not licensed in her discipline of practice (which would require a Ph.D. because she was a psychologist), the monitoring team believes she possessed the skills in general psychology, had the necessary leadership qualities, and was currently getting the advanced training in applied behavior analysis to be a qualified and effective director of psychology.	
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.	DADS established a policy (Psychological and Behavioral Services, policy #008) that required a peer-based system of review of PBSPs. No documents or conversations with the psychology department staff indicated that peer review was occurring at the facility. An active peer review system would allow the psychology staff to share their strengths and insights with each other and would result in improved overall quality of PBSPs. Peer review at the facility should occur weekly and, at minimum, consist of PBSP authors and those that supervise the implementation of behavior plans. The psychology department conducted weekly Behavior Therapy Committee meetings that were designed to review and approve new or annual PBSPs. The monitoring team believes that this meeting could be combined with a weekly internal peer review meeting. Additionally, the value of peer review could be extended by adding monthly	

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		external peer review meetings consisting of, at minimum, other Texas DADS BCBAs/supervisors (perhaps by teleconference). Operating procedures for these peer review meetings will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	The current data collection procedure utilized a structured ABC system. This was a recording procedure in which antecedent and consequence events were recorded for every target behavior that occurred. This system appeared to do a good job in collecting and analyzing target behavior, however, the monitoring team was concerned with the reliability of these data. This type of data collection system is typically used during assessment, but not during treatment monitoring. The reason for this is that ABC systems can be very difficult to collect reliable data because staff need to pick out the appropriate antecedent event and the specific consequence that occurred each time one of the target behaviors occurred (and some PBSPs had up to seven target behaviors, see section K11 below for more details). Additionally, in one of the homes (766) the data sheets were kept in a locked room, and in one of the day programs (B-wing), the data sheets were reported by staff to be kept in the residence. In the other homes, the data books were kept in various places, generally far from the individuals served. Staff and supervisors reported that they often tried to write down data on a separate piece of paper after it occurred and then record it at a staffing break or at the end of the work shift. This practice, however, was not likely to produce accurate data. Moreover, data reliability was not formally assessed and target and replacement behaviors were not routinely graphed. The monitoring team suggests that the data collection system be streamlined, data reliability be regularly assessed, and targeted and replacement behaviors be routinely graphed at a frequency (e.g., weekly, daily) that would be sufficient for data-based decision making. A system was in place for summarizing target behaviors monthly and presenting them in the annual review of the PBSP. There also was evidence that PBSPs were modified as necessary. Two examples are presented below: • Individual #276's annual PBSP was completed in Feb 2009, and it was modified in May of 2009 due to an increased health risk associated with community outings. • Individual #103's plan was modified (or target behaviors redefined) four times	

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		during 2009 as a result of substantial changes in his behavior. Despite these clear examples of data-based modifications in some PBSPs reviewed (six of 25 PBSPs reviewed contained modifications within the annual review period), five plans listed below revealed an absence of progress and/or an increase in undesirable behavior with no obvious change in the PBSP or the data collection system. • Individual #205: physical aggression, disruptive behavior, and self-injurious behavior • Individual #47: inappropriate social behaviors, self-injurious behavior • Individual #64: physical aggression • Individual #141: self-injurious behavior • Individual #306: self-injurious behavior, disruption In addition, data were not routinely graphed to make data-based decisions most effective. Direct care staff consistently indicated that their input was solicited in the modification of PBSPs and data collection systems, however no documentation of staff input in functional assessment development, PBSP development, or data collection was found. All target behaviors (including replacement behaviors) should be graphed regularly. These data should be graphed at intervals sufficient to make databased decisions. For example, daily, or more frequent data, may be necessary to identify the effects of medication changes on an individual's behavior. A sensitive data system that identifies this trend could, for example, assist the psychiatrist in the most effective use of a medication. Additionally, it is important when individuals' data trends in an undesirable direction that hypotheses be developed (perhaps requiring the redoing of the functional assessment) and modifications to the PBSP occur immediately and consistently for all individuals served. Finally, it is recommended that staff input into PBSP development and data collection be regularly requested and consistently documented.	
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,	SASSLC began conducting psychological assessments in December 2009. At the time of the on-site monitoring tour, psychological assessments had been completed for only four individuals. The format of the psychology assessments used at the facility (as per the DADS policy on psychological and behavioral services) appeared complete and addressed standardized assessment of intellectual and cognitive ability, adaptive ability, and a review of personal history. The new format also contained a section that reviewed the functional assessment results and that included an assessment of biological, physical, and medical status.	

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	and of other psychological needs that may require intervention.	The four psychological assessments available for review (i.e., Individual #325; Individual #234; Individual #152; and Individual #72), however, did not contain an assessment or screening for psychopathology or biological, physical, and medical status. If an adequate screening or assessment for these areas existed in the functional assessment, adding the results of the functional assessment into the psychological assessment (as suggested in the DADS policy) would address this concern. For individuals whose psychological assessment indicated a behavioral disturbance, a functional assessment was provided. The functional assessment format included procedures commonly accepted by the field of applied behavior analysis to be important to consider when attempting to understand the variable or variables maintaining a behavior. Both indirect and direct measures, such as staff interviews and ABC data collection, were used to identify relevant learned and biologically based behaviors. Additionally, relevant setting events, antecedents, and consequences related to undesired behavior were included. The functional assessment included hypotheses of the functions of the desired behavior. Finally, the functional assessment included an assessment of individual preferences and reinforcers, but those preference assessments were based exclusively on staff report. The behavioral literature suggests that the identification of preferences based on staff reports are often ineffective, and suggests the use of systematic preference assessments as a more effective method. Although the functional assessment format appeared to be complete, many of the functional assessments appeared similar, giving the monitoring team the impression that they perhaps were not in fact individualized, functional, or effective. For example, the Summary of Functions of Challenging Behaviors section of the PBSP for both Individual #276 and Individual #218 were almost identical and included, "… she engages in maladaptive behaviors in order to reduce the amount of perceived stress in her life." This statement was not only identical for both individuals, it was not functional because it did not suggest an obvious measure or objective action (i.e., how to know when she has perceived stress, or when the intervention has reduced it). The purpose of a functional assessment is to identify objective variables that are hypothesized to affect a behavior and, therefore, can be manipulated by direct care staff to reduce the likelihood of maladaptive behaviors and increase the likelihood of desired behaviors. A functional assessment is neither functional nor effective if it is not individualized, or if hypothesized functions are poorly defined or poorly understood by the staff who are responsible for implementing the PBSPs. Although a functional assessment was found in the records of every individual in the sample of individuals with a PBSP, the monitoring team could not identify any examples of the functional assessment being reassessed as an individual's behavior changed.	

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		Psychological assessments need to be conducted for all individuals served as per the requirement of this provision item. The monitoring team also suggests that an assessment of psychopathology and medical status be added to the current psychological assessment. Additionally, efforts need to be made to increase the effectiveness of functional assessments by ensuring that they are consistently individualized, written in objective and measurable terms, and reassessed when individual's behavior does not meet treatment expectations, or at minimum, annually.	
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.	It was not obvious from record review of the four existing psychological assessments that they were based on current, accurate, and complete data. Rather, they appeared to be based on a presentation of historical information. A policy and practice should be developed to ensure that • all individuals receive annual psychological assessments, • the information reported in the psychological assessment is based on current, accurate, and complete clinical data, and • that the assessments are completed by a psychologist qualified to conduct and interpret psychological assessments.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	The process of completing psychological assessments began in December in 2009, and only four were completed at the time of the on-site tour. Psychological assessments need to be conducted as often as needed, and at least annually, for each individual. Additionally, psychological assessments should be completed within 30 days for newly admitted individuals. Another important issue was whether all individuals at SASSLC who needed to be assessed received an assessment, such as a functional assessment, and a PBSP, if needed. This issue came up in regards to Individual #65. He was observed in a small room with five other individuals and one staff member. Individual #65 became aggressive towards the staff member, grabbing, scratching, and biting him. The house manager was nearby and assisted by directing the staff member to move behind the individual to avoid being aggressed upon. Then the house manager asked the individual what was wrong and if he was OK. The house manager then took him on a walk down the hallway and into the large living room. The incident was successfully de-escalated and restraint was avoided. The staff member, however, was hurt. He had a severe bite on his forearm that had broken the skin. The monitoring team later inquired about whether Individual #65 had ever demonstrated this behavior before and was told that it was not a common occurrence. Thus, this seemed to be a reasonable way to end an incident without escalation. Unfortunately, reviews of other facility documents indicated that this same	

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		individual had a history of aggressive behaviors and that a PBSP might be needed. The documents reviewed included emails between QMRPs, managers, and QE department staff over the course of a two-month period from July through September 2009. Some of the emails indicated that his behavior outbursts occurred once or twice per month and that a PBSP might be needed. There did not seem to be any follow-up to these emails and a PBSP was never developed. Severe aggression that results in injury to staff is usually worthy of assessment and a PBSP.	
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.	No services (other than PBSPs) were identified in the current psychological assessments. As indicated above, only four assessments were presented to the monitoring team. These appeared to be the only assessments completed at the facility. Given the range of abilities demonstrated across the individuals at SASSLC, it appeared likely that at least some of the individuals might benefit from other psychological services. It appeared that the facility did not have a system to determine if an individual might be appropriate for these other types of services, such as counseling. If psychological services other than PBSPs are identified as being needed, these services should be implemented within six weeks of the assessment. Additionally these services should reflect evidence-based practices and be goal directed with measurable objectives and treatment expectations. Finally the psychological assessments should include documentation and review of progress of these services. SASSLC's experience completing psychological assessments was limited. Therefore, subsequent monitoring visits will more closely evaluate the development and use of psychological assessments.	
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	Twenty-five of the 206 written PBSPs at SASSLC were sampled to assess compliance with this provision. All of the PBSPs had the necessary consents and approvals. Generally, the PBSPs contained many of the components one would expect to find in a PBSP, such as a rationale for the intervention, consideration of medical issues, operational definitions of target and replacement behaviors, and a description of potential functions of the maladaptive behavior. Additionally, the plans included both antecedent and consequent strategies for changing behavior. Some of the plans included treatment expectations and timeframes (e.g., Individual #276), but many plans did not (e.g., Individual #155). Similarly a few plans included a history of prior interventions (e.g., Individual #141), but many did not (e.g., Individual #315). It is recommended that a consistent format that includes treatment expectations be used for all PBSPs. All the sampled PBSPs discussed individual preferences, however, as discussed in section	

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	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.	K4 above, they all appeared to be determined by staff report. For some of the plans, the antecedent intervention portion of the plans appeared to be in line with the assessment results. For example, Individual #315's functional assessment revealed that he engaged in self-injurious behavior (SIB) to communicate his wants and needs. Therefore, asking for snacks in an appropriate manner was reinforced by providing praise and the item, when possible. On the other hand, it was not clear in many of the plans as to how the consequence events were related to the functional assessment results. For example, Individual #315's PBSP also stated that if he woke up screaming and engaged in SIB, to give him a snack so that his dangerous behavior did not escalate. This pattern was seen in many of the PBSPs. That is, presence of a functional assessment indicating that a target behavior was motivated by a specific environmental condition (e.g., access to a person or tangible item, or escape or avoidance of an unpleasant activity) and the specification of appropriate antecedent events (e.g., encouraging the individual to appropriately request the items, or appropriately state that he or she was no longer interested in the activity) followed by the inadvertent encouragement of dangerous behavior by providing the consequence that were hypothesized to maintain the target behavior in the first place. This was played out in the majority of functional assessments and PBSPs reviewed. Clearly, the effort and skill that goes into identifying the variable or variables maintaining the target behaviors and the extensive use of antecedent procedures to avoid the occurrence of the behavior represent exemplary use of behavioral procedures, and likely account for much of the improvement observed (i.e., dramatic decreases in restrictive procedures across the facility) in individuals' problem behaviors at SASSLC. On the other hand, it was clear that for many individuals, the programmed consequences were not based on functional assessment results at all. The contents of PBSPs (particularly the consequence events) should be more clearly based on functional assessment results. Finally, although the identification of replacement behaviors was present in the majority of PBSPs sampled, specific strategies for teaching these important behaviors was generally not present. Specific skill acquisition plans should be reliably implemented for replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation for other skill acquisition plans at the facility. These plans should be based upon a task analysis (when appropriate), have behavioral objectives, contain a detailed description of teaching conditions, and include specific instructions for how to conduct the training and collect data (see section S1 below for a more complete review and discussion on the use of skill acquisition plans at the facility).	
K10	Commencing within six months of	There was no evidence from observation or staff interviews that inter-observer	

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	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.	agreement measures existed for PBSP data at SASSLC. Having a system to regularly assess the accuracy of PBSP data is a best practice in applied behavior analysis, and a necessary requirement for determining the efficacy of treatment. Additionally, as discussed in section K4 above, PBSP data were not consistently graphed. Instead data were typically presented in a table. PBSP data (including replacement behaviors) should be graphed and presented in increments that would be sensitive to individual needs and situations (e.g., daily or weekly graphed data to assess the changes associated with a change in medication or target behaviors). These graphs should include horizontal and vertical axes and labels, condition change lines and label, data points, a data path, and clear demarcation of changes in medication, health status, or other relevant events.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	Generally, the PBSPs were written in a manner that could be understood by direct care staff, however there were exceptions (see examples below). Additionally, although all staff indicated that they understood the PBSPs and were trained on how to conduct them, observations suggested that actual implementation of PBSPs was mixed. • Individual #306's PBSP procedures were clearly presented, staff in her home were able to describe her plan, and they appeared to doing an excellent job of implementing it with integrity. • Individual #276's PBSP was very difficult to understand. It included eight target behaviors (one of which was delusional thinking which was not defined very well), and five or six steps to follow the occurrence of each target behavior. The plan was 18 pages long and as a consequence it was not surprisingly to find that staff could not consistently describe her plan, or even her target behaviors. In addition, there was no evidence that SASSLC implemented a system to monitor and ensure treatment integrity (whether the plans were implemented in the way they were designed). All PBSPs should be reviewed and modified, if necessary, to ensure that they include language that is appropriate to the typical educational background of direct care staff at SASSLC. Additionally, it is recommended that the number of target behaviors and size of the documents be minimized. Finally, the only way to ensure that direct care staff can and do consistently implement PBSPs as written, is to establish and implement a systematic treatment integrity assessment tool.	
K12	Commencing within six months of	A review of a sample of eight training logs indicated that SASSLC was providing	

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	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.	competency-based training on the overall purpose and objectives of the specific components of individual's PBSPs. Training log reviews and interviews with staff indicated that the training included a combination of didactic, modeled, and in-vivo training strategies. Training reportedly occurred both before implementation of the PBSP and throughout the duration of the PBSP. Staff training of the PBSPs was provided by the psychologist responsible for the plan. It was not clear, however, how, or if, the facility tracked who was trained and who needed to be trained. The Director of Psychology indicated that following training on the PBSP, the trainer sent a list of staff attending to the home supervisor. Following that, it was not clear who was responsible for tracking who might have missed the training and what system was in place to ensure that all staff received training. It was also not clear if the facility had a system to ensure that pulled and relief staff received training on PBSPs they were responsible to implement. It is recommended that the facility develop a more coordinated system between the psychology department and home and vocational supervisors to ensure that all staff (including pulled and relief staff) are trained in the implementation of each individual's PBSP.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	The psychology department employed nine (including the director of psychology) psychologists serving 283 individuals. This was slightly below the 1:30 ratio that the settlement agreement required. Additionally, the department had three psychology assistants, which was approximately two under the requirement of one psychology assistant for every two psychologists.	

Recommendations:

1. Although the monitors were encouraged that 50% of the psychology staff responsible for developing and monitoring individual's PBSPs were enrolled in a BCBA certification program, it important that the facility develop and implement a plan and policy to ensure that all staff writing PBSPs are BCBAs.

2. Establish both internal and external peer review committees.

3. Simplify the data collection system. Develop a method to assess the reliability of data collection. Routinely graph all target and replacement behaviors at intervals necessary for data-based decisions.

4. Seek staff input for PBSP and data collection system development and modification.

5. Complete psychological assessments for all individuals. Additionally, an assessment of psychopathology and medical status should be added to the current psychological assessment format.

6. Ensure that those individuals who need an assessment and possibly a PBSP receive those services.

7. Ensure that functional assessments are individualized and functional. Additionally, functional assessments should be reassessed at least annually, or more often if individual's behavior trends in an undesirable direction.

8. Psychological assessments should be based on current, accurate, and complete clinical data. Psychological assessments should contain needed services (beyond the need for a PBSP), and those services should be implemented within six weeks of the completion of the assessment.

9. Ensure that PBSPs are based on functional assessment results.

10. Ensure that specific training strategies and procedures are present for the development of replacement behaviors identified in the PBSP.

11. Develop a plan to obtain inter-observer agreement of PBSP data.

12. Ensure that all PBSPs can be understood and implemented with integrity by direct care staff. Develop a plan to monitor treatment integrity.

13. Develop a system to ensure that all staff are trained in each individual's PBSP.

14. Meet the required psychology and psychology assistant staff ratios.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o List of all individuals being treated for seizure disorders o Record reviews of the following individuals: • Individual #336, Individual #34, Individual #341, Individual #36, Individual #312, Individual #165. o Relevant Healthcare Guidelines Interviews and Meetings Held: o One meeting with Medical Director, Dr. Carmen Mascarenhas, o One meeting with Drs. Mascarenhas, David Hazlett, Albert Thomason, and Julie Moy. Dr. Moy was the central office DADS Director of Medical Services. o A conversation in House 673 for medically fragile individuals with Lola Faulkner, R.N., Nurse Manager for the Medically Fragile Unit; Pat Jones, House Supervisor; Isabella Jimenez, R.N.; Rosella Kliewer, QMRP; and Pat Jones, House Supervisor. Observations Conducted: o Medical rounds with Dr. Mascarenhas.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility had three primary care physicians, totaling 2.75 FTEs. All three primary care physicians (PCPs) were capable, genuinely concerned with the well being of the individuals served, and thorough in their approach. One of the physicians was an endocrinologist, which served great benefit to the facility. They struck a warm and collegial tone with each other and with the psychiatrists. There were two psychiatrists at the facility, totaling 1.0 FTE. In addition, there were specialty clinics and nursing services. No non-employee agency nurses were used. While, as noted below, the facility had not established policies and procedures pertaining to QA/QE, nor was medical quality of care being provided in a manner consistent with the Settlement Agreement (including the Healthcare Guidelines), medical services appeared to be meet, in general, the needs of the individuals, however, this was a baseline on-site tour and more assessment will be required during subsequent monitoring. The quality suffered primarily from inadequate integration with other disciplines, particular psychiatry.

	This deficit was neither for lack of awareness nor initiative on the part of the PCPs. On the contrary, they presented as acutely aware of the need for improved coordination of care, and expressed interest in innovation that might facilitate it.

#	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.	A state policy had not yet been developed for this provision. It is expected that once developed and implemented, the policy will provide the facility with guidance and direction in this area. Nevertheless, there was good compliance with annual physical exams, immunizations, cancer screening including stool guaiac, PSA, colonoscopies, and PAP smears. There was evidence of functional vision and hearing assessments consistent with current generally accepted professional standards of care. Preventive flow sheets were utilized and up to date. The primary care physicians saw individuals in their residences for routine medical care. The Medical Director described an excellent and efficient working relationship with a local facility, Methodist Hospital, for medical emergency care. The parties had identified applicable standards and those were called Health Care Guidelines. These had not yet been incorporated into the medical systems at SASSLC.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	State policy on medical services, once developed will provide guidance to the facility regarding this area. Even so, the facility had taken some steps regarding external reviews. Examples of reviews in place at the time of the on-site tour were: • A primary care physician and a psychiatrist conducted facility-wide reviews. This was contracted through the consultant entity, Columbus, and had occurred twice in the prior year. • Clinical death reviews 14 days after a death (45 days if there had been an autopsy). These were conducted by a community-based physician, Dr. McCoy in Houston, with Dr. Moy participating in Austin via teleconference. • A functioning Ethics Committee, chaired by an internist, Dr. Baruch at University Hospital in San Antonio. In addition, consultations were received from a number of community physicians, including the following: • Ophthalmology--Dr. Frey	

#	Provision	Assessment of Status	Compliance
		• Physiatry--Dr. Leonard • Neurology--Dr. Saravia • Orthopedics--Dr. Carlisle • Dermatology--Dr. Thurston • Podiatry--Dr. Veglia • Gynecology--Dr. Okoli	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	This provision was not yet being addressed at the facility. The medical team indicated that the process was to be implemented on a statewide level.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Dr. Mascarenhas indicated that they were committed to medical care consistent with current, generally accepted professional standards of care. The facility had not yet, however, integrated the agreed upon Healthcare Guidelines into new policies and procedures. All three physicians spoke out strongly against the utility of the "Health Status Team" meeting that had been in place for 15 months. They described the purpose of this meeting as assigning a risk level and making recommendations pertaining to risk. Their consensus was that this process already happened in multiple other venues, therefore, it was seen as duplicative. This represented a very significant time commitment for all attendees. They estimated that there were 22 of these meetings per year, each one requiring approximately an hour of preparation and up to two hours in the actual meeting. They thought that an alternative arrangement would be if the PCPs went to the quarterly psychiatry clinics. The monitoring team asked Dr. Moy, who was at the facility, to participate in a meeting about this concern. She supported the PCPs' concerns, adding that there was no evidence base in the literature that demonstrated that the instrument SSLCs were currently using was valid, and she was unable to find any validated instrument in the literature at all. Dr. Moy expressed interest in the facility staff members' ideas about changing the	

#	Provision	Assessment of Status	Compliance
		protocol in such a way that the staff would then see the process as meaningfully contributing to ensuring provision of medical care consistent with current, generally accepted professional standards of care. Dr. Moy clarified to the PCPs her wish that they continue to explore innovative ways of improving service. She emphasized that she did not want concerns about compliance with the Settlement Agreement to paradoxically interfere with initiatives that might improve standards of care. As noted elsewhere in this report, the monitoring team found numerous problems in the assignment of risk levels to individuals. The outcomes did not meet the Settlement Agreement requirements or follow the state's own policy. The monitoring team was encouraged to learn that the state would be looking in to this matter further.	

Recommendations:

1. In concert with statewide initiative, develop and implement facility policy and procedure pertaining to medical services.

2. All prescribing physicians should consult each other about any planned changes in the medication regimen of individuals, in advance of making said change.

3. Continue to develop ideas about functional alternatives to the "health status team" meetings, collaborating with Drs. Mings and Mitchell, and subsequently taking Dr. Moy up on her suggestion that they propose alternative models to her.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o DADS policy, Nursing Services, #010, dated 12/17/09 o Requirements of the separate monitoring plan, identified as Health Care Guidelines o Current decubitis ulcers (five individuals) o Current weight clinic document (diet roster), weight clinic minutes, and weight clinic notes from July-December, 2009 o Home 766 Weight Reduction program, notes regarding three women with Prader-Willi Syndrome o Home 766 Exercise Program Individual Tracking Sheet o Pharmacy cart delivery dates o Current unit staffing for LVNs o ER visits 1/1/09-12/30/09 and hospital admissions from 1/1/09 to 12/30/09 o Hospital report dated 10/2009 o Individuals with pneumonia diagnosis 1/1/09-12/31/09 o Risk lists for the following: Respiratory, Cardiac, Weight, Challenging behavior, Choking, Dehydration, Diabetes, Medical concerns, Skin integrity, Polypharmacy, Osteoporosis, Injury, Seizures, GI concerns, Urinary tract infection, Hypothermia, and Constipation o Weight clinic minutes 6/3/09 o Fractures and sutures 7/1/09-1/31/10 o List of 10 individuals who had the most injuries o San Antonio State School Health Management Plans for • Individual #31, Individual #35, Individual #21, Individual #34, Individual #30, Individual #23, Individual #36, Individual #32 o Job Description: Hospital Liaison Nurse o Aspiration Risk Assessment o Wound/Pressure Investigation Process o Memo regarding use of papoose boards dated 10/21/09 o Head injury protocol o Health management plans for: • Individual #30, Individual #31, Individual #32, Individual #33, Individual #34, Individual #35, Individual #36, Individual #21, Individual #23 o List of hospital discharge diagnoses for hospitalizations for the last three months o Aspiration worksheet o Individual #197 post hospital workup o Neurological Assessment Form o Reviewed documents for the following individuals: • Individual #1, Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, Individual #7, Individual #8, Individual #9, Individual #10, Individual #11, Individual

	#12, Individual #13, Individual #14, Individual #15, Individual #16, Individual #17, Individual #18, Individual #19, Individual #20, Individual #21, Individual #22, Individual #23, Individual #24, Individual #25 o Reviewed the Death Summaries for individuals who died in the last 12 months: • Individual #26, Individual #27, Individual #28, Individual #29 <u>Interviews and Meetings Held</u>: o Chief Nurse Executive o Five nurse managers (one was the hospital liaison nurse) o Six nurse case managers o Four LVNs o Spoke with numerous nurses on the living units o Clinical dietician o Dentist at the dental clinic o Spoke with facility pharmacist <u>Observations Conducted</u>: o Medication pass on Tuesday @ 7:30 am in Bldg 670 and 73B at 3:30 pm
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: A number of strengths in the area of nursing were noted at SASSLC. These were observed in the areas of nursing leadership, hospital liaison processes, and the management of individuals with weight issues Areas that needed attention included: • Nursing assessment: There was a failure to adequately identify health problems, such as GERD and aspiration, and there were no assessments for unique expression of pain and discomfort. • Annual health care plans: These were primarily based on what was available from a format for persons without disabilities. • Medication administration and documentation: Medication administration was satisfactory for the individuals observed and in some homes documentation was excellent. In other homes, the MARs were full of missing initials. • Charting to resolution for illness and injury: There were multiple examples of illnesses and injuries that had been labeled "will continue to monitor," but there was no further comment and no indication of when the illness or injury resolved. • Identification and management of health risk: Physician's orders sometimes appeared with no indication of when that practitioner was notified or if a nursing assessment was done.

	• Interdisciplinary collaboration: This necessary component was underdeveloped at SASSLC, but was necessary to solve numerous problems, such as positioning for intake and emptying, particularly for individuals with GERD and gastroparesis. In addition, the risk identification process reflected an isolated model, apparent across several areas in which no individual was identified to be at risk while at the same time, there had been many ER visits and hospitalizations for the issue. • Seizure management: Although seizure management was generally acceptable (see details in the health care guidelines section of this report on seizure management), seizure activity was inadequately described and this hampered the ability of the physician to provide appropriate treatment. Seizures fall into two major categories, but there are many subtypes in each. An inadequate description, such as, "Had a 10 second seizure," failed to provide the physician with adequate information about the antecedents (e.g., stared off into space, picked at clothing) and postictal states (e.g., difficult to arouse for an hour after the event). There was no real description of the seizure in many cases. There are more than 40 distinct types of seizures and the descriptors of before, during, and after are important to know because many individuals have more than one type. • GERD: There was no evidence that the nurses recognized and included, in both assessments and health care plans, information about the impact of positioning and alignment for individuals with a number of GI issues. For example, the individual needs to be elevated with the head and trunk in alignment at least 20 to 30 degrees. Nursing did, however, recognize the importance of bolus feeding. • Respiratory issues: There was a high rate of aspiration pneumonia. While 17 cases of aspiration pneumonia might seem low in a population of 280, a significant percentage of the 45 pneumonias were also likely to have been the result of aspiration. • Acute illness and injury: There was inadequate documentation of follow-up, particularly to resolution, for acute illness and injury. There was good management and follow along while the individual was in the acute care setting, and good plans for management following an acute condition, but it was difficult to track to resolution in the record in a number of cases.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status	A number of strengths in the area of nursing were noted at SASSLC. These were observed in the areas of nursing leadership, hospital liaison processes, and the management of individuals with weight issues The facility nursing assessment process lacked sensitivity to adequately identify and address health care problems in the following areas: • Aspiration risk assessment: In the 12 months between 1/1/09 and 12/31/09, 45 individuals experienced a pneumonia diagnoses and 17 of these were identified as aspiration pneumonia. At the time of the on-site tour, no individuals in the facility were identified at risk for respiratory health issues.	

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	sufficient to readily identify changes in status.	• During the same time period, 10 individuals were seen in the ER for respiratory events, and 61 individuals were admitted to the hospital with respiratory events. • Only three individuals were cited at risk for skin integrity, but five individuals were being treated for skin breakdown at the time of our visit. • Only one individual was listed at risk for cardiac issues and yet five individuals were hospitalized a total of seven times for cardiac problems • Only four individuals were listed at risk for injury, yet one individual was hospitalized. Thirty-seven individuals visited the ER a total of 50 times due to injuries in 2009, and only two of the identified individuals at risk were on the ER list. • Only five individuals were on the high risk list for seizures however nine individuals were hospitalized 13 times for seizure management, including four of the five on the high risk list. Five other individuals, not on the list, were hospitalized for seizure issues. Sixteen individuals went to the ER a total of 30 times for seizures, and only three of the five individuals on the high risk group were a part of this total, with the remaining 13 going a total of 17 times for seizure management.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The annual and quarterly nursing assessments often did not identify major health issues, such as GERD, constipation, weight instability, and other manageable issues. These were often missed and not addressed in acute and chronic health care plans and in those cases where they were addressed, it was done so in a superficial manner. • Individual #25: The annual nursing assessment failed to address GERD, which was one of her medical diagnoses. • No individuals were identified at high risk for GI concerns, yet 13 individuals were hospitalized for GI issues during 2009 and 17 individuals went to the ER to address these concerns. • Five individuals appeared on the high risk list for urinary tract infections, yet nine individuals were seen at an ER a total of 20 times in 2009, and 18 individuals were hospitalized a total of 23 times with a urinary tract issue included as a part of the discharge diagnoses. • No individuals were identified at risk for hypothermia, but three individuals were seen at the ER a total of four times for hypothermia, and six individuals were hospitalized seven times with hypothermia as one of their discharge diagnoses. • Some 10 individuals were on a list titled "Medical Concerns" without further specification.	
M3	Commencing within six months of	There were not enough effective interventions in place for conditions such as GERD and	

#	Provision	Assessment of Status	Compliance
	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.	chronic constipation. For example, Individual #19 had a recurrent aspiration pneumonia and a low albumin. He had very poor oral hygiene without recognition of the possibility that his oral hygiene might have contributed to his aspiration issues. He received phenytoin which can very quickly become toxic when the individual's albumin is low. The quarterly drug review recognized and cautioned about this, but there was no evidence that this was picked up in the nursing care plan. While nursing interventions were fairly competent if they were to be used for individuals without disability, they were lacking in comprehensiveness for individuals with complex disabilities. Health care plans and their associated nursing interventions seldom went deep enough; some conditions were being ignored altogether (most commonly GERD). This particular condition has been known to account for up to 80% of all cases of aspiration, but what was required to manage this and other associated GI issues was not addressed at this facility. A number of serious behavior disorders, such as pica, rumination, and hands-in-mouth, were not recognized as a potential symptom of GERD, and, therefore, were not a part of any assessment or intervention process. • Individual #21 had a plan dated 12/09/09 for high risk for aspiration related to a gastrostomy tube stated that the head of the bed should be elevated at least 30 degrees at all times. This was an appropriate statement, however, there were other actions and issues important to the individual's health that were not addressed, such as being fed sitting up or in a position that elongated the trunk and assisted the stomach into normal position. Individuals with physical disabilities should be assisted to a position that facilitates emptying for at least one hour after mealtime, such as elevated right side lying • Most of the plans appeared to be taken from a standardized care planning resource, which did not take into account the needs and issues for individuals with profound physical and mental disabilities, particularly those who had no effective means of communication. Nursing staff did not appear to be provided with sufficient opportunities to access relevant information and training. • Individual #5 had many falls and many minor injuries and had lost 10 pounds in two months from 12/09 to 2/10. He weighed 199 pounds in 1/09 and 174 pounds in 2/10. This was a 12.5% weight loss in a year (IBW was 160 to 200 pounds for this individual). There was no specific mention of Individual #5 in the weight clinic notes from 6/1/09 to 12/09. His dental records stated in 2006, 2007, and 2008 that oral hygiene was non-existent. Nursing care plans did not adequately address oral hygiene, unsteady gait, and did not identify lorazepam (a benzodiazepine) as a potential contributor to his falls. There was no evidence of collaboration with a psychologist to address his resistance to oral hygiene.	
M4	Within twelve months of the	The facility needed to make improvements in order to meet this provision item.	

#	Provision	Assessment of Status	Compliance
	Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Examples are presented below: • As noted above in section M3, Individual #5 had a history of recurrent aspiration pneumonia and many falls. He weighed 199 in 1/09 and 184 in 12/09 and by 2/10 his weight was down to 174. • The weight clinic notes seemed to identify individuals with weight loss issues (except for individual #5 as noted immediately above), but was short on strategies for intervention and feedback. • The neurological assessment protocol for head injury was difficult to track in the record. There were different protocols for severe, moderate, and mild head injuries. The head injury protocol (HIP) was in the record, but did not indicate the severity or date of resolution. • Individual #3 had an entry dated 12/25 noting stomach pain, but no follow-up occurred until 12/29 when an entry stated that there was no further complaint of stomach pain. There was no nursing assessment on 12/25, and no indication that anything was done at this point. The 12/29 entry stated that they "will continue to monitor." Nursing documentation in other areas was also very problematic, mostly because there was too much subjective information in the record. Statements, such as "slept well" and "had a good day," obscured important data. For example, homes 673 and 674, there were extensive entries for each day whether or not there was any meaningful nursing information to report.	
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.	There was a weight clinic that met monthly with membership consisting of the Nursing Director, Director of Habilitation, Chief Dietician, Physician, a QMRP, and the Clinical Pharmacist. This was the best example of interdisciplinary assessment and problem solving found at the facility during this on-site tour. The group was not part of the PNMT, but did a good job of identifying and intervening for those individuals who had unstable weight patterns. Most interventions focused on either increasing or decreasing calories. More attention should go to identifying root causes for some individuals, such as reflux esophagitis, cancer, or cardiac issues. Risk indicators need to be seen as overlapping and related. The process of defining someone as not at risk because there was a nursing or medical plan did not meet the generally accepted professional standard of care. Numerous problems and inconsistencies in the assignment of risk were listed in section M1 above and are not repeated here. The issue of assignment of risk is noted in numerous sections of this report and will require attention from the facility.	

#	Provision	Assessment of Status	Compliance
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.	Overall, the process of medication administration appeared to be reasonable and with good outcome for individuals. A review of 25 records, however, found many "holes" in the medication administration records (MARs) or treatment administration records. In some cases, there were as many as 25 or 30 undocumented medication administrations. The medication administration procedure was to have the nurse managers check the MARs once per week. Instead, it should be done much more often, such as daily. This activity requires a lot of effort, but is important. Many of the medications not signed for included AEDs which were sometimes prescribed for psychiatric purposes. For example in Individual #3's MAR, 25 medication administrations were not initialed, including chlorpromazine, divalproate, and carbamazepine. Only one record reviewed had no holes, though some only had a few. Examples are provided below. • Individual #3: Mineral oil not documented 8/9, 21, 22, 23, and 30; chlorpromazine not documented 10/7, 27; and divalproate not documented 10/7, 25, 11/7, and 11/25. There were 10 other doses of medication for which there was no documentation through the end of 2009. • Individual #20: Levalbuterol not documented 12/20/09 • Individual #17: Many holes in MAR • Individual #12: Many holes in MAR • Individual #15: Many holes in MAR • Individual #16: Many holes in MAR • Individual #4: Many holes in MAR • Individual #23: Many holes in MAR	

Recommendations:

1. Ensure that nursing assessments identify those concerns that are evident for each individual, especially those areas indicated in section M1 above.

2. Address and improve the system at the facility for assessing and assigning risk to each individual across the many areas of risk required by the state's own policy.

3. Implement an annual health care plan format that is appropriate for individuals with developmental disabilities.

4. Develop a better system for monitoring MARs. A daily check should be done and the facility can consider this becoming an audit-type task.

5. Similarly, an audit-type task could address the need for improvement in charting to resolution.

6. Explore ways of making entries into the record and progress notes that focus on active or newly developing health care issues. Routine and repetitive information, although important, could be moved to a more simplified system, such as flow sheets.

7. Nurses and direct care staff need training to document seizures in a way that is more helpful to the managing physician.

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o POI Monthly submission summarizing by month, for September 2009-January 2010 o Medication error reports inclusive from 12/11/09-1/28/10 o Medication administration records for records reviewed in sections J and L above o Quarterly pharmacy reviews for records reviewed in sections J and L above Interviews and Meetings Held: o Interview with Sharon Tramonte, Pharm. D.
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility benefitted from having a "thought leader" regarding pharmacy services on staff. Dr. Tramonte presented as highly organized and committed to excellence in her department. It was clear that Dr. Tramonte's workload represented well more than a full-time position. Part of the reason for this was that she had been a resource for all SSLCs statewide; presumably that demand will ease as more staff pharmacists are hired statewide.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication	A state policy regarding pharmacy services and safe medication practices had not yet been developed by DADS. It is expected that this policy, once in place, will provide guidance and direction to the facility and the pharmacy department. The psychiatrists described Dr. Tramonte as a helpful resource in this regard. There was documentary evidence of a quarterly pharmacy reviews. The specific requirements of this provision item, however, were not in place, such as a review upon the prescription of every new medication.	

#	Provision	Assessment of Status	Compliance
	regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.		
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.	The documentation of thorough quarterly drug regimen reviews was excellent. The template used to document the quarterly review was detailed and included allergies and sensitivities, DISCUS score and date, current medications, labs laid out in a table format making it easy to compare values by date, therapeutic drug monitoring, seizure frequency with dates listed, a pharmacology assessment yes/no checklist (which addressed the following: presence of polypharmacy as defined in the settlement agreement; appropriateness of dose, frequency, delivery device, and route of administration; presence of potential drug interactions; appropriateness of monitoring; appropriateness of pharmacotherapy; and presence of psychotropic medication in drug regimen), comments section, recommendations, and signature lines for the clinical pharmacologist, the primary care physician, and the psychiatrist. The quality of the information in the comments section was generally quite detailed in a way that demonstrated the rationale over time for psychopharmacologic interventions. In the case of Individual #5, for example, comments for the quarterly review period ending 1/29/09 included "He currently receives two antipsychotics. Previous attempts to discontinue the Olanzepine have resulted in increased stripping, psychosis and aggression.," and "The concurrent use of Benztropine, Olanzepine, Quetiapine, and Fexofenadine could result in an increase in anticholinergic symptoms (sedation, constipation, and dry mouth). Routine monitoring for these symptoms will continue." In the case of Individual #166, comments for the quarterly review period ending 10/30/09 included "an Oxcarbazepine level was obtained in October and again in January 2009. There is no correlation between blood level and efficacy or adverse effects. Continued monitoring of the Oxcarbazepine level in unwarranted… Laboratories reveal a mild intermittent anemia that is most likely due to the chronic use of anticonvulsants."	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18	While there was documentary evidence that Dr. Tramonte and the prescribers consulted often on these areas of concern, there was not any systematic means of monitoring these same concerns outside of the quarterly reviews already referenced. The facility had been	

#	Provision	Assessment of Status	Compliance
	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.	successfully phasing out usage of stat medications and chemical restraint. This is an area that will need attention from the facility and most likely will occur once the new policy on pharmacy services is in place.	
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.	The prescribers had documented either agreement with the recommendations of the pharmacist or their rationale for not following the recommendations. The documented responses, however, tended to be cursory and generic, making it difficult to assess what the physician thought of or did with the recommendations. For example, in Individual #111's quarterly medication review for the period ending 1/26/09, Dr. Tramonte wrote in her recommendations, "Recommend re-evaluating the listed indications for his medications and writing clarification orders as needed. The last TSH level was significantly above normal limits. A repeat level is warranted." Dr. Mitchell wrote, "Reviewed" and signed the document. Dr. Hazlett signed without comment.	
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.	Nursing had been charged with completing these. As previously discussed in section J above, the MOSES and DISCUS were variably present in the records. When present, there were instances where the assessment was demonstrably incorrect. This was a serious problem and should receive attention from the facility.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely	There was no coordinated, integrated process for identifying, reporting, and following up on significant or unexpected adverse drug reactions. For example, there were no examples of adverse drug reaction reports (ADRs).	

#	Provision	Assessment of Status	Compliance
	identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.		
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	A system for drug utilization evaluations was in place and Dr. Tramonte was instrumental in the statewide rollout of such reviews. Specific compliance with the Health Care Guidelines section on medication and pharmacy activities will be reviewed in more detail during subsequent on-site tours.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The reviewed medication error reports demonstrated clear and detailed documentation of errors, and a plan for follow-up. The data were presented in a way that was easily subject to analysis for trends. It was not clear on this visit the extent to which the data had already been analyzed and what role the data played in any actions or follow-up remedial action at the facility. This will be evaluated during the next on-site tour.	

Recommendations:

1. The pharmacist should, with each new prescription, make recommendations to the prescribers regarding side effects and allergies, drug interactions, need for lab, vital sign, or other monitoring. There should be consistent documentary evidence of this occurring.

2. Given that the statewide system for pharmacy services for the SSLCs was currently under construction, it will be useful for the pharmacists to be dialoguing regularly, one component of which should be a "best practices" review.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Reviewed Settlement Agreement: Section XI. Physical and Nutritional Management, and P. Occupational and Physical Therapy o SASSLC Budgeted, Filled and Unfilled Positions by Job Code o CMS Survey dated 04/09/09, 06/03/09, 08/07/09, 09/04/2009, 11/23/09, 12/09/09 o Levels of Supervision, revised 09/01/09 o Current Census by Home o Common Elements of Physical and Nutritional Management o Applicable standards identified as Health Care Guidelines Section VI-Nutritional Management Planning and Section VIII-Physical Management o Physical Nutritional Management policy #012, 12/17/09 o Nutritional Management Policy #013, 12/17/09 o At-Risk Individuals Policy #006, 10/05/09 o Handbook, Habilitation Therapies Physical Nutritional Management, by Karen Hardwick, Ph.D., OTR, FAOTA (September 2007) o Best Practice Guidelines (July 2008) o Credentials for staff as submitted (incomplete response to this request) o Continuing Education records for the speech and language therapists and the occupational therapist o Training outlines including: Lifting/Transfer of consumers, Use of Wheel Locks at SASSLC, Basics of Good Body Mechanics, Osteoporosis, Assessment Checklists for Transfers o PNMP Monitoring form o SASSLC Mealtime Competency Training form o SASSLC Physical Management Competency Training Form o List of Therapy staff and PNM Team members o PNM assessments and updates completed in the last quarter o Continuing Education records for OT staff (Patricia Hajny, OTR) o PSPs for: • Individual #21, Individual #229, Individual #239, and Individual #79 o Habilitation Therapy OT/PT/ST Update Evaluations for the following: • Individual #253, Individual #302, Individual #79 o SASSLC Organizational Chart January 2010 o Habilitation Physical Management Monitoring Forms o Meal Observation Sheets o Personal Record documents including: Individual Information Sheets, , Medical Evaluations,

	Nursing assessment for last 12 months and monthlies, Hospitalization documentation for last 12 months, Current Personal Support Plans and all addendums and quarterly reviews for last 12 months, OT/PT/ST section of record, NMC reports for last 12 months, Integrated Progress Notes, Health Status Review Checklists, NMC Screenings, OT/PT Assessments, Communication Assessments/Updates, OT/PT/ST Evaluations/Updates, Related updates and Reviews for the following individuals: • Individual #319, Individual #92, Individual #31, Individual #335, Individual #332, Individual #265, Individual #144, Individual #333, Individual #45, Individual #18, Individual #40, Individual #164, Individual #227, Individual #215, Individual #323, Individual #91, Individual #333, Individual #79 (requested but not received) o Physical/Nutritional Management Plan for each individual o PNMP format o Dining Plan format o Occupational/Physical Therapy Services #014P, 11/04/09 o Work order spreadsheet o Physical Nutritional Management Wheelchair clinic Progress Notes o List of Individuals with Other Ambulation Devices o List of Individuals with Orthotics and/or Braces o List of Individuals Who Use Wheelchairs as Primary Mobility o Current Diet Roster (02/08/09) o List of names: individuals who had 10% weight change in six months (undated) o List of names: individuals on modified diet textures and/or liquid consistencies downgraded in past 12 months o PNMP/NMC meeting agendas/minutes: January – December 2009 o Health Risk Assessment Rating Tool: • Individual #313, Individual #213, Individual #5, Individual #295, Individual #301 o Health Status Risk Ratings for Home 671 (11/17/09 and 11/10/09); 674 (12/15/09); 672 (01/28/09) o List of Hospitalizations and ER Visits o SASSLC Health Issue lists o List of Pneumonia Diagnoses o List of individuals with pressure sores FY 2009 o Nutritional Management Screening Tools o List of all incidents or injuries since July 1, 2009 o Physical/Nutritional Management Plan for each individual o Dining Plans for all individuals <u>Interviews and Meetings Held</u>: o Margaret Delgado-Gaitan, MA, CCC-SLP o Retha Skinner, MOT, OTR o Kelly Patrick, OTR o Patricia Hajny, OTR

	o Ron Hoffman, MS, CCC-SLP o Allison Block, MA, CCC-SLP o Jan Schaefer, PT o Meeting with QMRPs o Discussions with various supervisors and direct care staff o Discussions with various day program staff <u>Observations Conducted</u>: o Mealtimes o Living areas and day program areas o PNMP/Wheelchair Clinic Individual #82 and Individual #45
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: SASSLC had a system of PNM supports and services that included a group that met monthly to address a variety of PNM concerns. This team (NMC), however, did not include critical team members, such as the physician, physician assistant, nurse practitioner, or PT. The only registered dietitian attended most meetings and the dietary technician attended the meetings in her absence. These meetings were well attended by the SLP acting as chairperson and one OT, as well as two to three registered nurses. Some team members had background, experience, and continuing education, but this was not available to each of those participating on the NMC. The meeting minutes suggested that the meetings were efficiently run and reflected consistency with review parameters. Documentation was well organized, readily identifying PNM issues and status based on extensive record review by OTs prior to the meetings. Follow-up was lacking for those who would be considered at highest risk, particularly post-hospitalization. The current systems that were intended to assign and manage risk issues were not coordinated and integrated; they functioned in a parallel manner. Assignment of risk did not consider thresholds and outcomes related to recommendations and interventions. It was surprising that there were no individuals considered to be at high risk based on the Nutritional Management Screening Tool and the Health Status Risk Assessment tool. A number of issues were observed by the monitoring team to indicate that PNMPs were not consistently and properly implemented. Staff training was not competency-based and monitoring did not occur with sufficient frequency to ensure that staff compliance was routine. The existing monitoring methods were evolving at the time of this review, but plans were not in place to use risk levels to drive the intensity and frequency of PNMP monitoring. There was also no plan in place to track and trend findings to permit targeted and timely staff training.

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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,	PNM team consists of qualified SLP, OT, PT, RD and as needed, consultation with MD, PA, RNP. The current state-approved policy, dated 12/09/09, stated "the NMT is typically comprised of the: a. Physician; b. Occupational Therapist (OT); c. Speech Language Pathologist (SLP); d. Registered Nurse (RN); e. Dietician; and f. Other disciplines as indicated by need including but not limited to Physical Therapy, Certified Occupational Therapy Assistant, Licensed Vocational Nurse (LVN), psychologist, QMRP, home staff, and others." The purpose of the Nutritional Management Team was to: 1. Identify individuals at risk for dysphagia/aspiration; 2. Ensure individuals receive adequate nutritional intake; 3. Decrease instances of choking/aspiration; 4. Decrease health problems secondary to aspiration; 5. Identify individuals with gastroesophageal reflux and other gastrointestinal (GI) conditions; 6. Make evaluation and treatment recommendations; 7. Provide training to staff in Nutritional Management issues; and 8. To conduct other activities as appropriate to ensure safe eating and adequate physical and nutritional health. A PNM team was in place at SASSLC. There was no meeting conducted the week of the on-site baseline review. Membership included SLP, OT, nursing, a dietitian, and a dietary technician only. PTs or MDs/PAs/RNPs did not participate. This group at SASSLC was referred to as the Nutritional Management Committee. NMC meeting minutes were submitted for meetings held from January through December 2009. A meeting was held each month during this year. Attendees were listed for each meeting. The meetings averaged three hours, ranging from two and a half hours to up to four hours, in length. Attendance was documented as follows: • SLP: 12/12 meetings • OT: 12/12 meetings • RN: 12/12 meetings (at least 2-3 RNs attended each meeting) • RD: 10/12 meetings • Dietary Technician: 10/12 meetings Though both the dietitian and dietary technician did not attend all meetings, at least one of these team members was present at all 12 meetings. They were both in attendance for eight of 12 meetings. Participation by PT, psychology, and the physician was not documented. There is documentation that members of the PNM team have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management need. Resumes/CVs for team members were not submitted as requested. The SLP and OT members were licensed in their respective fields of practice as evidenced by licensing credentials submitted. There	

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	the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	was no evidence of licensure, specialized training, experience or demonstrated competence for the RNs, RD, or dietary technician. Continuing education documentation for OT and SLP team members was submitted as requested. Margaret Delgado-Gaitan, MA, CCC-SLP was a licensed speech-language pathologist with more than 20 years of experience in providing services to individual with developmental disabilities, most of which included her employment at SASSLC. Ms. Gaitan served as chairperson for the NMC. She had documented PNM related continuing education in the last year including: • PNM for SLPs sponsored by DADS (2 contact hours) Patricia Hajny was a licensed OT with many years of experience working with individuals with developmental disabilities. She had documented PNM-related continuing education in the last year including: • Activities Training for Program for Students with Severe Disabilities sponsored by ESC 20 (6 contact hours) • Wheelchair Seating: Configuration to Maximize Control Function and Health sponsored by ESC 20 (6 contact hours) • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities sponsored by DADS (6.50 contact hours) • PNMP and Wheelchair Clinic Teleconference sponsored by DADS (1 contact hour) • PNMP and Wheelchair Clinic Teleconference Summer 2009 sponsored by DADS (4 contact hours) State policy identified that "each regular member of the NMT should complete ongoing training in the area of physical and nutritional management for persons with developmental disabilities." Per documentation submitted by SASSLC, PNM-related training during the last 12 months was evident only for the SLP and OT. There was no indication that SASSLC had a plan for training and, therefore, all NMC members were not receiving any ongoing training specific to their duties and responsibilities on the this team. <u>PNM team meets regularly to address change in status, assessments, clinical data and monitoring results</u>. Per state policy, meetings were to be held at least monthly, with additional meetings held related to the following: eating/health problems, changes in risk level by the HST, after esophagrams or other medical or diagnostic tests, before finalizing treatment decisions, to address follow-up activities, and at any phase in the Nutritional Management process. Meeting minutes were submitted with evidence that the NMC met monthly during 2009. Documentation served a dual purpose as both agenda and meeting minutes. The agenda/meeting minutes were maintained by the chairperson. Per the agenda used for	

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		the meeting attended, categories for review included PNMP/PSP, aspiration pneumonia, follow-up from last NMC meeting, six month follow-up, texture referrals, modified barium swallow studies, choking events and additional discussion which included significant weight loss, and other individual-specific topics. The average number of individuals reviewed per meeting ranged from 20 to 46 individuals across these categories. Reason for review was clearly stated for each individual, and the reason for previous review with month and year was also identified. Prior to the meeting, an extensive record review was completed by OT and SLP staff. Each individual's current health status based on the record review was summarized under recommendations/plan. This review also included any reflux medications, swallow studies, diet order, weight range and current weight, and other PNM-related concerns, including positioning. Statements reflecting NMC discussion was documented and recommendations were clearly stated. The individual's NMC risk rating was listed for each PNMP/PSP review. A specific plan for subsequent review was outlined in many instances. When a specific action was recommended there was a scheduled follow-up. For example, in the case of Individual #20, the meeting minutes for 12/17/09 reflected that a swallow study was recommended because of aspiration pneumonia on 11/19/09. Follow-up was scheduled to discuss the findings in January 2010. Consistent follow-up from previous meetings was noted. <u>PNM plans are incorporated into individuals' Personal Support Plans (PSPs)</u>. Each of the PSPs reviewed reflected integration of the PNMP in the following ways: • PNMP was listed as a potential support to address identified risk factors based on the Health Risk Screening Tool in the Risk Tracking Record section of the PSP. • The Assessment section of the PSP listed recommendations from OT/PT/ST, nutrition and diet plan or nutritional management assessments including recommendations to modify or continue the PNMP with review every 90 days. • Team discussion was reflected in the General Discussion section of the PSP and included OT/PT, Nutritional Management, Oral Motor/Feeding and Communication. • Specific strategies outlined in the Action Plan section that corresponded with the strategies in the PNMP. <u>Identification, assessment, interventions, monitoring, and training as outlined in sections O-2 through O-8 as described below.</u> See below.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify	<u>A process is in place that identifies individuals with PNM concerns</u>. The current policy implemented on 01/31/10, a Nutritional Management Screening Tool, was utilized in the "discovery or referral phase" of the process to identify each individual's Nutritional Management Risk. Risk indicators were identified across three levels of risk: High (Level	

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	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.	1), Medium (Level 2), and Low (Level 3). Per the screening tool submitted by SASSLC, risk factors were for aspiration pneumonia, choking, weight loss, GERD, and so on. The screening was too narrow in focus related to physical management concerns that may impact health status. Identification of the risk level was to drive further assessment, intervention, and frequency of review of risk status. The Nutritional Management Screening tool was completed annually at the time of each individual's PSP meeting. The NMC reviewed each individual scheduled for his or her annual PSP meeting in the upcoming month. Record review findings were reviewed and discussed with a consensus on the NMC Screening level. This level was documented on the form with data to support the Committee's decision. The level was also documented in the meeting minutes for that month. The screening tool was not administered in conjunction with the health status review checklists and the two were essentially not related to each other. Screenings completed for PSP meetings held in December 2009 (18) and January (25) and February 2010 (19) were submitted. One for Individual #224 was not scored. There were 48 individuals rated at Level 3, with review to occur as needed. There were 13 individuals rated at Level 2, with review to occur from 30 days to one year. There were no individuals designated at Level 1 whose review was to occur at the next NMC meeting per policy. There were a number of individuals rated as only Level 3 though they presented with more significant PNM health risk concerns. Some examples included: • Individual #254 –GERD diagnosis and hiatal hernia; no evidence of review per 2009 meeting minutes • Individual #163 – Choking with Heimlich (04/27/08 and 05/05/08); no evidence of review per 2009 meeting minutes • Individual #40 – Congestion /early pneumonia in last year, enteral nutrition; Reviewed on: 11/19/09, 12/17/09 • Individual #194 – Hemoglobin/hematocrit (H&H) = 10/30.9; reviewed on: 08/25/09 • Individual #224 – H&H = 11.4/33.9; no evidence of review per 2009 meeting minutes • Individual #349 - Possible aspiration pneumonia (5/08), bilateral infiltrates on chest CT (10/08), enteral nutrition; reviewed on: 11/19/09,12/17/09 • Individual #304 – Recurrent emesis (six times in last year); no evidence of review per 2009 meeting minutes • Individual #193 – Left lower lobe pneumonia (3/09); reviewed on: 02/24/09, 03/26/09, 08/25/09 • Individual #25 – GERD diagnosis; no evidence of review per 2009 meeting minutes; reviewed on: 02/24/09	

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		• Individual #132 – Emesis eight times in last nine months; reviewed on: 01/27/09, 08/25/09 • Individual #268 - Weight loss of pounds in three months; no evidence of review per 2009 meeting minutes There were a number of individuals rated as only Level 2 with significant PNM health risk concerns. Some examples included: • Individual #253 – Pneumonia, bronchitis, and asthma; reviewed on: 01/27/09, 03/26/09, 04/27/09, 07/28/09, 08/25/09, • Individual #333 – Pneumonia (10/09), aspiration pneumonia (07/08 and 01/09, two diagnoses that month; reviewed on: 01/27/09, 08/25/09 • Individual #306 – Recurrent aspiration pneumonia four to five times in the past two years, emesis nine times in the last year, low H&H= 11.1/33.2; reviewed on: 02/24/09, 09/29/09, 08/25/09, 09/29/09, 11/19/09, 12/17/09 • Individual #302 - Recurrent pneumonia, weight loss of 16 pounds in three months, 15-20 episodes of emesis; reviewed on: 01/27/09, 02/24/09, 03/26/09, 04/27/09, 06/30/09, 07/28/09 • Individual #167 – Aspiration pneumonia four times in 2008, GERD diagnosis; reviewed on: 03/26/09, 04/27/09, 05/27/09, 06/30/09, • Individual #18 – Acute respiratory failure, pneumonia, respiratory failure, left lower lobe pneumonia in last year, GERD diagnosis; reviewed on: 01/27/09, 08/25/09, • Individual #21 – Enteral nutrition, chronic gastritis, asthma, GERD diagnosis, suspected colonic ileus, rectal tube four times to relieve colon gas distention; reviewed 11/19/09 • Individual #106 – Modified barium swallow study in 2/08 with diagnosis of severe oropharyngeal dysphagia, laryngeal penetration, and aspiration for all consistencies, and significantly delayed cough response, enteral nutrition, choking incidents in 1997 and 2005; reviewed on: 01/27/09, 05/27/09, 06/30/09, 08/25/09, 10/27/09, 11/19/09, • Individual #66 – Recurrent aspiration pneumonia (10 occurrences since 2007), enteral nutrition, GERD diagnosis, screening stated "no active aspiration pneumonia for 2 years;" reviewed on: 02/24/09, 03/26/09, 07/28/09, 12/17/09 • Individual #277 – Choking event with Heimlich (03/19/08), two occurrences of pneumonia in the last six months, reflux esophagitis; reviewed on: 02/24/09, 05/27/09, 06/30/09, 07/28/09, 08/25/09, 10/27/09, 12/17/09 • Individual #164 – Aspiration pneumonia (01/09 and 04/09) with additional pneumonia diagnoses; reviewed on: 02/24/09,03/26/09, 04/27/09, 09/29/09	

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		Additional concerns were that follow-up for some issues were not conducted in a timely manner. For example: • Individual #333 was reviewed for aspiration pneumonia in January 2009 with recommendations for PST to address oral hygiene concerns. Individual #313 was hospitalized for aspiration pneumonia from 02/29/09 through 03/04/09 and again on 03/24/09 through 03/29/09 with projectile vomiting, but review by the NMC did not occur until 04/27/09. • Individual #217 was hospitalized for aspiration pneumonia on 06/16/09 through 06/19/09, but there was no review by the NMC until 12/17/09 for PNMP/PSP annual review. The pneumonia in October was reported, but there was no evidence of discussion and there were no recommendations. • Individual #66 was hospitalized with recurrent aspiration pneumonia on 10/01/09 through 10/08/09. Review on 10/27/09 did not report pneumonia. The discussion was related to medication for constipation and the nurse was to report on this in November. There was no evidence of follow-up on either issue through December 2009 per the meeting minutes submitted. Observations conducted by the monitoring team found that implementation of dining plans across a number of homes was insufficient to ensure safety for all those with choking and/or aspiration concerns, particularly with regard to position, alignment, and support as well as food texture, liquids consistency, adaptive equipment, and assistance strategies. It was of concern that these issues had not been identified and addressed appropriately. The monitoring team observed numerous instances of inadequate alignment and support during meals and other times during the day. Some examples were: • Individual #235, Individual #190, Individual #324, Individual #302, Individual #273, Individual #333, Individual #229, Individual #189, Individual #345, Individual #38, Individual #281, Individual #200, Individual #151, Individual #287, Individual #323, Individual #45, Individual #236, Individual #18, Individual #75, Individual #119, Individual #124, Individual #273, and Individual #70. Inadequate trunk alignment and support, foot support, and/or head alignment was noted for each of these individuals. The monitoring team observed numerous instances of incorrect food texture or liquid consistency offered to individual and/or other concerns inconsistent with the dining plan.	

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		The Habilitation Director accompanied the monitoring team to the many homes observed during meals. She was very active in intervening and providing on-the-spot coaching to staff when errors were detected. It was of great concern, however, that there were so many errors during mealtime placing these individuals at risk of harm from aspiration or choking. In many of these cases, the errors occurred after staff had completed the system designed to prevent these. The kitchen staff was to serve the correct diet after reading the diet order, including chopping foods to one-half inch for those requiring a chopped diet. Then another staff was to check the food against the dining plan for accuracy and provide the correct adaptive mealtime equipment. Then once it was delivered to the table, but before it was served to the individual, staff were to read the dining plan out loud to another staff to double check that all was correct. Thickening of liquids occurred at the table by staff. Despite all of these checks, a large number of errors were noted as the individual was eating his or her meal. Some of these examples included: • Individual #325- No beverage was served with his meal; his cup was to be one-third, full but was two-thirds full, and there was no dycem mat provided. Two staff were observed to review this plan and did not catch these issues. • Individual #341 – Ice was served in her beverage, but discovered and corrected by supervisor. • Individual #119 – She was to eat in a chair with armrests and support for her feet, but she was seated in a wheelchair with her legs elevated. • Individual #230 – Her dining plan stated that she ate with her left hand, but she was eating with her right; she did not have a beverage available, though the dining plan stated she should drink throughout the meal. • Individual #81 – His dining plan stated that he should have nectar-thick liquids. Staff was spoon-feeding milkshake thickened liquids. When staff was asked about this she held the cup for him. The plan suggested he could drink on his own. Again when asked, staff gave him the cup and he drank independently. When asked about the thickness of fluids, staff stated, "I would say it is nectar-thick." The supervisor intervened at that time and indicated that it was too thick and the correction was made. • Individual #212 – He ate with his right hand, but staff were reaching across from the right to provide assistance which interfered; the table was too low. He was to alternate bites with sips, but staff was assisting with food only and not encouraging fluids.	

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		• Individual #328 – Liquids were thicker than prescribed per the dining plan. • Individual #110 – Staff were spoon feeding liquids rather than using a control-flow cup. When the monitoring team member stood to observe and look at the dining plan, the staff member put on the lid. • Individual #152 – She was to receive nectar-thick liquids. Staff provided liquids that were thinner than nectar-thickness. • Individual #93 – The individual was taking snack in a day program with a plastic picnic spoon, though the plan stated he should use a plastic-handled spoon. He was also seated in a recliner and his food was placed very far in front of him, making access difficult. • Individual #181 – He also was taking snack in the day program with a plastic picnic spoon rather than plastic-handled spoon as designated in his dining plan. • Individual #309 – While taking snack in day program, his dining plan prescribed a weighted spoon and high side plate, and also to remove his helmet when eating. He was observed being fed cereal by staff from a paper cup using a plastic picnic spoon, and with his helmet on. • Individual #307 – This was another example of taking snack in the day program, using a plastic picnic spoon rather than a long-handled plastisol spoon. • Individual #229 – Staff were instructed to provide assistance for scooping at her wrist; staff instead was holding her hand to assist throughout. Staff could not demonstrate correct placement when asked. • Individual #296 – He was served very large pieces of lettuce rather than chopped salad. • Individual #191 – Food served was larger than chopped texture. • Individual #234 – Eggs offered were larger than ground as prescribed per dining plan. • Individual #163 – Eggs served were not ground as per dining plan. Chopped fruit was mixed with bran. When pointed out, food was returned to the kitchen and	

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		corrected. • Individual #8 – Her dining plan provided instructions to provide verbal and physical prompts to put her spoon down. She was eating rapidly with no supervision or intervention. • Individual #324 – He was observed taking large bites with a youth spoon. • Individual #7 – She was seated between two women who were eating and she did not yet have food. She was observed to take chopped food from one individual. Staff intervened. She was noted to cough. It was of concern that her dining plan warned staff that she may attempt to take food from others, yet she was seated without food of her own between two others who did have food. When asked, it was stated that this incident was to be reported to nursing. • Individual #238 – He was to receive finely chopped foods, but was served regular scrambled eggs. • Individual #178 – His dining plan prescribed nectar- thickened liquids; his were thicker than nectar. • Individual #268 – He was to receive regular liquids from a glass because he was able to eat and drink independently. If he refused, staff were instructed to offer thickened liquids from a bowl. Staff did not offer this opportunity and offered only honey-thick liquids from a bowl. • Individual #105 – She was offered large pieces of salad and large pieces of strawberry even though her diet order was chopped. • Individual #6 – He was offered large pieces of strawberry even though his diet order was ground. • Individual #289 – The dining plan stated that he should be offered one-quarter glass of fluid at a time. He was observed to drink two full glasses without pausing or staff intervention. • Individual #5 – He was to receive nectar-thickened liquids, but what he was served was too thick. • Individual #93 – He was observed taking huge bites of food without intervention	

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		by staff even though his plan instructed staff to intervene. Occasionally staff was heard to tell him to "slow." • Individual #181 – His plan indicated that he should receive chopped food with finely chopped fruits and vegetables; he was eating pieces that were larger than one-half inch. • Individual #65 – His plan indicated that he should receive chopped food with ground meat. Some pieces were up to one-inch. When kitchen staff was asked about the large pieces of potatoes served, they commented that they were soft. Clearly this staff did not understand that the size of piece was the issue regardless of "softness." • Individual #256 – He received sliced potatoes that were larger than one inch even though he was on a chopped diet with ground meat. Also, some pieces of broccoli were larger than one inch. He was also served ground strawberries that was soupy with some large chunks. Process includes level of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels. The NMC Risk Assessment tool was utilized consistently during the NMC meetings for those with upcoming annual PSP meetings. As described above, the risk level designation was not always consistent with the specific health risk concerns identified by the Committee. Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team. All PNM-related assessments were completed per the annual staffing schedule rather than based on increased risk level. Interim assessments were conducted for some individuals based on referral, such as for Individual #323. There was no evidence, however, that the assessment was comprehensive, that is, that it involved other team members. The Health Status Review Committee met monthly to review all individuals living at SASSLC and assigned the following risk levels in 18 domains: **High Risk (Level 1)**: This rating typically applies to an acute or unstable condition that requires timely collaboration and increased intensity of intervention to achieve an optimal health outcome. A physician can determine that any condition is High Risk at any time without collaboration from the HST. Individuals discharged from the hospital should have their risk level reviewed by the physician.	

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		Once a High Risk condition is identified, the PST will meet within 5 working days to formulate a plan. The plan will be implemented within 14 days. The PST will meet at least every 30 days to monitor the effectiveness of the plan of care until the individual's condition is stabilized and the risk level is reduced. **Medium Risk (Level 2)**: This rating typically applies to ongoing conditions that are stable but require active monitoring to insure optimal health outcomes. This level also applies to conditions that may normally be considered high risk but have appropriate supports in place that have rendered the condition stable over time. Individuals at Medium Risk are reviewed and monitored by appropriate members of the PST at intervals between 30 and 180 days. The PCP or members of the PST will determine how often the PST will meet to monitor the effectiveness of the plan of care. **Low Risk (Level 3)**: This rating typically applies to conditions that are stable and require minimal or no active treatment. Individuals at Low Risk are monitored by appropriate members of the PST at intervals greater than 180 days but at least annually unless there is a change in the health condition and risk rating. These ratings did not correlate with the NMC screening in any way. All comprehensive assessments are conducted by the PNM Team, identify the causes of such problems, and contain proper analysis of findings and measureable, functional outcomes. Assessments were generally not conducted outside of the annual staffing schedule. Annual assessments were "updates" with extensive documentation of facts, but with little analysis conducted and no measureable outcomes generated.	
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.	All individuals identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP). Each individual living at SASSLC had a PNMP and a dining plan. The format was generally consistent. As appropriate, PNMP consists of interventions /recommendations regarding: a. Positioning/alignment; b. Oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; c. Food/Fluid texture; Adaptive equipment; d. Transfers; e. Bathing; f. Personal care; g. In-bed positioning/alignment; h. General positioning (i.e., wheelchair, alternate positioning); i. Communication; and j. Behavioral concerns related to intake. The format for PNMPs included supports and strategies related to assistive equipment, communication, mobility, transfers, movement techniques, positioning (seating, bed), bathing/toileting, dining equipment, and dining plan. Pictures of adaptive mealtime equipment were attached as well as a picture of the individual in his or her mealtime position. An additional picture showed the individual in his or her seating system/wheelchair as indicated. Each individual had a PNMP. The dates identified on the plans were inconsistent. Some had initiation date, some had revision date, and others had the date for the PSP. In some cases, the PSP cited was more than 12 months old. There were several plans that were dated more than 12 months earlier and there was no evidence that they had been reviewed since that time. Some dining plans were also dated	

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		more than one year earlier, including Individual #80, Individual #5, Individual #289, and Individual #6. A system of boxes designated specific changes made to the plan. This was intended to highlight the differences in the current plan from the previous one for staff. The PNMPs were generally comprehensive with regard to the format, though it was not always evident that the stated focus of the plan and interventions outlined addressed each of the individual's identified PNM risk concerns. Individuals who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. As stated above, all individuals at SASSLC had PNMPs even if they were NPO, receiving all their hydration and nutrition via enteral tube. PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team. During the NMC meeting, PNMPs were reviewed for individuals with PSPs scheduled in the upcoming month. A review of diet orders, current weight, and a brief health status review was conducted. Recommendations were made to the PST as indicated, the Nutritional Management Screening Tool was completed, and a risk level designation was assigned and documented. PNMPs are reviewed annually at the PSP meeting, and updated as needed. See above. PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results. Clinicians appeared to routinely modify the PNMP as indicated by a change in status. The records reviewed included versions of plans with revision dates and many had boxes indicating that a change had been made from the previous plan. By report, changes in the plan were typically communicated to home managers via email and they, in turn, were to train the staff with regard to these changes. There was little evidence that PNMP monitoring triggered any changes in the PNMPs. There is congruency between strategies/interventions/recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. There was generally congruency between what the therapy clinicians recommended in the annual update or interim updates.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan. As cited above, there were a large number of errors related to staff implementation of the PNMP and dining plan. In some cases, staff appeared to know what was supposed to be provided, but did not use the correct strategies. In other cases, staff did not appear to understand the significance of these errors. Many had occurred despite implementation	

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	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.	of a system to check that the diet order, adaptive mealtime equipment, and assistance strategies were consistent with the plan. These errors had occurred after the system of checks was implemented and it failed to identify significant errors before the meal was served to the individual, placing them at risk of harm from aspiration and choking. Individuals are in proper alignment and position. As cited above, a number of individuals were noted by the monitoring team to be in improper alignment. Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and/or increased risk of aspiration. The intent of the PNMPs and dining plans was that they be followed across all settings. Errors in use of adaptive mealtime equipment and other assistance strategies were noted for several men in the day program setting (Individual #93, Individual #181, Individual #309, Individual #307). The correct mealtime equipment was not available to individuals in this setting. PNMPs/dining plans, however, were present. Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. In some cases, when errors were identified by the monitoring team with regard to diet texture, staff were able to verbalize the correct diet texture and rationale. It was of concern, however, that they had not advocated making the correction before serving it to the individual. Several staff were noted to change what they were doing to correct implementation while being observed. It was of concern that these staff appeared to know what they were supposed to do, but had chosen to do something different other than that prescribed in the plan. In other cases, staff believed that they were offering the diet in an acceptable way.	
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.	Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. Foundational training was provided to new employees in the area of physical nutritional management in a one-day training. This training addressed mealtime supports as well as lifting and transfers. The only portion of the training that required return demonstration for competency was related to body mechanics and transfers. Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/posttest, which may also include return demonstration as applicable. By report, skills-based competency check offs were limited to transfers only. Other competencies were practiced in some cases as in thickening liquids, but check-off of specific skills was not conducted in other areas of PNM supports. Testing in those areas consisted of a multiple-choice test. All foundational trainings are updated annually. Per the documentation submitted, annual	

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		re-training for physical management was conducted every two years. Other PNM training was not updated annually at the time of this review per his report. Staff are provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for home supervisors and the managers were then responsible to train their staff. Documentation of the home managers' training was maintained by the therapy department, and sign-in sheets for inservices provided to direct care staff was maintained by the home. Staff training provided was not necessarily competency-based. Sign-in sheets were not requested for this baseline review, so validation of this process will be necessary in subsequent reviews. PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff that have successfully completed competency-based training specific to the individual. Clinical staff provided inservice training to supervisors. In some cases, they emailed the home manager with changes made to the PNMP. At that time, the supervisor was responsible to complete the training for his or her staff. There was no consistent method used to provide PNM-related training and no consistent method to document that specific competencies were achieved. The type, frequency, or intensity of training did not vary dependent on PNM risk levels. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. Same as above. Changes to the plan were often e-mailed to the supervisor who was responsible for conveying the change to staff.	
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.	A system is in place that monitors staff implementation of the PNMPs. On a regular basis (at least monthly), all staff will be monitored for their continued competence in implementing the PNMPs. Staff implementation of the PNMP was monitored on a very limited basis. Only 49 PNMP monitoring forms were completed between 09/01/09 and 12/31/09. None of the completed forms, however, identified the staff providing supports to the individual monitored. There were seven dedicated PNMP Coordinators recently hired who were to be responsible for monitoring. The current plan for monitoring focused on individuals and did not systematically ensure that staff were monitored to validate continued competency. In the event that issues were identified from the monitoring, there was generally evidence that staff received re-training on that specific finding. Additionally, 57 Meal Observation Sheets were completed by Habilitation Therapies staff. These sheets were not person-specific, but reviewed all individuals in the dining area at that time. Again, no staff were identified who were observed during this monitoring. Copies were forwarded to the home managers/supervisors in some cases. There were 57	

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		observations completed in September (13), October (17), November (13), and December (14) 2009. They were completed by OTs (28) and SLPs (29), across breakfast (14), lunch (38), and dinner (2). One completed observation designated both breakfast and lunch on the same form and two others did not designate a meal. It was of concern that not only was there a very limited number of mealtime observations documented, but that at least 94% of them occurred on first shift only. Completion of these observation sheets was as follows: • Home 665: 2 • Home 668: 10 • Home 670: 8 • Home 671: 10 • Home 672: 10 • Home 673: 3 • Home 674: 7 • Home 766: 7 • No home noted: 1 (12/3/09) A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. SASSLC did not submit a policy that specifically addressed the monitoring process. Policy #012 Physical Nutritional Management, approved on 12/17/09 with implementation on 01/31/10, was reviewed. It included a section on PNM monitoring which outlined the following: • PNMPs should be monitored as scheduled and as needed by residential supervisors, nursing, therapy, and other professional staff to assess effectiveness of plans and to make changes as indicated; • Supervisors should report problems and training needs; • Professional staff should monitor for proper use of equipment and intervention strategies; ensure proper implementation and to correct problems; • Individuals with identified PNM issues should be monitored regularly by NMT; • Daily monitoring of cleanliness, wear and need for repair by direct support staff; and • Monitoring of equipment at least annually and as needed by therapy staff. There was no policy that outlined frequency or distribution of monitoring based on PNM risk level or any other designation. There were no plans to routinely validate monitors to ensure consistency and accuracy. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). At the time of this on-site review, the PNMP	

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		coordinators were to be assigned to cover all homes on a monthly basis. The primary focus of the tool used was related to mealtimes and the presence of plans and equipment. Condition and cleanliness of equipment was reviewed using the tool, but effectiveness was not. Focus on positioning was limited. It was not apparent that observational monitoring of bedtime and bathing positions were done routinely. All members of the PNM team conduct monitoring. At the time of this review, only OTs and one SLP had conducted formal PNM monitoring. Other clinical staff reported routine monitoring on an informal basis, but there was no documentation of this. Other SASSLC professional staff and supervisors were to conduct monitoring, though this system was not yet in place. As stated above, mealtime observation was conducted by all OTs and all STs. PT was not involved in monitoring of PNMPs or meal observations at the time of this on-site review. Discipline-specific review and assessment was conducted by the RN and RD/dietary technician team members but there was no evidence that they participated in the formal review of PNMPs or dining plans. Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team. The PNM team identified trends, and addresses such trends, for example, to enhance and focus the training agenda. There was no trend analysis of PNMP monitoring or mealtime observations at the time of this on-site review. Plans to do this had not been developed. Nevertheless, the monitoring team observed individuals eating in improper alignment or with incorrect support during the on-site review. Diet texture or liquid consistency errors were also noted. Even so, very limited diet texture, position/alignment or transfer compliance errors were noted by the SASSLC monitors from 09/01/09 through 12/31/10. Validity of this system and of the monitors was of concern. This will be a critical element to address regarding training of the new PNMP monitors. Immediate intervention is provided if the person is determined to be at risk of harm. There was recurrent evidence of intervention at the time of this on-site tour by the Habilitation Therapies Director who accompanied the monitoring team during observations throughout the week. In addition, issues identified were documented on the form, with evidence that the monitor intervened, made corrections, located missing equipment, generated work orders, and so forth. Less consistently, there was evidence that the home manager was notified of any concerns identified at that time. Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. Based on the issues identified from monitoring, issues related to equipment were generally remedied at the time of the monitoring or very soon after, based on work orders submitted. Other issues identified	

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		resulted in immediate intervention by therapists with on-the-spot training, however there was no system available to track if follow-up by other staff, such as home managers, had occurred to complete the necessary action steps to address any identified concern. System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. By report, supervisors were notified of issues identified via monitoring. There was, however, no consistent method of documentation to this effect. Process includes intermittent internal validation checks to ensure accuracy. No validation checks were conducted at SASSLC at the time of this review by report or documentary evidence submitted.	
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.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk. NMC meetings were held monthly to review individuals with regard to aspiration pneumonia, six-month follow-ups for level 2 NMC risk screenings (there was no one identified at high PNM risk), texture referrals, MBS studies, choking (no incidents of choking in the last year), significant weight loss, PNMP/PSP reviews and follow-ups from previous meetings. The approach utilized included a review of previous PNM history and discussion to identify potential recommendations. Follow-up was consistent, but actual trend analysis on a person-specific and/or systemic basis was extremely limited. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators. PNMP monitoring was conducted using the Physical Management Plan Monitoring Form and focused predominately on staff compliance with implementation of the PNMP, though specific staff were not identified. There were 14 indicators on that form that addressed the presence and condition of equipment, the individual's position and alignment and staff performance related to PNMP schedule, availability of the PNMP, correct transfer and lifting techniques and correct usage of assistive equipment. Only 49 monitoring forms across all homes were submitted, completed between September through December 2009 for only 36 individuals, or 13% of the facility census. Frequency of monitoring was insufficient to address each individual's PNM needs and to ensure that the PNMP was effective. Frequency of monitoring was not driven in any way by need or risk level. Additional person-specific monitoring by clinicians was generally in response to a request, referral, or identification of a problem rather than scheduled routine monitoring of health status and the effectiveness of supports to address identified PNM health risk indicators. There was no mechanism in place to tabulate findings from follow-up monitoring for trend analysis per individual or system wide.	

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		Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted. There was no evidence that the NMC reviewed the findings of PNMP monitoring or mealtime observations to ensure resolution of any identified concerns. The individual's PNM status is reviewed annually at the PSP, and all PNMPs are updated as needed. Annual updates were completed by OT/PT and SLPs on an annual basis. A summary of findings from those reports was included in the PSP. There was generally discussion of the PNMP in the OT/PT/SLP sections of the PSP with recommendations to continue, but recommendations for changes to the PNMP were not consistently summarized. On at least a monthly basis or more often as needed, the individual's PNM status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. There was no evidence in the records submitted of routine monthly review by the PST or member(s) of the NMC. Quarterly reviews included review of specific action steps that may be an aspect of the PNMP, generally related to availability of equipment only. Members of the PNM team complete monitoring system. There was evidence of meal observations conducted by all OT (50%) and SLP (50%) clinicians. Physical management plan monitoring was conducted by PTs (21%), SLPS (11%), and OTs (68%). Immediate interventions are provided when the individual is determined to be at an increased risk of harm. Limited concerns were identified related to improper implementation of plans related to diet texture, dining plan instructions, and position and alignment in the monitoring tools submitted, though a number of these were identified based on the observations of the monitoring team and described above. Most issues identified via facility monitoring were related to missing equipment or the need for repairs. When they were, there was generally documentation of intervention at that time. It was of concern, however, that this system appeared to be ineffective in ensuring staff compliance, competency, and individual safety as described above. When errors were pointed out by the monitoring team, the staff responded quickly to remedy the concern.	
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	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status. There were approximately 51 individuals with gastrostomy tubes per the Current Diet roster dated 02/08/09.	

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	Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Individuals who received enteral nutrition were included in the sample, but only 50% appeared to have been reviewed by the NMC, per the minutes submitted. These reviews either specified that the purpose was for enteral review or PNMP/PSP review. While others may have been reviewed for other reasons, a specific review for continued medical necessity of enteral nutrition was not evident. The need for continued enteral nutrition is integrated into the PSP. Issues related to enteral nutrition were evident throughout the PSP with regard to diet order, nutritional assessment, and other medically-related information. In only one instance, (Individual #92), was there a specific section for "gastrostomy tube," though there was no evidence that team discussion had taken place with review of objective data to make the determination that in his case the gastrostomy tube continued to be appropriate for him. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. In the case of Individual #95, it was reported in the NMC meeting minutes (September 2009) that she had PEG tube placement in October 2007, but that it had been removed in May 2009. The reason for removal was due to "multiple self-removals." She had lost weight since the tube had been removed, but by report, she remained within her recommended body weight range and her weight had stabilized over the previous two months. There was no evidence of review by the NMC that year with the exception of review of concern for weight loss one month earlier. There was no evidence that the NMC had been involved in the decision to remove the PEG tube via review or assessment. There is evidence of discussion by the PST regarding continued need for enteral nutrition. There was insufficient evidence, however, that the PST discussed the individual's condition and that enteral nutrition continued to be medically necessary. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). State policy did not clearly define the depth of assessment required. There did not appear to be a standard for how these assessments were to be completed and there did not appear to be collaboration across disciplines. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. Via PNMP/dining plans there were strategies designed to address diet texture, liquids consistency, position and alignment, and assistance techniques. As described throughout this review, however, there were numerous examples of inadequate implementation of these plans by staff. The current system of monitoring and the three-tiered check system prior to meals were ineffective in the identification and remediation of these errors and this put individuals at risk of harm for aspiration and/or choking and	

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		increased the potential for tube placement.	

Recommendations:

1. Include PT staff in NMC meetings; consider closer collaboration with the Health Risk Screening process with the MD as well.
2. Ensure increased opportunities for annual continuing education opportunities to include all NMC team members.
3. Establish measurable outcomes related to occurrences of risk indicators or identified PNM concerns.
4. Provide a more thorough analysis of objective data to drive a comprehensive approach to interventions. Ensure that consideration is given to assessment of potentials and functional skill acquisition as described in OT/PT and Communication sections below.
5. Utilize the monitoring system to fine-tune PNMPs and dining plans for consistency and accuracy and to ensure improved staff compliance with proper implementation. Trend analysis of monitoring should be utilized to better target staff training.
6. Revise current new employee training to ensure that it addresses skills-based competencies rather than only knowledge-based learning objectives. Competency check-offs should include an activity analysis, highlighting the skills necessary to complete the task. Staff should be expected to perform each skill to criteria to achieve competency. Create annual refresher courses with competency-based check-offs to ensure continued competence.
7. All individual-specific training must be competency-based and documented with staff sign-in sheets. Only staff who have been checked off should work with those at highest risk.
8. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency.
9. Consider revision of monitoring tool to better assess staff performance of basic skills. Findings should drive staff training plans. A mechanism to ensure that staff performance related to implementation of PNMPs is systematically evaluated will be critical to ensure continued competency.
10. Ensure that re-validation of monitors occurs on a regular basis to ensure consistency and accuracy.
11. Conduct trend analysis of all monitoring data. Review findings and make system adjustments.
12. Review the existing systems of risk assessment to ensure greater integration. Risk levels should be determined by potential risk of harm. Implementation of supports and services to minimize risk do not automatically reduce the individual's potential for risk of harm. The interventions must be effectively in place long enough to attain and maintain stable risk status for a prescribed length of time before risk level is downgraded.

13. PNM review should focus on PNM concerns with follow-up through to problem resolution. Set outcome measures with regard to specific risk indicators and timeframes for achievement. For example, Mary will be pneumonia free for six months. Interventions should support achievement of identified outcomes. NMC should continue to monitor until the individual attains and maintains at the goal level.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o Reviewed Settlement Agreement: Section XI. Physical and Nutritional Management, and P. Occupational and Physical Therapy o SASSLC Budgeted, Filled and Unfilled Positions by Job Code o CMS Survey dated 04/09/09, 06/03/09, 08/07/09, 09/04/2009, 11/23/09, 12/09/09 o Levels of Supervision, revised 09/01/09 o Current Census by Home o Training outlines including: Lifting/Transfer of consumers, Use of Wheel Locks at SASSLC, Basics of Good Body Mechanics, Osteoporosis, Assessment Checklists for Transfers o PNMP Monitoring form o SASSLC Mealtime Competency Training form o SASSLC Physical Management Competency Training Form o List of Therapy staff and PNM Team members o PNM assessments and updates completed in the last quarter o Continuing Education records for OT staff (Patricia Hajny, OTR) o PSPs for: • Individual #21, Individual #229, Individual #239, Individual #79 o Habilitation Therapy OT/PT/ST Update Evaluations for the following: • Individual #253, Individual #302, Individual #79 o SASSLC Organizational Chart January 2010 o Habilitation Physical Management Monitoring Forms o Meal Observation Sheets o Record documents including: Individual Information Sheets, , Medical Evaluations, Nursing assessment for last 12 months and monthlies, Hospitalization documentation for last 12 months, Current Personal Support Plans and all addendums and quarterly reviews for last 12 months, OT/PT/ST section of record, NMC reports for last 12 months, Integrated Progress Notes, Health Status Review Checklists, NMC Screenings, OT/PT Assessments, Communication Assessments/Updates, OT/PT/ST Evaluations/Updates, Related updates and Reviews for the following individuals: • Individual #319, Individual #92, Individual #31, Individual #335, Individual #332, Individual #265, Individual #144, Individual #333, Individual #45, Individual #18, Individual #40, Individual #164, Individual #227, Individual #215, Individual #323, Individual #91, Individual #333, (Individual #79 requested but not received) o Physical/Nutritional Management Plan for each individual o PNMP format o Dining Plan format

	○ Occupational/Physical Therapy Services #014P, 11/04/09 ○ Work order spreadsheet ○ Physical Nutritional Management Wheelchair clinic Progress Notes ○ List of Individuals with Other Ambulation Devices ○ List of Individuals with Orthotics and/or Braces ○ List of Individuals Who Used Wheelchairs as Primary Mobility <u>Interviews and Meetings Held</u>: ○ Margaret Delgado-Gaitan, MA, CCC-SLP ○ Retha Skinner, MOT, OTR ○ Kelly Patrick, OTR ○ Patricia Hajny, OTR ○ Jan Schaefer, PT ○ Discussions with various supervisors and direct care staff ○ Discussions with various day program staff <u>Observations Conducted</u>: ○ Mealtimes ○ Living areas and day program areas ○ PNMP/Wheelchair Clinic • Individual #82, Individual #45
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The reputation of the PT and OT clinicians was excellent per report of QMRPs and other facility staff with regard to their responsiveness to requests. The OT and PT clinicians were experienced and dedicated to supporting the individuals living at SASSLC. There was an established process to conduct integrated assessments that the therapists continued to review and refine. The primary focus of OT/PT supports was related to implementation of the PNMP and assistive technology, particularly wheelchair seating devices. There were limited opportunities to address more functional outcomes and provide direct services outside of acute concerns. Achievement of the elements of the Settlement Agreement will require this group of clinicians to work smarter and more efficiently, but it will be critical that careful assessment of staffing be conducted to ensure that there is an adequate workforce to effectively accomplish all that is required. Positioning in wheelchairs was a noted concern. Numerous individuals were observed in improper alignment and the lack of use of snug pelvic positioning devices and foot rests were recurrent issues noted by the monitoring team as well as noted by the facility's own PNMP monitors based on the completed forms submitted. Careful review of seating systems, more extensive staff training, diligent monitoring, increased

	frequency of repositioning, and staff attention to detail will be critical to resolution of this problem.

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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.	The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. The census at SASSLC was approximately 283 at the time of this baseline review. The department director, Margaret Gaitan, was a speech-language pathologist. There were seven newly created positions for PNMP monitors, with four positions filled with staff working in that capacity and/or in training at the time of this review. OT services were provided by three full-time occupational therapists: Kelly Patrick, OTR, Retha Skinner, MOT, OTR, and Patricia Hajny, OTR. Ms. Skinner was listed as a physical therapist per the organizational chart submitted. No evidence of licensure or continuing education was submitted for her to verify her discipline, though assessments submitted identified her as an OT and per interview with the professional staff, the monitoring team understood her to be an occupational therapist. Given the census of 283 at the time of this on-site review, average caseloads for each OTR included approximately 94.50 individuals. There were no vacant OT positions. There were no COTAs employed at SASSLC. There was one OT technician. PT services were provided by three physical therapists, working part-time. Edward Harris, PT worked four days per week at the time of the on-site review, but plans were in place for him to begin full time employment in the near future. He focused predominately on direct PT treatment. Additionally, two other PTs worked half-time, Janice Schaefer, PT and Raelynn Stowlowski, PT. Ms. Schaefer worked primarily on wheelchair seating consultations and participated in the physical medicine clinic. Both part-time therapists completed annual assessments. There were 1.5 FTE PT positions vacant at the time of the on-site review. There were no PTAs employed at SASSLC, though there was one vacant position available. There was one PT technician. Fabrication of seating systems occurred on site. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at SASSLC, fabricating custom components, and completing repairs and modifications. At the time of this review, there were two full-time fabricators. Evidence of licensure was submitted for Janice Schaefer, PT, Patricia Hajny, OTR, and Kelly Patrick, OTR. Continuing education verification was submitted for Ms. Hajny only, totaling 29 contact hours related to wheelchair seating, and evaluation and treatment of individuals with developmental disabilities. All individuals have received an OT and PT screening. If newly admitted, this occurred	

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		within 30 days of admission. By report and record review, each individual had received a screening and/or an OT/PT assessment. Two Habilitation Screenings completed by OT/PT were submitted. In one case, the screening was completed well within 30 days of admission (Individual #308), but the other for Individual #323, it was not possible to verify that it was completed within 30 days. All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. Each individual living at SASSLC received some level of direct and/or indirect OT/PT supports and services. For example, each individual had a PNMP and a dining plan. Assessments or updates were submitted for 22 individuals for review. A list of referrals for OT/PT assessment was not part of this document request so it was not possible to verify this element in the baseline review. If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status. Based on staff interview, the therapists did not follow a schedule of this nature. The primary format of assessment was in the form of an update. OT/PT Assessments/Updates were completed for those receiving supports and in some cases OT, PT, and SLP completed the update together. The assessment headings and the signature pages differed greatly and were inconsistent. For example, there were nine OT/PT Updates with OT and PT on the signature page. There were two OT/PT Updates with OT, PT, and SLP on the signature page. There were four OT/PT/SLP Updates with only OT and PT on the signature page, and six OT/PT/SLP Updates with each of these disciplines on the signature page. There was one document submitted that was titled an Occupational/Physical Comprehensive Evaluation. OT and PT only were included on the signature page. Twenty out of 22 assessments or updates were current within the last 12 months; one was undated on the copy submitted (Individual #302) and another was dated in the future, 07/02/10 for a PSP on 07/31/10. Comprehensive assessments and annual updates were very similar in content and format and were generally thorough with regard to report headings. In some cases, however, the content was predominately clinical information with a limited focus on functional abilities. For example, Individual #227 received a PT/OT/SLP Annual Update on 09/29/09 by a PT and OT. Other than a description of his eating and drinking skills, no other description of his fine motor abilities was included. It was stated that he was not observed to use his right arm functionally and only that he used his left hand for "activities." It was reported that he required maximum assistance in all areas of self-care except feeding. There was no indication whether he had potential to engage in self-care at a participatory level, such as to pull his arms out of the sleeve or hold his foot up for a shoe. There was a more extensive description of his mobility and locomotion.	

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		There was an extensive review of "health status" and "relevant consults and diagnostics." This was accomplished via extensive record review by the clinicians, however, content with regard to review of supports and services provided over the previous year and rationale for the provision of those supports, including assistive equipment was not consistently provided. Assessment detail and clinical reasoning also varied greatly from report to report. In many cases, there was insufficient baseline outlined in the assessment to use for assessing progress as a result of intervention. Neither an analysis of findings nor a rationale was provided as a foundation for the recommendations identified. Some examples included: • Individual #31 – His OT/PT Update on 01/15/10 cited an OT/PT consult on 03/04/09. It was documented that the PST had requested the development of a weight loss program. A Restorator exercise program was recommended, but there was no description of the course of this intervention or effectiveness. There was no mention whether the program was still in place or whether it had been effective. His weight was reported as increased at the time of this update, but there was no discussion or analysis of that in relation to the OT/PT consultation/intervention. There was no recommendation related to this issue. • Individual #215 – Per the OT/PT Update on 02/23/10, he had experienced at least eight falls between 03/31/09 and 12/29/09, most with abrasion injuries. He had received a gait evaluation on 12/15/08 after a fall with no recommendations listed. He was seen in the Physical Medicine clinic on 01/14/09 with a recommendation for gait training. There was no indication that this had been provided. He was diagnosed with a stress fracture on 01/20/09; cast shoes were provided and "gait training to be initiated." He was again seen in Physical Medicine Clinic on 04/08/09; it was reported that he was "doing much better," but it was unclear as to what was better, the stress fracture or his gait. He was walking with a gait belt at that time but there was no baseline reported relative to distance, frequency, or endurance. He had experienced falls prior to and subsequent to this clinic on 04/08/09. In the Mobility/Locomotion section of the update, it was reported that he ambulated approximately 410 feet with a gait belt and needed minimal assistance from one staff. There was no indication as to whether this was an improvement and, if so, to what degree from his pre-intervention status. There was no discussion as to if or how this related to the frequency of his falls other than to state that his falls were after being disrupted by others. Only one of the falls reported, however, was attributed to him being bumped by another individual. He had experienced seven of the eight falls after the initiation of PT intervention. There was no description of the course of treatment with regard to frequency or progress. The recommendation was to continue direct PT until the walking program could be turned over to home and work staff. Specific criteria required to transition this	

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		plan to direct care staff was not identified. • Individual #302 – Per his OT/PT/ST Update (undated), he was seen in Physical Medicine Clinic on 07/08/09 with a history of "unsteadiness." It was reported at that time that his gait was stable and that he would be discharged from PT. There were two PT consultations after that time, but the purpose was not identified. There was no mention of continued PT intervention even though gait analysis was documented, and that he walked up to 260 feet with a gait belt at all times, and that he needed moderate assistance when unsteady. It was unclear if this was an improvement from his previous assessment or prior to initiation of direct PT. In the recommendation section, it was stated that he should "continue to receive direct PT for gait training since his protective responses are compromised." Again there was no functional goal/objective identified or rationale as to how intervention would address this concern. <u>Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral</u>. This standard was not specifically reviewed because the sample did not include individuals who did not receive some level of therapy supports and services. For example, all individuals were provided a PNMP and a dining plan. Each received an OT/PT update. By report, this was provided, but will require further validation in a subsequent review. <u>Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment</u>. Per the 22 assessment/updates reviewed, all but two individuals required the use of a wheelchair. Of those 20 assessments, only seven assessments documented appropriateness of the existing seating system (Individual #253, Individual #92, Individual #31, Individual #144, Individual #176, Individual #306, Individual #66). Of those seven, only Individual #306 (01/12/10) and Individual #66 (12/15/09) had seating systems that met their needs per the assessment report. Wheelchair Clinic Progress Notes indicated that further assessment had been conducted to address identified concerns and included Individual #176 (01/22/10), Individual #31 (01/15/10), and Individual #144 (09/01/09). <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions</u>. An extensive outline of diagnoses, active medical problems, health status over the previous year and relevant consultations were included in each of the OT/PT Updates. A number of these also included ST as well. Specific health risk indicators were not clearly highlighted, however. Recommendations for interventions did not consistently relate back to specific health risk indicators. In many cases, some of the recommendations were canned statements rather than person specific. OT/PT	

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		assessments recommended the following for a number of individuals reviewed: "Continue with Physical Nutritional Management Plan (PNMP) to ensure skin integrity, proper handling and optimal health." This was noted for Individual #31, Individual #144, Individual #176, Individual #333, Individual #18, Individual #164 and others. There were a variety of reasons why a PNMP would be provided and these should be outlined in a more person-specific manner that related to identified health risks. These assessments also recommended the following for a number of individuals reviewed: "Staff should monitor mobility, equipment use, choking episodes, weight changes, vomiting, and respiratory illness and report any problems to the Habilitation team." This was noted for Individual #229, Individual #164, Individual #234, Individual #215, Individual #302, Individual #227 and others. Monitoring by staff may also need to address additional issues that are unique to each person and should be outlined. <u>Evidence of communication and or collaboration is present in the OT/PT assessments</u>. OT and PT completed a combined assessment report. This was comprehensive, thorough, and well integrated. These assessments were conducted collaboratively and recently had begun to include the speech-language pathologist as well. The process was observed by the monitoring team on 02/09/10 and it appeared to be very effective (Individual #82 and Individual #45). In some cases, more than one clinician of the same discipline participated in the assessment process. While this was a great learning opportunity and may have been necessary for difficult cases to ensure better problem-solving, as a routine practice this did not make the best use of therapists' time. This was of particular concern due to the apparent staff shortage across all disciplines.	
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	<u>Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP</u>. Plans developed were limited to PNMPs and dining plans. Plan development was the responsibility of habilitation staff and, in the case of PNMPs and dining plans, implementation was by direct care staff. Each of the PNMPs and dining plans developed included dates, such as initiated, reviewed, and revised. Not all PNMPs were current within the last PSP year or 12 months prior to this on-site baseline review. For example, the PNMP for Individual #230 was dated 12/15/08 with no evidence of review since that time. This was also noted for Individual #224 (12/16/08), Individual #39 (11/04/08), Individual #208 (06/10/08), Individual #310 (05/27/08), Individual #1 (06/25/08), and Individual #185 (05/29/09). There were 280 PNMPs submitted. Several were associated with PSPs that were over 12 months old. It could not be determined if these actually had not been revised since that time or if the wrong documents were submitted. <u>Within 30 days of development of the plan, it was implemented</u>. Implementation dates	

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	movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	were not evident based on the documentation submitted. By report, all plans were in place and, in cases where a revision was necessary, each of the plans was modified with immediate implementation. Appropriate intervention plans are: a. Integrated into the PSP; b. individualized; c. Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and c. Contain objective, measurable and functional outcomes. There was evidence of OT/PT intervention for four individuals in the baseline sample selected. This included Individual #215, Individual #323, Individual #31 and Individual #92. Review of PSPs revealed that recommendations for adaptive equipment identified in the PNMP were well integrated into the PSP action steps. In the case of direct OT or PT intervention, this was not consistently noted, however. In addition there were no objective, measurable, and functional outcomes with established criteria associated with direct therapy interventions. Documentation offered objective measures, in some cases, but did not compare and contrast progress over time. Treatment was discontinued without clear evidence that an established goal had been achieved. Some examples included: • Individual #31 –The PSP was dated 02/24/09. He was 6.5 pounds above his ideal body weight at that time at 124.5 pounds. There was no evidence of discussion regarding an exercise program, though an action step stated that he would achieve "or come near to achievement" of his IBWR of 92 to 118 pounds. He was to have manual and power wheelchairs available to him. The quarterly review dated 05/28/09 reported an average weight of 125.5 pounds during the previous quarter. Per this quarterly review, OT/PT agreed on 03/03/09 to research Restorator equipment for exercise to augment a calorie restricted diet to promote weight loss. Per the quarterly review dated 08/26/09, it was noted that his weight averaged 124 pounds during the previous quarter. There was no discussion or report of OT/PT intervention. Per the quarterly review dated 11/20/09, Individual #31's weight had averaged 123.5 during the previous quarter for a net loss of approximately only one pound since his PSP in February. Again, there was no reference to OT/PT supports or services. A single progress note was submitted for Individual #31 reflecting OT direct intervention designed to "increase activity level: to improve over all endurance by exercising with Restorator, using upper extremities; to support self-care." There were no specific criteria identified to measure progress or relate the plan to weight loss. The therapist's only comment was "good participation and motivation with exercise." He participated in fifteen 15-minute sessions. The plan of care was to continue. Per his OT/PT assessment dated 01/15/10, direct therapy was not recommended. There was no report as to implementation of the exercise program or with regard to his progress. It was not clear if it continued to be	

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		implemented at the time of his assessment. Per his Nutritional Progress Review dated 01/20/10, Individual #31 weighed 129.5 pounds or 123% of his IBWR. This represented a weight gain of five pounds. Since concerns for weight gain had been identified nearly a year earlier, it was of concern that intervention to address this health risk issue had not been adequately implemented. There was inadequate documentation in this regard as well. • Individual #92 – His PSP was dated 07/29/09. His OT/PT assessment was dated 07/03/10 (it was assumed to be an error). Recommendations included continued power wheelchair training "when battery is available" (reportedly ordered but not delivered at that time). Continued recreational walking with a Rifton walker was also recommended. It was reported that he walked with a therapy technician one to two times weekly as part of the PNMP Walking Program. He had received a power wheelchair in April 2007 with training three times per week. He was focused, but not safe, without 1:1 supervision. A new battery was on order and he was not using the power wheelchair at that time. The walking program was listed in the PSP action plan. Action step 4G stated: "Batteries for power chair will be ordered in the next 6 months." It was unclear why the action was to order batteries if, as reported, they had already been ordered, but not received. He was also to have access to the power wheelchair per action 4H. The only quarterly review submitted was dated 01/28/10. Walking in the Rifton walker was reported as "maintained" and was to continue without change. Action step 4G was reported as "not met" for the previous quarter. A notation indicated that the OT technician was to begin working with Individual #92 in February 2010. A notation in the PSP indicated "power chair service with battery" on 11/03/09. It was of concern that this equipment had not been available to him for well over six months. There was no functional, measurable outcome established for the walking program or for the power wheelchair training program. A single progress note was submitted for January 2010 regarding an intervention by OT. The service objective stated, "Restorator exercises with legs to increase activity level to improve strength and endurance to support transfer ability." There was no rationale for this intervention and no mention of the need in the quarterly review dated 01/28/10. The only comment by the therapist was that he had attended 13 sessions with two refusals. There was no report of baseline measures prior to intervention and no report of progress after 13 sessions. • Individual #215 – His PSP was dated 03/23/09. The PT assessment review stated only "Continue direct PT until Individual #215's walking program can be turned over to home and work staff." There were no criteria established with regard to this outcome. There was no report of progress or current status documented in the PSP. There was an action step, 4Ia that indicated he should use an Eva walker when walking for stability. His OT/PT Update was dated	

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		02/23/10. It did not relate to the PSP submitted as current. There was a report of his current status with regard to ambulation and that PT services should continue with "the goal of restoring strength, stability and endurance during gait." There were no specific criteria established. Baseline lower extremity strength was reported as 4+/5 and he was able to ambulate approximately 410 feet with a gait belt and minimal assistance from one staff. He required verbal cues for redirection and turns. Per the quarterly review dated 06/26/09, the report from Physical Medicine Clinic stated, "Individual #215 is doing much better. Walking with a gait belt. Continue with current plan." No additional report by PT was documented as to progress or course of intervention. There was no action step in the PSP related to PT treatment. The quarterly review was dated 09/24/09. There was no report as to progress related to PT intervention at that time. Progress notes for PT treatment were submitted from January 2009 through January 2010. The service objective was "patient to ambulate at least two times weekly with PT and hands on assist of one, gait belt, and an Eva walker. Comments included that he ambulated a distance of 265 feet with a gait belt and moderate assist of one using an Eva walker. Progress was evident month to month up to an average of 1000 feet in May 2009, June 2009 and July 2009 with a gait belt and standby assistance. He was to be discharged at that time. There were no further progress notes until January 2010 when it was stated that Individual #215 "was progressing well with treatment." He was ambulating a distance on only 410 feet with minimal hand-held assistance and gait belt at that time. There was no reference to this regression since his discharge from PT six months earlier. The service objective was stated as "restore strength, stability and endurance during gait." There were no measurable criteria identified so as to measure progress. • Individual #323 – A Habilitation Therapy (OT/PT) Screen was completed on 09/02/08. Direct OT/PT services were not indicated. He was independent with transfers and ambulation, but with an abnormal gait pattern. The current PSP was developed on 09/11/09 and OT/PT services were not indicated at that time. Intervention was initiated in December 2009 following a Falls Risk Assessment conducted by the PT on 12/02/09. There was no rationale provided in the fall risk assessment for the assessment itself or for the initiation of direct therapy and no expected measurable goals were established. The nursing quarterly assessment, dated 11/19/09, reported that he had fallen on 09/27/09. He was hospitalized for 10 days until 10/27/09. An integrated progress note dated 12/01/09 addressed possible strategies to address unsteady gait getting on and off the bus including a gait belt and stepping stool. That same day he had been referred for a helmet due to "recurrent head injuries." He had recently experienced "head trauma/intercranial bleed." It was not clear if this was a second head injury or the one that occurred in September. He was provided a	

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		wheelchair in 12/14/09 for use when gait was unsteady. The stated service objective was "to help Individual #323 resume safe, functional ambulation." It was not clear from the assessment or the progress note in December 2009 as to his baseline prior to intervention. It was documented in the progress note that he had "shown steady progress" and was able to ambulate up to 260 feet with minimal to moderate assistance of one person with a gait belt. His bilateral lower extremity strength had increased to 4-/5 throughout. Direct PT was to continue to increase lower extremity strength, improve his stability and endurance with gait, and to increase efficiency of transfers. An integrated progress note on 01/04/10 reported that he was discovered lying on his back next to his bed. There were no reported injuries, but circumstances regarding the fall were unknown. The subsequent progress note in January 2010 documented that Individual #323 ambulated up to 460 feet independently and transferred from sit to stand with standby assistance from staff. Staff were to be inserviced on 01/22/10 and he was released to walk in the home with supervision. No previous discharge criteria had been established. The progress note further stated that Individual #323 had experienced a fall in the bathroom discovered upon conclusion of the staff inservice. Circumstances related to the fall were again "unknown," by report. He moved to another home and continued to ambulate with contact-guard assistance. PT was to continue through the month of February. Interventions are present to enhance: a. movement; b. mobility; c. range of motion; d. independence; and e. as needed to minimize regression. A limited number of direct interventions were provided by one OT clinician primarily for acute concerns. These included hand therapy interventions, stretching, standing frame, and Restorator exercise for strengthening and endurance. The PT soon to become a full time employee was reported to provide more direct intervention. Only one of the individuals included in the baseline sample participated in PT (Individual #215). The purpose of PT in this case was to restore strength, stability, and endurance, however, there were no specific measurable outcomes related to this intervention. There was only one month's progress note (January 1010). He was seen 12 times that month. Treatment was to continue for the next month. By report, he was "showing progress," but there were no specific criteria to measure changes as result of this intervention. The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used. Each of the PNMPs reviewed listed specific assistive technology and equipment to address the person's needs. In most cases, the rationale established via assessment was insufficient. Therapists provide verbal justification and functional rationale for recommended	

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		interventions. There were no activity plans submitted but all monthly progress notes submitted had a stated purpose for the interventions provided. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. Monthly PT progress notes were submitted for Individual #215 from January 2009 through July 2009 when he was discharged because he was functionally ambulatory with standby assistance and a gait belt. The service objective was that Individual #215 was to "ambulate at least two times weekly with PT and hands on assist of one, gait belt and an Eva Walker." There were no specific measurable criteria stated in order to measure progress. There was also a progress note submitted for January 2010 when it appeared that PT had been resumed. Though it was stated that the objective was to restore strength, stability, and endurance during gait, there was no measurable outcome for this intervention. It was not clear when or why PT had been re-instated for Individual #215. Monthly OT progress notes were submitted for Individual #31 and Individual #92 for January 2010 only. There were no measurable outcomes for either of these interventions. The purpose was stated, but not in measurable terms so as to track progress. There were no other monthly progress notes submitted for those individuals included in the baseline sample. Each time an individual was seen in PNM Wheelchair Clinic, a progress note was generated that also served as a work order for the fabricators to perform repairs, modifications, or to fabricate new seating systems. Each note provided a description of the current wheelchair and identified problems or concerns, but did not describe the specific rationale for the selection of a specific product or surface. The corresponding solution was documented as a modification or repair. The team members conducting the evaluation signed the form, but there was no mechanism on that form to document completion of repairs, modifications, or delivery of new seating components. A previously used form permitted the fabricators to record the date on which the work was completed. There was no current system to reflect review of the effectiveness of the changes as a result of the wheelchair clinic findings.	
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	Staff implements recommendations identified by OT/PT. As described above there were numerous instances of incorrect implementation of dining plans. In addition, staff implementation of position and alignment guidelines was inadequate or alignment and support was insufficient for safe and optimal function (see below). The monitoring forms submitted noted failure to competently implement the PNMPs over 50% of the time (see below).	

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	competency-based training in implementing such plans.	Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations. The only competency-based training aspect of new employee orientation provided in the area of OT and PT supports was related to transfers. Practice checklists were used to guide participants in the steps required for proper body mechanics and to complete safe stand-pivot transfers, two-person manual lifts, and to use a mechanical lift. By report, this was repeated every two years or as needed or directed by a home supervisor. Training in other areas of new employee orientation relied on written test questions and classroom participation. Person-specific training was provided to home managers and by report, was competency-based. Home managers were then responsible for training of staff assigned to their home. Evidence of competency was documented by a sign-in sheet rather than a checklist of specific competencies related to implementation of OT/PT recommendations. Informal coaching of staff occurred as an aspect of PNMP monitoring when concerns were noted. In addition, the monitoring team observed professional staff providing correction and coaching for staff when performance errors were noted during mealtimes. This was not formally documented. Staff verbalizes rationale for interventions. Staff were generally not able to recognize when an individual was not in adequate alignment. This was evidenced by the number of individuals observed by the monitoring team in improper alignment during this on-site baseline review. As such, staff clearly were not able to identify the rationale for such interventions. Examples included the following individuals: • Individual #235, Individual #190, Individual #324 Individual #302, Individual #273, Individual #70, Individual #333, Individual #229, Individual #164, Individual #189, Individual #345, Individual #38, Individual #281, Individual #200, Individual #151, Individual #287, Individual #323, Individual #45, Individual #236, Individual #18. As described above, numerous errors were noted with regard to food texture and liquid consistency as well as mealtime adaptive equipment prescribed on the PNMPs. Staff did not re-position individuals prior to mealtime and were clearly unable to identify the importance of proper alignment for safety, to ensure adequate nutrition and hydration and to promote independence.	
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	System exists to routinely evaluate: a. fit; b. availability; function; and c. condition of all adaptive equipment/assistive technology. By report, fabricators, therapists and technicians conducted regular monitoring for fit and function. There was no system to document the frequency of this monitoring to ensure that it occurred routinely and across all homes. In addition, staff were responsible to notify Habilitation Therapies for concerns related to adaptive equipment and assistive technology. As described below this system was marginally effective as a number of equipment-related concerns were	

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	physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	noted during formal PNMP monitoring. The number of concerns identified approached 50% suggesting that the home staff were not competent to recognize and report equipment related concerns. PNMP monitoring was intended to address equipment issues and effectively numerous concerns. As identified below, however, only a limited number of individuals were monitored on a monthly basis, averaging less than 6% of the 229 individuals with adaptive equipment identified in their PNMPs. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. At the time of this review, policy #014 Occupational/Physical Therapy Services addressed monitoring by mandating that a system be implemented that addressed: 1. the status of individuals with identified occupational and physical therapy needs; 2. the condition, availability, and appropriateness of physical supports and assistive equipment; 3. the effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and 4. the implementation of programs carried out by direct support staff. There was no formal policy regarding how this monitoring system should be implemented with regard to frequency or how to follow-up in the case that issues were noted during this process. On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs. The current system of monitoring did not specifically target review of staff competence. The current system was more person-specific and did not identify the staff providing supports at the time the monitoring was conducted. There was no mechanism in place to track the frequency or findings through formal review of competency for staff. For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff. Per an undated document Lifting/Transfer of Consumers submitted with document request materials, it was policy that all individuals would "be moved as designated in his/her PNMP, in DADS guidelines, or according to DADS PMAB guidelines." All new employees attended a one-day training related to physical management as an aspect of the new employee orientation. The portion of that training related to transfers was skills-based with return demonstration and included basic body mechanics, stand/pivot transfer, two-person manual lift, and use of a mechanical lift. Per	

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		this document, all direct care staff were to complete lifting/transfer training every two years or as needed when indicated by supervisory staff. Additionally, supervisors that "substitute" staff were to receive training on the PNMP prior to working with an individual with documentation on a sign-in sheet. This system appeared to apply to all individuals with PNMPs rather than only for those at increased risk. As reported by Margaret Gaitan, Habilitation Therapies conducted a "competency-based" training for home managers who, in turn, were to provide the training for their staff. Sign-in sheets for training of home managers was maintained by Habilitation Therapies and sign-sheets for training of SPECS and direct care staff was to be maintained in the home. The statement by Ms. Gaitan referred to "PNMP monitoring, etc." but not specifically to the implementation of the components of the PNMP itself. Sign-in sheets were not requested related to transfers and lifting during this on-site baseline review, so further assessment of implementation and documentation of this system will be necessary in the future. <u>Responses to monitoring findings are clearly documented from identification to resolution of any issues identified</u>. The current system for monitoring included a mechanism to document that an identified concern was corrected, that the home manager was informed and/or a record of a suggested plan of correction. This was noted on 25 out of 34 forms where an issue was documented. There was no specific place on the form to document follow-up, such as if the home manager provided training to staff regarding an identified issue, or that the wheelchair was power washed on a specific date after the problem was noted, or that repairs had been completed. In a number of cases, the monitors documented that they searched for and found missing equipment or re-aligned the individual. Moreover, in cases where the home manager should locate the current PNMP, clean the wheelchair, monitor staff related to transfers, and so forth, there was no mechanism to document that on the form in order to track problem resolution. <u>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available</u>. There was a system in place at SASSLC to attempt to address this issue at meals with regard to adaptive mealtime equipment. The kitchen staff plated the meal and a home staff person received it to check the food against the diet order as well as to provide the appropriate adaptive mealtime equipment. When delivered to the table, one staff read the plan to the staff providing assistance to the individual as a "double check" to ensure that the diet served was correct and that the correct adaptive equipment was available. As described above, however, this check and balance system was often not effective in addressing this concern. Seven PNMP Coordinators were recently hired and were being trained to provide routine monitoring and were to be responsible for obtaining and/or reporting missing equipment and need for repair. This system was too new to evaluate its effectiveness.	

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		The current system was primarily reactionary, with staff reporting a problem rather than a proactive system that quickly and routinely identified missing and dirty equipment as well as repair and preventative maintenance needs. By report, basic wheelchair checks were conducted to identify routine maintenance and issues related to cleanliness in addition to the physical management plan monitoring conducted by the therapists. There did not appear to be a specific schedule for this. When staff noticed an issue, they brought the individual to the wheelchair shop to get it fixed. Findings of the PNMP monitors identified concerns related to wheelchair maintenance/cleanliness on 24 of 49 monitoring forms. In many cases, a work order was generated at that time or the wheelchair was taken to the shop for repair (Individual #248; Individual #75, Individual #23, Individual #212, and Individual #77). In some cases, monitors cited the same problem in the same home on multiple dates. For example, monitoring conducted in Home 673 on 12/07/09 and again on 12/14/09 identified multiple individuals without shoes/orthotics as prescribed in their PNMPs. In another home, issues related to missing PNMPs were cited on 09/28/09, 10/05/09, 10/15/09, 11/12/09, and 11/24/09 for multiple individuals and in some cases for the same individuals multiple times (Individual #268, Individual #106, Individual #69, Individual #50). The current system of monitoring, staff training and follow-up was not effective to address these recurrent concerns in a timely manner. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs</u>. It did not appear that the current system of monitoring adequately addressed issues related to the effective implementation of the PNMPs because it did not occur with sufficient frequency and for a sufficient sample size of those with identified needs. It was not clear how an individual was selected for monitoring based on the current system. Though monitoring forms were requested as completed by all facility staff, only those forms completed by Habilitation Therapies staff were submitted. This represented monitoring completed for the months of September through December 2009. The form itself indicated that Home Supervisors were to complete two monitoring forms per month. There was no evidence that this was done, however. Monitoring was completed across five homes, at various times of day. The monitoring occurred between 4:30 AM and 5:40 PM with 41 out of 49, or 84%, completed for observations occurring between 4:30 AM and 2:00PM, that is, on first shift. There were 16 completed in September, 14 in October, 7 in November, and 12 in December 2009. Completion across homes was as follows: • 668: 3 • 670: 8 • 671: 5 • 673: 19 • 674: 14	

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		Monitoring was completed for 36 different individuals representing only 13% of the census (283). "Random samples" were also conducted in homes 671 (3) and 673 (2). Monitoring was conducted multiple times during those four months for Individual #284 (3), Individual #136 (2), Individual #92 (2), Individual #190 (2), Individual #61 (2), Individual #199 (2), and Individual #234 (2). If the PNMP was not implemented appropriately it would not effectively meet that individual's needs. Only 33% of the completed monitoring forms cited full compliance with implementation of the PNMP. Approximately 53% of the forms submitted identified concerns related to effective implementation of the PNMP, while another 17% cited issues related to cleanliness or need for repair only. Documented implementation issues included improper transfer techniques; not wearing shoes, TED hose, elbow pads or orthotics as per PNMP; sitting in the wrong wheelchair; missing wheelchair parts; loose lap belts; feet unsupported in wheelchair; improper positioning; and head incorrectly supported with headrest. Approximately 15% of the forms submitted cited that the PNMP was not available, though five of these forms monitored multiple individuals so this problem was identified for more than 15% of the individuals monitored during that quarter. While the system effectively identified issues during the actual monitoring, it did not appear to effect change in compliance with PNMP implementation. If a plan was not properly implemented it could not be effective for the individual for whom it was intended to support. Though it appeared that the therapists conducting the monitoring provided on-the-spot training and feedback to staff, there was no system to review and conduct trend analysis of the findings in a way to drive staff training needs. Also, there was no follow-up system to determine if the problem identified was corrected in a timely manner or if it was a prevailing concern as was the case in Homes 671 and 673 described above. In addition, the monitoring results suggested that the system currently depended on to identify problems with equipment was not effective, that is, that home staff reported needs for repair or recognized when a wheelchair required cleaning. Issues related to wheelchair maintenance, repair, and or cleaning were noted on approximately 49% of the monitoring forms submitted. This showed that monitoring by the therapists was effective in identifying these concerns, but the monitoring conducted did not occur frequently enough or for enough individuals to effectively identify all the needs in this area. Home staff may not be sufficiently trained to effectively recognize and report these concerns. While the plan to use dedicated PNMP monitors and other professional staff to supplement routine monitoring conducted by Habilitation Therapies should improve the frequency and density of monitoring occurring at SASSLC, it was not possible to evaluate this during the baseline review. <u>Data collection method is validated by the program's author(s)</u>. There was no standard	

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		system of validation of data collection by the program author. Implementation of plans that required data collection was done by Habilitation Therapies staff only.	

Recommendations:

1. Careful analysis of OT/PT staffing is needed to ensure that all elements of the Settlement Agreement can be implemented and sustained.

2. At the time of the annual staffing, OT and PT should review all existing plans for appropriateness and accuracy of text and pictures. This should be indicated by changing the PSP staffing date. Subsequent revisions should be designated by the date the plan was revised.

3. Training of PNMP monitors must be competency-based to include didactic presentation of monitoring strategies, follow-up steps, documentation and interaction with staff and supervisors as well as hands-on opportunities to complete the monitoring form and validation by a licensed clinician to ensure accuracy and consistency. Documentation should verify successful performance of all skills based competencies. Minimum criteria should be established and independent monitoring should not be permitted for each PNMP Coordinator until those criteria are met. Routine monitoring of the PNMP Coordinators should be conducted to validate continued competency.

4. PNMP monitoring should be completed routinely to ensure that all individuals with a PNMP are monitored and that frequency of monitoring is driven by health/PNM risk indicators. Monitoring should also ensure that a sufficient sample is obtained for staff compliance review.

5. The monitoring system must include a mechanism to ensure that issues and concerns identified are addressed with documentation of problem resolution. Each identified concern must be addressed via a mini-plan of correction with evidence of completion such as staff training, submission of work order, equipment replacement, etc.

6. All monitoring results must be tabulated for trend analysis to identify systems issues to guide training and follow-up as well as to celebrate areas of excellence.

7. All staff training must be competency-based to include activity analysis of specific steps and skills required to successfully execute plan implementation. Checklists developed should be used to guide training with demonstration, practice, return demonstration to establish competency and subsequent rechecks for continued compliance.

8. OT/PT assessments should present a better picture of the individual and his or her baseline. This should include likes, dislikes, functional abilities, potential for skill acquisition, and analysis of barriers to successful life skills performance. Specific risk assessment must be included to ensure that supports and services coordinate to minimize these concerns and to identify the impact those risks have relative to participation in meaningful activities throughout the day. This analysis will provide the foundation for appropriate interventions to promote functional skill development and further recommendations of supports and services necessary for success. Goals should be measurable and meaningful to the individual. Creative use of groups will ensure greater capacity to provide appropriate therapeutic intervention.

9. Provide greater integration of therapy supports into the development of more meaningful programming in the day areas.

10. Documentation of therapy interventions should relate to progress toward achievement of a measurable goal(s). Therapy interventions should be included as an action step in the PSP. When discharge is anticipated, this may be reflected in quarterly reviews. In the case that therapy intervention is indicated in the interim, the specific need, rationale for intervention, specific measurable goals and discharge criteria should be documented in the form of a PSP addendum to ensure appropriate integration into the PSP process.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: Documents Reviewed: o Dental records of the 25 individuals in the sample listed in section M. Interviews and Meetings Held: o Dr. Carol Willborn, who provides dental care to the individuals at SASSLC. She was from another state agency o A dental hygienist at SASSLC who provided dental services, at least quarterly, to the majority of the individuals Observations Conducted: o The dental facility
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Dental services at SASSLC were inadequate and were of major concern to the monitoring team.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these	The absence of adequate dental services was one of the most important problems identified at SASSLC. Dental hygiene for all but a handful of individuals, in spite of quarterly cleanings, was totally inadequate, and all but one or two individuals in the sample had advanced periodontal disease and poor to non-existent oral hygiene. Moreover, important administrative changes had, or were about to occur. First, restraint with a papoose board was banned by the state in August 2009. Although restrictions on restraint are laudable, individuals who do not respond to pre-treatment sedation must wait for an appointment for anesthesia and this could take up to a year. As a result, there was no appropriate dental care for these individuals and no reasonable alternatives were presented by the state or facility. Second, as of July 1, 2010, there will be no further services from Dr. Willborn's clinic. SASSLC was authorized to hire a full-time dentist and two dental hygienists. There had, as far as the monitoring team could determine, been little effort to recruit or hire these	

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	standards.	individuals. Third, without the availability of Dr. Willborn's clinic, SASSLC must provide the space for dental service to occur. The facility was very crowded, so finding additional appropriate space for a dental clinic will be a major challenge. Without planning and vigorous effort, by July 1, 2010, there will be no dental services at SASSLC. Some problems with obtaining consent for treatment were noted by the dental staff. In particular, consents were not returned by LARs for many individuals, adding yet another impediment to their receiving dental care and services.	
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.	Reporting focused primarily on reasons why care could not be provided. The dentist reported on multiple attempts to provide services as well as the status of oral hygiene, which according to her, there were only three to four individuals across the entire facility who had even fair oral hygiene. For the most part, the dental records of these individuals stated that there was virtually no dental hygiene. The majority had been seen at least quarterly with scaling occurring at those times. Cleaning teeth no more than once every three months was more the rule than the exception. Some examples of the problems found in the records are below. • Individual #5: A dental assessment on 7/06 indicated non-existent oral hygiene. Similar notes were entered on 11/07, 12/08, and 2/09. A note on 2/10 indicated behavioral issues during an appointment. • Individual #17: The record indicated a need for effective brushing. • Individual #25: Assessments persistently mentioned oral hygiene as an issue, but no real plans to address the issue were evident. • Individual #22: "Very poor oral hygiene" was noted in the record. • Individual #23: Poor oral hygiene and heavy plaque were noted in the record. Again, the facility was planning to address individuals' fear and resistance to dental procedures with the development and implementation of desensitization programs.	

Recommendations:

1. Planning for a dental care system should begin immediately. Perhaps the current dentist's arrangement can be extended while this is developed.

2. An adequate site for the SASSLC dental clinic should be immediately identified with plans for completion as soon as possible.

3. Recruitment for the dental and dental hygienists should occur immediately.

4. A process to address the need for dental service with a concurrent restriction on the use of restraint needs to be implemented.

5. Oral hygiene and how to accomplish it should be addressed by the facility. Nurses should assume responsibility for assuring that adequate oral hygiene is accomplished because of its impact on health in general.

6. A number of individuals were not currently receiving needed dental care due to a problem with consents. According to the dentist, for every 10 consents submitted, only one was returned in a timely manner. This process needs to be given a higher priority by facility management.

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 Reviewed Settlement Agreement: Section XI. Physical and Nutritional Management, and R. Communication o SASSLC Budgeted, Filled, and Unfilled Positions by Job Code o CMS Survey dated 04/09/09, 06/03/09, 08/07/09, 09/04/09, 11/23/09, 12/09/09 o Levels of Supervision, revised 09/01/09 o Current Census by Home o Communication Services policy #016, 10/07/09 o Training outlines including Communication Inservice Emphasis on AAC, sign language handouts, and New Employee- HRD Training Augmentative Communication o PNMP Monitoring form o SASSLC Mealtime Competency Training form o SASSLC Physical Management Competency Training Form o List of Therapy staff and PNM Team members o PNM assessments and updates completed in the last quarter o Continuing Education records for speech department staff o PSPs for: • Individual #21, Individual #229, Individual #239, Individual #79 o Habilitation Therapy OT/PT/ST Update Evaluations for the following: • Individual #253, Individual #302, Individual #79 o Augmentative Communication Reviews: Individual #17 o Speech and Language Updates: • Individual #239, Individual #122, Individual #235, Individual #79, Individual #21, o SASSLC Organizational Chart January 2010 o Habilitation Physical Management Monitoring Forms o Meal Observation Sheets o Personal Record documents including: Individual Information Sheets, , Medical Evaluations, Nursing assessment for last 12 months and monthlies, Hospitalization documentation for last 12 months, Current Personal Support Plans and all addendums and quarterly reviews for last 12 months, OT/PT/ST section of record, NMC reports for last 12 months, Integrated Progress Notes, Health Status Review Checklists, NMC Screenings, OT/PT Assessments, Communication Assessments/Updates, OT/PT/ST Evaluations/Updates, Related updates and Reviews for the following individuals: • Individual #319, Individual #92, Individual #31, Individual #335, Individual #332, Individual #265, Individual #144, Individual #333, Individual #45, Individual #18, Individual #40, Individual #164, Individual #227, Individual #215, Individual #323, Individual #91, Individual #333, Individual #79 (requested but not received)

	○ Physical/Nutritional Management Plan for each individual ○ PNMP format ○ Dining Plan format ○ Occupational/Physical Therapy Services #014P, 11/04/09 ○ Work order spreadsheet ○ Sample dining plan: Individual #317, 01/13/10 ○ Adaptive Equipment spreadsheet ○ Augmentative Communication review format ○ Speech-language evaluation format ○ Communication dictionary for each person submitted ○ Communication Services policy #016 11/04/09 ○ List of communication devices ○ AAC Priority Screen ○ Communication Audit form ○ Communication Tracking Sheet <u>Interviews and Meetings Held</u>: ○ Margaret Delgado-Gaitan, MA, CCC-SLP ○ Allison Block, MA, CCC-SLP ○ Roland (Ron) Hoffman, MS, CCC-SLP ○ Discussions with various supervisors and direct care staff ○ Discussions with various day program staff <u>Observations Conducted</u>: ○ Mealtimes ○ Living areas and day program areas
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The speech and language department had initiated completion of comprehensive assessments for individuals based on the screening conducted in 03/08 through 03/09. With only two clinicians undertaking this effort, it had been slow. In addition, an ever-expanding workload was developing with each assessment, implementation of interventions and AAC devices, and provision of other supports. AAC was provided to only approximately 35% of those who were nonverbal or had limited verbal skills with an identified need for AAC based on findings of this screening. In addition, there were 11 individuals who had existing AAC devices to augment their functional verbal skills, though there were another 19 who might also benefit from these supports. As a result, the ability to meet each individual's needs for supports and assessment was extremely challenging for these two therapists. The job of identifying, implementing,

	monitoring, and maintaining AAC was a difficult task in and of itself, however, the role of the SLP also included supports and services in the area of mealtimes. The current level of staffing would be inadequate staffing to meet the needs of the 283 individuals living at SASSLC in both of those areas. Effective recruitment will be key to selecting well-qualified speech clinicians with experience serving people with developmental disabilities. Collaboration with other disciplines outside of the Habilitation Therapies department was limited and impacted the relevance and integration of communication supports across environments. The foundation of communication skills must be well integrated within the home, work and leisure settings. SLPs must be able to lend their expertise to others to ensure that staff can capitalize on communication opportunities, appropriately reinforce communicative intent in a timely and effective manner, and promote communication-based skill acquisition integrated into all activities throughout the day. Communication books were available for many of the individuals in the homes. Some individuals had specific skill acquisition plans focusing on teaching individuals to effectively use their communication books. When visiting every home and vocational site, however, the monitoring team never once saw an individual using his or her communication book in a functional manner (i.e., using it to communicate); they only appeared to be used for training purposes.

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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.	The facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience. At the time of the on-site tour, there were three full time speech and language pathologists. Margaret Delgado-Gaitan, MA, CCC-SLP was the Director of Habilitation Therapies and while she was a very hands-on leader as observed by the monitoring team, only two clinicians were responsible for full-time caseloads, Allison Block, MA, CCC-SLP and Roland (Ron) Hoffman, MS, CCC-SLP. This was of concern because each individual living at SASSLC communicated in some manner and as a result required the direct and/or indirect supports from a speech language pathologist resulting in caseloads of approximately 142.50 individuals each for communication and the same 142.50 individuals each for oral/motor mealtime. There was one vacant position for a SLP. There was one ST technician to provide supports to the clinicians. There was evidence that Ms. Block and Ms. Delgado-Gaitan had attended continuing education in the last three years. Ms. Block had attended the Texas Speech-Language-Hearing Association convention in 2006 and 2007. In addition, there was evidence submitted that she had attended courses in April and October 2009, totaling 39.5 hours, related to physical and nutritional management, pocket endeavor training, communication issues for individuals with developmental disabilities, augmentative communication, issues in evaluation and treatment of individuals with developmental	

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		disabilities, and ethics for SLPs sponsored by DADS. Additional courses were listed including the TSHA conference in 2008 and 34.5 hours of programs sponsored by TSHA and DADS. There was no evidence of participation in continuing education by Mr. Hoffman. Ms. Delgado-Gaitan had attended a two-hour course sponsored by DADS titled Physical and Nutritional Management for SLPs in April 2009. Supports are provided to individuals based on need and not staff availability. At the time of this on-site review, each clinician had a caseload of approximately 142 individuals in two critical service areas: communication and mealtime supports. Given this ratio, it would be extremely difficult to adequately meet the needs of the individuals at SASSLC. Basic supports included at least an annual assessment or update, development of communication strategies for use by staff, communication dictionaries, dining plans, and the routine monitoring and revision required. This did not include those who would require direct speech-language services more intensive supports necessary for using AAC systems, and/or attention to address increased risk for aspiration or choking during meals. As described below, assessments were not completed in a timely manner for a number of individuals in the sample and as such they would not receive appropriate communication supports and services.	
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.	All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission. Per the tracking sheet submitted, 280 individuals had received a communication screening (the reported census was 283, so at least three individuals had not yet been screened) and were rated at one of four priority levels as follows: • Priority 1 = 70% nonverbal, good potential for immediate use of Assistive Technology (AT) • Priority 2 = <70%) nonverbal, likely needs training for use of AT • Priority 3 = limited verbal, but may benefit from AT • Priority 0 = verbal, no need for AT, or AT already provided By report, screenings had been conducted from March 2008 through March 2009. There were 85 individuals considered to be Priority Level 0 or 30% of the census (283). Of those considered to be primarily verbal with no AT needs or who already had appropriate AT (Priority Level 0), most were considered to be functionally verbal. Individual #316 was listed as functionally verbal, but with decreased intelligibility. Individual #347 and Individual #15 were identified with limited verbal communication. Individual #49, Individual #254, Individual #12, Individual #263, Individual #342, and Individual #172 had no descriptor listed. There were 30 individuals at Priority Level 3, or 11% of the census and most were listed with limited verbal skills. Individual #269 and Individual #132 were considered to be nonverbal. Individual #169 was identified as	

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		functionally verbal. There were 124 individuals considered to be at Priority Level 2, or 44% of the census. Most of these were considered to be non-verbal with five exceptions. Individual #40 was considered to have limited verbal skills and Individual #358 was functionally verbal. Individual #330, Individual #73, and Individual #337 had no designation as to their verbal skills. There were 41 individuals at Priority Level 1 or 15% of the census. Most of these individuals were identified as non-verbal with the exception of Individual #80, Individual #190, Individual #234, Individual #34, Individual #41, and Individual #50 who were listed with limited verbal skills. There were two individuals included on the tracking sheet but with no screening score including Individual #12 and Individual #128. Five initial assessments for individuals newly admitted were submitted for review. Three of these were recent admissions. A full speech and language evaluation had been completed for Individual #122, Individual #235, and Individual #323 following their admissions. Each of these evaluations was completed by Roland Hoffman, MS, CCC/SLP, and each had occurred within the 30-day timeframe. Each was thorough and comprehensive. The other two initial evaluations were completed by a clinician who was no longer employed at SASSLC, Michelle Kolar, MA, CCC-SLP. These evaluations for Individual #319 and Individual #164. One of these was completed within 30 days of admission (Individual #319) while the other for Individual #164 was completed nearly nine months after his admission. Of great concern was that there was no evidence of a more current assessment or update for either of these men, though the evaluations submitted were over 12 years old. Only Individual #164 was listed as in need of evaluation and was considered a Priority Level 2. Individual #319 was identified with limited verbal skills and considered a Priority Level 3. <u>All individuals identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills</u>. Per the tracking sheet, 127 individuals had received a communication assessment. There were 68 additional individuals identified as still needing an evaluation nearly a year after the screenings had been completed. Approximately 87 individuals were listed as not needing an evaluation. While the majority of these had been identified at Priority Level 0 and were considered to have functional verbal skills, there were a number of individuals who were at Priority Level 3 with limited verbal skills and may have benefitted from further assessment. They included the following: Individual #5, Individual #244, Individual #145, Individual #72, Individual #206, Individual #99, Individual #90, Individual #212, Individual #193 and Individual #194. The comprehensive communication evaluation format outlined background information, communication history, receptive and expressive language skills, articulation, voice	

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		fluency, AAC, environmental controls, clinical impressions, communication strengths, and recommendations. This format was comprehensive in scope, though in many cases the section related to AAC was very limited and did not reflect extensive assessment of individual potentials in this area. For example, the possibility of AAC was dismissed for some individuals based on very limited information such as for Individual #21, Individual #235, Individual #239, Individual #333, Individual #265, and Individual #40. The system used to determine who needed an evaluation was inconsistent and unclear. There were individuals who were listed at Priority Level 0, considered verbal and not in need of AT, who had received evaluations, including Individual #316, Individual #182, and Individual #150. Individual #14 was listed as Priority Level 1, 70% nonverbal with good potential for immediate use of AT, yet he had not yet received an evaluation per the tracking sheet. Additionally, there were another 62 individuals considered to be Priority Level 2 who had not as yet received an evaluation. There were only four individuals at Priority Level 3 who had not yet been evaluated and listed as needing an evaluation. As stated above, there was another 10 individuals listed as Level 3, but an evaluation was not indicated. The screenings had been completed approximately 11 months prior to the time of this on-site review with 68 evaluations still outstanding. In the sample reviewed by the monitoring team, there were five speech and language evaluations submitted, completed for individuals newly admitted. Speech and language updates were submitted for 14 individuals and two augmentative communication reviews. Findings for these individuals per the screening conducted were as follows, with the most current assessment/update in parentheses: • Priority 0, no evaluation indicated: Individual #215 (03/19/92) • Priority 3, no evaluation indicated: Individual #319 (09/03/97) • Priority 3, evaluation completed: Individual #144 (09/30/09), Individual #323 (09/12/08) • Priority 2, evaluation needed: Individual #227 (08/16/00), Individual #332 (10/10/97), Individual #265 (10/01/91), Individual #18 (01/15/10), Individual #164 (05/14/97) • Priority 2, evaluation completed: Individual #91 (AAC Review 02/25/10), Individual #45 (02/25/09), Individual #40 (11/25/09), Individual #21 (12/03/09), Individual #79 (03/23/09), Individual #239 (10/02/09) • Priority 1, evaluation completed: Individual #17 (AAC Review 11/05/09), Individual #333 (02/09/09), Individual #31 (02/12/10), Individual #92 (06/26/08) Of those listed above, only Individual #91, Individual #144, Individual #45, Individual #31, Individual #79, and Individual #92 had been provided communication-related AT.	

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		Individual #122 and Individual #235 were not included on the tracking sheet, but had received speech and language assessments following their admission to SASSLC. Individual #122 used some sign language, single words paired with gestures and a communication book. Individual #235 was a functional communicator using speech, vocalization, gestures and facial expressions. Evaluations listed as completed for Individual #333, Individual #92, and Individual #323 were over one year old. This was of concern because Individual #92 and Individual #311 appeared to be in need of communication supports and services. Many individuals living at SASSLC received some level of direct and/or indirect communication-based supports and services and were to receive an assessment of their communication abilities annually. An annual update was completed that was similar in content to the speech and language evaluation, but was less comprehensive. Using the update approach can be a very effective method to provide an annual review of status and to formulate a foundation for supports and services for the year when used in conjunction with a comprehensive assessment completed at least every three years. In that case, the comprehensive assessment remained in the personal record with subsequent updates until the third year when the group of assessments was replaced with a new comprehensive assessment. Each update made reference to the most current comprehensive assessment and was considered complete only in the presence of the comprehensive assessment document. The update referenced changes in the individual's general information and communication status over the last year as well as described supports and services provided and the effectiveness of each. Recommendations for support planning for the upcoming year were documented. In the case that it was determined via a comprehensive assessment that no supports and services, direct or indirect, were indicated, a clear statement was in the evaluation report to the effect that further assessment was not required, unless there was a change in status was required. Otherwise, an update and three-year comprehensive evaluation was the standard. Of the 21 speech and language assessments submitted for review, five were initial evaluations and identified as comprehensive, though as stated above, two of these were over 12 years old. No additional updates were submitted for either of these individuals (Individual #164 or Individual #319). Individual #319 was identified as requiring significant staff supports for effective communication including the use of sign language and a communication book to augment his verbal communication efforts. These were not listed as available to Individual #319, he was considered Priority Level 3 and no evaluation was indicated per the tracking log. The previous assessment was completed in 1997. It was of concern to the monitoring team that he had not benefitted from these supports. Individual #164 was described as a functional communicator, yet the screening indicated that he was Priority Level 2 and required an assessment. Additionally, Individual #323's evaluation was completed 17 months prior to the on-site	

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		review with no direct speech-language therapy recommended even though it was unclear if further assessment and/or updates were indicated. No other comprehensive assessments were submitted for him. Other documents submitted included Speech and Language Updates for 14 individuals. By report, these updates were completed for each individual rather than a comprehensive assessment each year. Of this sample, four updates were completed by Mr. Hoffman, six were completed by Ms. Block, four were completed by Ms. Kolar, and one was completed by Mary Ann Moses, MA, CCC. Only two of the four assessments by Mr. Hoffman were current within the last 12 months. One was dated 02/09/09, expiring the week of the on-site review (Individual #333) and the other for Individual #92 was dated 06/26/08, well over a year old. The evaluation updates by Ms. Kolar were for Individual #332 (10/10/97), Individual #215 (03/19/92), Individual #227 (08/16/00), and Individual #265 (10/01/91). There was no evidence of a more recent assessment by a SLP and these assessments were up to nearly 10 to 18 years old. The six updates completed by Ms. Block were each current within the last 12 months. If receiving services, direct or indirect, the individual is provided a comprehensive Speech-language assessment every 3 years, with annual interim updates or as indicated by a change in status. By report, each individual received an annual update only. This was noted for Individual #31, for example, who participated in direct services with a SLP, and Individual #45, who received indirect supports. A more comprehensive assessment was not conducted every three years. For persons receiving behavioral supports or interventions, the facility has a screening and assessment process designed to identify who would benefit from AAC. Note: This may be included in PBSP. There was no system to prioritize assessments or vary AAC services based on the need for behavioral supports. While it was reported that the SLP collaborated with the PST to address these needs, the process was not formalized. Individuals determined via comprehensive assessment to not require direct or indirect Speech Language services receive subsequent comprehensive assessment as indicated by change in status or PST referral. Each of the evaluations or updates reviewed, identified the need for at least indirect communication supports. At the time of this review, annual updates were completed, though not all evaluations were current within the last year. While new or emerging communication-related issues may be addressed via the PSP, a new comprehensive assessment was not completed at that time. Policy exists that outlines assessment schedule and staff responsibilities. The state policy dated 10/07/09 required that review and revision of the "communication provisions of the PSP as needed, but at least annually." There was also reference to a	

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		schedule of comprehensive communication assessments "set forth" in the Communication Master Plan. As stated above, the plan used to guide completion of assessments was inconsistent and a number of individuals had not yet received an assessment one year after completion of the screenings. Findings of comprehensive assessment drive the need for further assessment in augmentative communication**.** A number of the more current updates and initial evaluations submitted addressed AAC in an abbreviated manner within these reports (Individual #122 and Individual #144, for example). In the case of Individual #92, however, a specific AAC section was not included in the update completed on 06/28/08 though he had a 32-phrase electronic communication device. There was a brief discussion of this device in a summary of functional communication skills. There was no evidence that the SLP completing this update interacted with Individual #92 or even observed him using this device. By report, he was reluctant to use it mounted in front of his work jig. It was reported that staff were to encourage his use of the device, but that this was "done inconsistently." By report, he was also reluctant to use communication boards. There was no evidence of investigation by the clinician to further address these issues other than to state that staff should encourage him. Direct speech therapy had been discontinued in March 2009 due to his lack of motivation. In the cases of four other individuals (Individual #21, Individual #333, Individual #235, Individual #239) who had received updates by this same clinician, AAC was deemed to be inappropriate due to failure to maintain attention, shift eye gaze to pictures when named, identify objects, show interest in pictures, imitate signs, and /or understand that a two message device could assist with communication. These same individuals were also identified with communication strengths including visual and tactile awareness of environment, visual tracking, looks up when spoken to, responds to name, identify common objects used in daily activities, demonstrate function of common objects, follows one-step directions, inconsistently answers questions, and indicates preferences by making brief eye contact, for example. On the other hand, a different clinician recommended AT/AAC for five out of six updates completed. Strengths and limitations similar to those identified for the four individuals described above were also noted for Individual #79, Individual #18, Individual #45, and Individual #144. In one case, direct speech and language services were recommended by this clinician for Individual #31. As stated above, there were approximately 68 individuals with some level of AAC including communication books, sign language, various voice output devices, communication boards, picture folders and wallets, talking picture frames, object rings, laptop computer with head switch, and so on. Most of these appeared to be functional, though some only within a specific context or environment.	
R3	Commencing within six months of	Rationales and descriptions of interventions regarding use and benefit from AAC are	

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	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.	clearly integrated into the PSP. In some cases, the findings of the speech and language assessment/update were not clearly integrated into the PSP. Some examples included: • Individual #17 – His AAC review dated 11/05/09 indicated that staff should use a Total Communication approach, using speech and sign language. The evaluation cited in the PSP (11/17/09) was dated 11/13/08 and indicated only that a communication dictionary was recommended. • Individual #122 – His Speech and Language Evaluation dated 12/04/09 indicated that staff should use a Total Communication approach (sign language and speech) as well as a communication book. He also had a picture folder with 73 Board maker symbols and he was able to identify a number of the items. His PSP dated 12/11/09 stated only that he was non-verbal and used sign language, gestures, and expressions as his primary method of communication. • Individual #235 – The Speech-Language Evaluation dated 12/09/09, listed eight special considerations for general speech enhancement and the recommendation for use of communication folders to stimulate language and vocabulary growth. The PSP dated 12/17/09 stated only that staff were to "provide language modeling to improve her communication abilities." A training objective to "identify 3 common objects by function" was included in the Action Plan #3. The PSP contains information regarding how the individual communicates and strategies staff may utilize to enhance communication. PSPs were reviewed (22) to assess this element. In many cases, only a brief statement of communication skills was included, such as "communicates via gestures and body language," or "is non-verbal using sign language, gestures and/or body language." In other cases, the PSP listed recommendations from the assessment (Individual #239, for example) or offered no description of the individual's communication abilities (Individual #235, for example). Individual #91 had a Cheap Talk device for use in his home and in the Forever Young program. This device was not mentioned in his PSP dated 03/16/09. There were two training objectives related to activation of a switch, and picture identification by pushing a corresponding button. Recommendations in his evaluation were to promote opportunities to make requests. There was no mention of this in his PSP or addendum. Rarely did a PSP outline how staff were to communicate with the individual. On one occasion, the monitoring team observed staff providing vibration to Individual #79. She consistently appeared to be withdrawing from the stimulation. When asked, staff indicated that an evaluation had been conducted that identified that she did not tolerate vibration. As a result, it was determined that she should get this sensation in a sensory stimulation program. The response tracked was whether she tolerated it or not. It was of concern that communicative intent, or withdrawal from the stimulus, was not	

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		addressed and shaped to promote choices of preferred activities. SLP professional staff input would be vital to ensure that programming and enhancement of communicative intent were appropriate for each individual and to model appropriate interaction. Staff were well intended, but misguided as to effective strategies to use with this individual. Further discussion of this issue with another staff revealed that activities like this one were intended to impact an individual's tolerance for self-care activities in the home, however, there was no effort to establish a baseline or to track potential changes in an individual's ability to better accept handling during self-care as a result of a specific sensory stimulation program. As a result, a program of this nature was not functional or meaningful in the individual's life. <u>AAC devices are portable and functional in a variety of settings</u>. In total there were approximately 68 individuals provided communication-related AT. One individual in Priority Level 0, Individual #22, had a voice output device by the front door of his home that indicated "I'm leaving." Individual #316, also Level 0, was listed as functionally verbal, but with decreased intelligibility. He had been provided a communication wallet. Individual #347 and Individual #15 were identified with limited verbal communication. Neither had AT per the tracking sheet submitted. Individual #49, Individual #254, Individual #12, Individual #263, Individual #342, and Individual #172 had no descriptor listed and no communication-related AT identified. Individual #269 and Individual #132 were at Priority Level 3 and were considered to be nonverbal, though only Individual #269 had AT (communication book). There were 11 individuals at this level with AT. There were 124 individuals considered to be at Priority Level 2 and most of these were considered to be non-verbal. There were 23 individuals listed as Priority Level 2 with AT. Most of these individuals at Priority Level 1 were identified as non-verbal with the exception of Individual #80, Individual #190, Individual #234, Individual #34, Individual #41, and Individual #50 who were listed with limited verbal skills. There were 29 individuals at this level with AT. Less than 50% of the devices provided were portable and functional across settings. Many were specific to a room or activity. Some examples included: • Communication frame in the living room (Individual #211) • 2-message device to request markers and paper (Individual #93) • VOCA device to request a snack in Forever Young (Individual #61) • Device mounted in activity room to request lotion (Individual #135) While these appeared to be excellent options for these individuals, only Individual #211 had additional AAC options available to him, though still limited only to the nurses' station and living room. In the case of Individual #335, he was observed to be without his communication system on 02/12/10. When staff were asked about the devices, they	

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		indicated that they were unsure of where it was. They looked for it for a while and then stated that it was in "default." This meant that it was in need of repair and they were unsure of when it would be returned to him. This was also true of Individual #92, per staff report. He had also been seen earlier in the week, on 02/09/10, without his device. Homes 665,668, 670, 671,672, 673, and 674 each had a variety of devices available to each person in the home for use in various areas of the home. They were located in activity rooms, nurses' stations, dining rooms, and so forth. The monitoring team occasionally observed their use by individuals and their staff in an effective, naturally occurring manner. AAC devices are meaningful to the individual. Though only 68 individuals had AAC devices of some kind, they appeared to have the potential to be meaningful and functional. In most cases the device was listed as adaptive equipment and referenced in the communication section of the PNMP. As stated above, however, there was little to no reference in most of the PSPs reviewed. It was of concern that communication in general and specifically related to AAC needed to be more integrated into the PSP to provide direction to all staff in methods to effectively communicate with an individual as well as to promote and enhance communicative intent throughout the day, across a variety of environments. Staff are trained in the use of the AAC. A one-hour training was provided to new employees related to services provided by the speech-language department and use of communication books, folders and other forms of AAC, deaf awareness, and sign language. It was of concern that while there were limited hands on activities integrated into this training, it was not competency-based, with demonstration, practice, and return demonstration. By report, as with other staff training conducted by Habilitation Therapies at SASSLC, the approach used was to provide competency–based training for home managers who then were, in turn, to provide training for their staff. Specific training records were not reviewed during this baseline review by the monitoring team. Communication strategies/devices are integrated into the PSP and PNMP. Refer to previous discussion regarding sections of PSP related to communication above. Communication strategies/devices are implemented and used. As stated above, a number of individuals had devices but there was no evidence of functional use throughout the day. General AAC devices are available in common areas. A number of devices were available in common areas in at least seven of the homes. Effective use of a few of these was observed by the monitoring team, primarily in the dining rooms.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	Monitoring system is in place that tracks: a. the presence of the AAC; b. working condition of the AAC; c. the implementation of the device; and d. effectiveness of the device. Physical Management Plan Monitoring forms completed in the last three months by Habilitation Therapies staff, Quality Enhancement, nursing staff, home managers, psychology and other staff were requested. Only 52 completed forms were submitted and each had been completed by Habilitation Therapies staff only. There was no evidence that monitoring had been completed by any other staff during the last quarter of 2009. The form itself stated that Home Supervisors were to complete two monitoring forms each month, though there was no evidence that this was done. The completed forms were for monitoring conducted in seven homes, though six forms did not designate a home. Approximately 40% indicated that the monitoring was conducted at a mealtime. There was only one item on the form that addressed AAC use. Item 4A asked, "Is assistive equipment available and used correctly? (foot rest, lap belt, communication device, helmet, environmental control device, etc.)." There were no comments on any of the forms submitted that communication devices were monitored and all issues identified on the forms for this item related generally to positioning equipment, such as wheelchairs. There was no item on the monitoring form that addressed the effectiveness of a communication device. A Communication Audit log was submitted that addressed availability, use, and condition of AAC devices for the months of October, November, and December 2009. While this system appeared to identify concerns related to condition and working order of devices, it was ineffective in resolving issues noted. In addition, effectiveness of a communication device was not addressed via this audit system. For example: • Individual #6 – In 10/09, it was noted that objects were missing from his object ring. The ring was not replaced until 11/16/09. • Individual #75 – In 10/09, it was noted that his picture folder was missing. The folder was not replaced until 11/16/09. • Individual #174 – The condition of her communication book and/or picture folder were noted to be in poor condition in 10/09 and 11/09. These were not replaced until 12/01/09. • Individual #135 – It was noted that the device mounted in the activity room to permit her to request lotion was not working in 11/09 and 12/09. A notation 12/09 indicated that the device needed to be replaced. There was no evidence in the tracking sheet that this had been done. • Individual #158 – It was reported that his communication book for home and work were missing in both 11/09 and 12/09. It was stated that it was in the psychologist's office. It was of concern that an individual's communication	

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		system was unavailable for two months because it was in staff's office. There was no notation as to why or how this issue was to be resolved. • Individual #257 – His two-button VOCA was reported missing in 12/09, and there were no notations as to how this issue was to be resolved. • Individual #129 – His voice output object board was reported unavailable in 10/09, 11/09, and 12/09. There was a notation in 11/09 and 12/09 that a new device had been ordered. It was of concern that Individual #129 had been without his device for more than three months. • Individual #86 – His object board by his room was reported to be torn down in 11/09 and "in the cart in speech office" in 12/09. A notation was made to ask the SLP about a solution. It was of concern that Individual #86 had been without this device for over two months. • Individual #45 – Her VOCA switch for a radio was reported to be missing in 11/09 and 12/09. There were no notes as to how this concern was to be resolved. • Individual #335 – His voice output device was reported to not be in working order in 11/09 and 12/09. The notation was that Individual #335 was getting a new device and to continue "to remind therapist he doesn't have a device." As reported above, staff indicated that Individual #335 still did not have a working device as of 02/12/10. • Individual #92 – There was no evidence that the AAC devices for Individual #92 had been monitored. As described above, staff reported that his device was in "default" or in need of repair as of 02/12/10. • Individual #95 – Her picture schedule was missing as of 11/09. It was reported to be missing again in 12/09 with a note to look in a cart in the speech office. There was no evidence that this had been located. Note that there were 41 individuals who had not been monitored at all. <u>Monitoring covers the use of the AAC during all aspects of the individual's daily life in and out of the home</u>. There was no clear consideration or schedule to ensure that each device was monitored across all aspects of the individual's day. <u>Validation checks are built into the monitoring process and conducted by the plan's author</u>. At the time of the on-site review, there was no evidence that validation checks were occurring at SASSLC to ensure ongoing consistency of findings across monitors and across time. New PNMP monitors had been recently hired and initial training had begun for these staff. They were to be assigned to conduct PNMP monitoring in addition to that conducted by other professional staff. Some training of these staff was ongoing at the time of this review and observed by the monitoring team. This training was on-the-job	

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		and numerous opportunities for hands on practice, problem-solving and informal validation were noted.	

Recommendations:

1. Aggressively recruit experienced speech clinicians to ensure all communication needs are appropriately met.

2. Provide greater opportunities for continuing education opportunities for SLPs in the area of AAC to ensure that they have the knowledge and skills to appropriately select AAC systems and to capitalize on individual communicative potentials particularly for those with less overt communicative intent.

3. To ensure that AAC provided is functional and meaningful for individuals consider the following:
    - For those with existing AAC, identify potentials, at least annually, for further individual growth in the use of individual systems, and/or ways to move on to more complex AAC systems to expand meaning and function, across settings and communication partners.
    - Change messages on single message VOCAs regularly to increase motivation for communication and interest levels by the individual and staff who are responding.
    - For individuals effectively using single message devices, move toward access of multiple VOCAs and the start of dual switch use. Individuals do not need to understand the message to have a response; communication is learned through responses from communication partners. There are no prerequisite skills needed to address AAC/AT skills in the area of communication.

4. SLPs should take an active role in the mat assessments currently completed by OT and PT. Look at all aspects: swallowing, respiration, vision and switch access sites, in a variety of positions.

5. Implement more communication during mealtimes. Individuals can initiate requests, interact with peers, and make social comments.

6. Initiate more opportunities for group interaction in the day programs. Model communication and interaction methods and strategies for staff in those programs.

7. Ensure that plans, assessments, and other documentation are consistent with regard to communication devices and how they are used.

8. Collaborate with psychology to design communication and behavior support plans to ensure coordination and effective intervention strategies.

9. Ensure that the monitoring system is regularly scheduled across all homes and is communication-focused to determine if the interventions and strategies that are being used continue to be functional, meaningful, and appropriately implemented.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Documents Reviewed: o Personal Support Plans for: • Individual #95, Individual #155, Individual #218, Individual #103, Individual #205, Individual #304, Individual #64, Individual #40, Individual #335, Individual #241 o Skill Acquisition Plans for: • Individual #205, Individual #225, Individual #201, Individual #95, Individual #3, Individual #64, Individual #140, Individual #6, Individual #71, Individual #295, Individual #80, Individual #244, Individual #250, Individual #78, Individual #32, Individual #110, Individual #228, Individual #343, Individual #276, Individual #315, Individual #150, Individual #221, Individual #47 Interviews and Meetings Held: o Daisy Ellison, MA, Director of Psychology o Discussions with a variety of staff from clinical, administrative, and direct care o Meeting with the facility's Qualified Mental Retardation Professionals (QMRPs) and their department head Observations Conducted: o Observations occurred in every day program and home. These observations occurred throughout the day and evening shifts, and included many staff interactions with individuals including, for example, • Assisting with daily care routines (e.g., ambulation, eating, dressing), • Participating in recreation and leisure activities, • Providing training (e.g., skill acquisition programs), and • Implementation of behavior support plans
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The quality of the skill acquisition programs was not consistent with that required by this provision of the Settlement Agreement. It was not clear how or why many of the skill acquisition programs were chosen, all plans were found to be missing critical training components, and there was no systematic method of

	measuring acquisition data or the integrity of staffs' implementation of the plans. The monitoring team was encouraged by the positive and pleasant interactions observed between staff and the individuals served at SASSLC, however, actual measures of individual engagement indicated that improvement in individual engagement was needed in most settings. There was no evidence that community activities were developed to address individual's needs for service or his or her preferences.

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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 incorporates a wide variety of aspects of programming at the facility regarding skill acquisition, engagement in activities, and staff training. To monitor this provision, the monitoring team looked at the entire process of habilitation and engagement. The facility was awaiting the development and distribution of a new policy in this area. It is expected that the policy will provide direction and guidance to the facility. <u>Skill acquisition plans</u>: Review of records and interviews with staff revealed that skill acquisition plans had been developed and implemented for each individual served at SASSLC. There were, however, several aspects of the current plans that needed to be improved in order for these plans to effectively promote the growth, development, and independence of the individuals. All personal support plans (PSPs) reviewed identified at least two skill acquisition plans (e.g., Individual #155) and as many as nine (e.g., Individual #304). In the review of PSPs, skill acquisition plans, and conversations with direct care staff, it was not clear why these particular skill acquisition plans were chosen for each individual. The facility should consider utilizing various assessment and curriculum planning tools for individuals with disabilities. One discussed with the QMRPs was the ABLLS-R (Assessment of Basic Language and Learning Skills-Revised). Although the tool was designed for children with learning and language disorders, autism, and other disabilities, the facility might find the contents helpful, especially in designing an instructional curriculum for individuals with the most severe learning needs. Skill acquisition plans should address needs identified in documents, such as the psychological assessment, psychiatric assessment, language and communication assessment, personal support plan, positive behavior support plan, and relevant medical assessments. The PSP should clearly indicate the integration of these documents and their contents into the decision process of choosing skills to teach individuals at the	

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		facility. The overall goal of skill acquisition programming should be made clear to direct care staff implementing the plans, and others who might read the plan, that these plans were developed to promote growth, development, and independence. Once developed, skill acquisition plans need to contain the proper components. 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: • well-written behavioral objectives that define behavior and training conditions, • operational definitions of target behaviors, including a task analysis when appropriate, • description of teaching conditions, • detailed and clear teaching instructions (e.g., shaping, prompting, fading of prompts), • opportunity for the individual's response to occur, • specific consequences for correct and incorrect responses (including individualized use of positive reinforcement), • a plan for generalization and maintenance of the skill once mastered, • regularly monitoring of results, and • modification or discontinuation if objectives are met or if progress has stalled. The comprehensiveness of the skill acquisition plans reviewed at SASSLC varied greatly. The best plans contained a task analysis, behavioral objectives, operational definitions, specific instructions, and instructions on what to do if the individual responded correctly (e.g., Individual #64's communication goal; Individual #3,'s communication goal). Most plans, however, included few, if any, of the components of effective skill acquisition programs (e.g., vocational goal for Individual #225) and not one acquisition plan reviewed was complete as per the above listing. This was even more evident in a set of SPOs submitted to the monitoring team by the head of the QMRP department. These were, presumably, typical examples of SPOs at SASSLC and, as indicated below, were fraught with problems. • Individual #244: She had a plan for learning money management. The goal was for her to make a purchase from a snack machine, but the specific skill being taught was teaching her to point to the numerals 1, 2, and 3 that were written on a piece of paper. The plan called for measuring the amount of assistance she needed to do so (rather than her actual performance), doing the training only once per week (probably an inadequate frequency if she was to successfully learn this skill), and the absence of any positive reinforcement (an ineffective	

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		way to teach). • Individual #244: She had a plan to teach her about her medications. Specifically, she was to answer the questions, "how do you take pills?," and "where do you put lotion?" by making gestures to indicate her mouth and her skin. Positive reinforcement was not included in this plan. • Individual #244: She was to improve her reading comprehension. To do so, staff were directed by the plan to read her a story (always the same story) and ask her to point to a picture of the quilt maker, and to answer the same specific questions every session: "are the quilts beautiful or ugly," and "what does the quilt maker make blankets for?" The plan was to do this only once per week and no positive reinforcement was included. • Individual #140: One of his SPOs was to do one on-campus and one off-campus activity per week. This was more of a participation plan than a learning plan. • Individual #140: The plan was for him to work on money management by answering six questions, including, "explain the difference between saving and spending," "understand where we save money-bank," "understand how saving money works," "understand what a bank is for," "understand why we save money," and "understand the terms banking and saving." This plan was to be done once per week and included the use of praise. It was unclear as to what the correct response was supposed to be. • Individual #140: He had a plan to learn to brush his teeth. The written plan listed six steps to this process. Implementation was once per week, there were no further details as to what staff were to do, and no positive reinforcement was included. • Individual #250: He had a plan to chew each bite of food. It was to be implemented every day with data collected only once per week. It included the use of verbal praise, but did not indicate exactly what it was that he was to be learning. • Individual #250: This plan included the use of a picture book about communicating being ill or upset. The plan was unclear regarding how to teach and if teaching was to occur when he was actually ill or upset or if, instead, they were to prompt him to point to these pictures at other times. • Individual #250: He had a goal to learn money management, but the specific skill was to identify a picture of a quarter. • Individual #6: The skill taught in one of his plans was to point to his medications when they were along side other medications and to provide him with praise. It was unclear as to what he was supposed to do and this plan might have perhaps been dangerous if allowed him the opportunity to perhaps ingest the wrong medications. • Individual #295: His plan was to choose a shirt to wear. Although this was a	

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		reasonable skill to learn, the written plan did not provide direction to staff as to how to teach him to do so. Additionally, it was not clear from the review, as to how skill acquisition data were monitored and evaluated to ensure that they were most effective. In observing the implementation of skill acquisition plans in the A-wing of the vocational area, the monitoring team learned that data collection for Individual #110, Individual #228, and Individual #343 was done as a running note (i.e., no data sheet or standardized data collected, just free-form running prose describing the individual's behavior). In reading the notes, one could not determine if any of the individuals were or were not making progress. Finally, there was no evidence that a method for assessing the integrity of implementation of skill acquisition plans existed at the facility. Meetings with various staff revealed that the QMRPs were responsible for writing and monitoring the majority of skill acquisition plans at SASSLC. The limited exceptions were vocational plans (which were generally written and reviewed by the vocational staff) and some communication plans (which were often written by occupational therapists). It was clear that many of the QMRPs did not possess the training and background in the use of effective, evidence-based instructional methodology for individuals with developmental disabilities. They had received limited training in the use of instructional procedures, education, materials adaptation, and other components of generally accepted professional standards of care regarding skill acquisition programming. There were 13 QMRPs, one for each home. In addition to their responsibility for skill acquisition programming (development and implementation), the QMRPs also had the primary responsibility for coordinating services, organizing and facilitating annual and quarterly PSP meetings, holding interim PSP meetings as needed, completing the injury risk assessments and the PALS assessments, and participating in the completion of the rights assessments and level of supervision reviews. They estimated that sixty percent of their time was taken up in meetings. The QMRPs would benefit from assistance from psychology and other departments in developing and monitoring skill acquisition plans related to their expertise. The facility should consider ways of allowing staff with training in developing acquisition plans, and expertise in the area of the plan (e.g., plans teaching desensitization of medical interventions might be written by the psychology staff) to be responsible for writing skill acquisition plans. The facility might consider other ways of increasing the efficiency of the QMRPs, such as the availability of portable laptop computers and the addition of administrative or clerical assistance.	

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		<u>Engagement in Activities:</u> 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. The monitoring team was pleased to learn that SASSLC, under the direction of the facility director, had spent considerable time and effort developing what they called Active Treatment. The goal of active treatment was to ensure that individuals at SASSLC were actively involved in meaningful activities during all waking hours. Every home the monitoring team visited had staff, typically divided among small groups of individuals, attempting to involve the individuals in discussions, movies, or structured games and programs. As is the often the case with any new initiative, the monitoring team found that some staff were much more effective at establishing and maintaining individuals in meaningful activities than were other staff. Nevertheless, the monitoring team was struck by the commitment of staff to active treatment, and how effectively some staff members were able to provide it. These variations in staff skills in maintaining individual engagement are reflected in the variations in the examples provided below and the engagement scores reported below these examples. • In Home 665, four staff were present during breakfast and there were numerous instances where the staff said, "thank you" and "good job" to the individuals. This was nice to see and the individuals were responsive to these interactions. • During this same breakfast routine, three of the staff used manual sign language in addition to verbal for many signs, including coffee, milk, and good morning. The individuals were responsive to these interactions, too. • Icon boards were on the walls in many of the homes. Although no instances of use of these boards were observed, they can set the occasion for interactions between individuals and staff. • In many of the homes, the staff used small activity rooms that were made available for small group activities. It was good to see that staff were splitting up into these smaller groups rather than having everyone gather in one large living room for long periods of time. • In the living room area at Home 671, the staff and individuals had created small groups within the larger room. One group was talking about days of the week	

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		while another was working on making greeting cards, using colored pens. • In one of the small activity rooms in Home 671, six individuals and two staff were working on an activity involving a large toothbrush and a large fake plastic mouth. Most of the individuals did not appear interested in the activity, though the staff were doing a very good job of attempting to gain their attention. • In Home 668, five individuals were in one of the small back rooms with one staff member. He was doing a nice job of circulating his attention, but the group activity involved touching a picture of a pineapple. An activity in which none of the five individuals appeared to have any interest. • A new position of Active Treatment Coordinator was created recently. The goal is for this person to help with activities and materials to help ensure engagement. The monitoring team, however, heard many reports of these staff being pulled into the staffing ratio due to staffing shortages. Overall, SASSLC had made progress towards improving engagement for the individuals. The next step is for the facility to work on individualizing activities, staff training, data collection, and management of engagement. Individualizing refers to ensuring that engaging activities are preferred, and are appropriate to the skill capabilities of the individual. Another one of the most direct ways to improve active treatment is to objectively monitor individual engagement by collecting data, and establishing specific engagement goals in each home and day program site. Of course, variability across sites is expected, based upon the type and number of individuals and staff in each setting. A specific, detailed, and reliable method for collecting engagement data will be required. The process should also include the reporting of data to managers and staff. The monitoring team was also very pleased with the positive and pleasant interactions observed in every home and day program environment at SASSLC. Generally, it appeared that staff enjoyed working with the individuals, and that the individuals generally appeared to enjoy their interactions with staff. Engagement of individuals in the day programs and homes at the facility was measured multiple times, in multiple locations, and across days and time of 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 residence and day program are listed below. Overall, the average engagement level across the facility was at 44%. As can be seen in	

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		the table below, there was considerable variability across homes and day programs. An engagement level of 75% is a typical target in a facility like SASSLC. So although the observed quality of the interactions was good, and the commitment to active treatment was apparent, the engagement of the individuals had room to improve. Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
Home 665	3/5	1:5
" "	3/7	1:7
" "	5/8	3:8
" "	4/8	2:8
Home 766	4/8	3:8
" "	8/9	2:9
Home 672	2/7	2:7
" "	3/11	4:11
C wing	1/8	2:8
" "	3/8	2:8
Home 674	2/6	2:6
" "	2/6	2:6
" "	4/8	4:8
A wing	12/18	5:18
" "	8/18	3:18
B wing	6/10	3:10
" "	7/10	3:10
" "	9/11	3:11
" "	10/11	3:11
Home 670	3/7	4:7
" "	3/14	3:14
Home 668	2/8	1:8
" "	1/7	1:7
Home 673	5/12	6:12
" "	4/12	6:12
" "	5/8	4:8
Home 671	2/8	2:8
" "	2/4	1:4

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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.	Conversations with the QMRPs, other staff, and review of PSPs indicated that the facility attempted to annually assess individuals' preferences, strengths, skills and needs in the areas of living, working, and engaging in leisure skills. Although some tools such as the Positive Adaptive Living Survey (PALS) were reported to be used to assess individual skills and strengths, it was unclear how the information from the PALS was used in any systematic way to either assess if individuals had made progress from previous years, or to choose skills to teach during the upcoming PSP year. Additionally, although functional assessments and PBSPs included a discussion of preferences, no evidence of systemic preference and reinforcer assessments was found (see section K5 above for a discussion of the value of systematic preference assessments). Subsequent monitoring visits will continue to identify and evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration. The monitors noted that some discussion of barriers to community integration often occurred at PSP meetings and in the living options section of the PSP. This issue is discussed in more detail in the review of provision T of this report.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As discussed in section S1 above, it was unclear from staff interviews and record review whether skill acquisition plans were developed in response to each individual's needs. Additionally, it did not appear that the acquisition plans consistently resulted in a desired change in behavior. For example, the monitoring team reviewed the effects of six skill acquisition plans to develop or strengthen replacement behaviors (i.e., skill acquisition plans to take the place of undesirable behavior) that contained at least six months of acquisition data. Across those six individuals, acquisition data for a total of 12 replacement behaviors was found. Of those 12 acquisition plans, only two (one for Individual #47, and one for Individual #205) clearly demonstrated that the plan resulted in the learning or acquisition of the desired behavior. Despite the fact that the other 10 plans failed to show any meaningful change in the desired behavior, they continued to be conducted for	

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		several months (in most cases, 12 months), without modification, suggesting that acquisition data were not regularly monitored, or modified as a function of individual behavior. The monitoring team noted that skill acquisition plans were regularly conducted by staff and data were collected by staff. As discussed in provision S1, however, it was not clear if they were conducted with integrity, and there was no evidence that the data were graphed. Additionally the majority of skill acquisition plans reviewed did not include a written implementation schedule, the appropriate use of reinforcement, and specific instructions on the use of prompting and practice.	
	(b) Include to the degree practicable training opportunities in community settings.	Although it was clear that individuals did have regular access to community activities, it was not clear these community activities were developed to address individuals' needs for services or preference. Conversations with staff revealed that training was rarely provided in the community. The exceptions were the training provided to seven individuals who were employed in the community. Three individuals worked on a landscaping job, three at local restaurants, and one was employed by Sea World.	

Recommendations:

1. Ensure that skill acquisition plans are based on individual needs identified in documents such as the psychological assessment, Psychiatric assessment, language and communication assessment, PSP, PBSP, etc.
2. Ensure that all skill acquisition plans contain the components necessary for learning and skill development.
3. Incorporate expertise from departments other than QMRP to develop and monitor appropriate skill plans (e.g., psychology to write plans for teaching replacement skills and desensitization to medical intervention plans, etc.).
4. Ensure that decisions to modify, discontinue, or continue skill acquisition plans are based on the effectiveness of the plans.
5. Develop a method to access if skill acquisition plans are implemented as they were written (treatment integrity).
6. Develop a plan to address, monitor, and maintain reasonable levels of individual engagement in all settings.
7. Provide systematic assessments of individual's preferences, skills, strengths, and needs.
8. Ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.

9. Improve employment training opportunities for individuals in the community. Explore whether SASSLC can become a DARS vendor.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, 10/30/09, and six attachments (exhibits) o SASSLC Policy: Most Integrated Setting Practices, Standard Operating Procedure 300-21, 11/3/09 (same document as Texas DADS SSLC Policy). o The Revised Texas Promoting Independence Plan o Promoting Independence Advisory Committee 2009 Stakeholder Report o Promoting Independence Advisory Committee Department Activity Reports, January 2010 o Referral Update for all facilities through 12/31/09 o Regional MRA and SMRF Quarterly Continuity of Services Meeting, 4/29/09 o SASSLC weekly enrollment report, from 12/31/09 o Description of CLOIP process (8 pages) o MRA Service Coordinator CLOIP worksheet (2 pages) o Admissions Placement Coordinator Manual: section II o List of four individuals currently referred for placement as of 1/15/10 o List of 10 individuals who have requested placement, but were not referred o List of five individuals placed since 7/1/09 o List of all alleged offenders committed to the facility o List of eight individuals admitted to the facility since 7/1/09 o Flyer advertisement for Provider Fair scheduled for 10/8/09, and information and tips for SASSLC staff who might be escorting an individual to the fair o List of SASSLC self-advocates (individuals) educational opportunities since 7/1/09 o PSPs for 13 individuals • Individual #268, Individual #225, Individual #141, Individual #25, Individual #69, Individual #253, Individual #224, Individual #77, Individual #335, Individual #113, Individual #205, Individual #140, Individual #153 o Job descriptions for two staff responsible for admissions, transitions, and discharges o Presentation information regarding microboards, conducted 8/17/09 o CLDP for the five individuals who moved since 7/1/09 • Individual #202, Individual #237, Individual #44, Individual #210, Individual #153 o CLDP (in development) for one individual who was in transition o Most recent completed post-move monitoring checklist for each of the five individuals who had moved since 7/1/09 • Individual #202, Individual #237, Individual #44, Individual #210, Individual #153 o CLOIP for six individuals

	• Individual #202, Individual #237, Individual #44, Individual #210, Individual #153, Individual #162 Interviews and Meetings Held: o Carol Young, Director of Admissions and Placement o Anna Cruz, Post-Move Monitor o Candace Jennings, Ombudsman o Carly Perez and Satira Hollis, Bexar MRA staff members o Interview and discussion with a group of about 20 individuals o Phone session with DADS and DOJ on 3/11/10 regarding the community system and referral processes, participants included Donnie Wilson, Continuity of Services Coordinator, DADS central office. Observations Conducted: o Attended one annual PSP meeting • Individual #132 o Attended one annual CLDP meeting • Individual #162 o Visited the home of one of the individuals who transitioned since 7/1/09 • Individual #153
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Overall, SASSLC had a number of staff who were dedicated to providing most integrated setting options to individuals. Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. SASSLC was at the early stages of implementing the new state policy on most integrated setting practices. As a result staff were engaged in a variety of activities and some new staff had been hired or assigned to this process. Each PSP reviewed contained a living options discussion and most included some discussion of the type of supports that would be needed if the individual were to move. Most of the discussions, however, appeared to be brief and done in a rote manner. The CLOIP was implemented for every individual reviewed. As indicated, below, it should not be considered to be an assessment for placement and further work will need to be done to create an assessment for each individual. SASSLC conducted a number of educational activities and participated in regular meetings with local MRAs. This was the first year for many of these activities and the group plans to develop more over the coming years.

	The facility transitioned five individuals to the community since 7/1/09. Attempts were made to ensure that the transitions were done thoroughly and followed policy and procedure. SASSLC was beginning the post-move monitoring process and expected to put it fully into place over the next few months.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018 and was dated 10/30/09. The purpose of the policy was stated in the first paragraph and noted that it was to encourage and assist individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the United States Supreme Court's decision in Olmstead v. L.C. The policy stated that it applied to all DADS SSLCs and numerous definitions were included. The policy also detailed procedures for assisting individuals with movement to the most integrated setting, identifying needed supports and services to ensure successful transition, procedures for identifying obstacles for movement, and post-move monitoring procedures. The policy also described procedures to meet other items in this provision of the Settlement Agreement. The policy called for encouraging individuals to move to the most integrated setting consistent with the determination of professionals on the individual's PST that community placement was appropriate; that the transfer was not opposed by the individual or the individual's LAR; and that the transfer was consistent with the individual's PSP. The policy provided detail on the types of meetings, documents, and processes that were to occur. The policy did not specifically note that placement must take into consideration the statutory authority of the state, the resources available to the state, and the needs of others with developmental disabilities. The policy did, however, note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations. SASSLC had adopted the state policy in full. It was printed and numbered as an SASSLC document with an SASSLC heading. The monitoring team looked to see if the policies and procedures were being implemented consistently. SASSLC staff were beginning to implement the policy and	

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		expected to eventually implement the policy in full. The Director of Admissions and Placement told me that they were midway through implementation and would continue to work towards full implementation. The Director of Admissions and Placement was familiar with the new policy and its components. Further, the post-move monitoring position had recently been filled and PSP documents and processes included many of the requirements of this new policy. Therefore, it is too early to comment on the implementation of the policies at SASSLC because implementation was so recently initiated and full implementation was not yet in place. Moreover, the state is expected to provide additional guidance to the facilities regarding a number of aspects of the policy and it is likely that some procedures and forms will be modified. During the on-site tour, the monitoring team heard about upcoming revisions to the policy on most integrated setting practices and looks forward to receiving the updated policy when it is completed. The January 2010 DADS Promoting Independence Advisory Committee report noted the number of Home and Community-Based Services (HCS) slots that were appropriated by the legislature. There were more than 5,000 slots appropriated and additional new slots were to be made available specifically for individuals living at SSLCs. As noted below, very few individuals were in the referral process at SASSLC. This did not, however, appear to be a function of whether or not a slot was available. No examples of funding as an obstacle were observed during this on-site tour or in any documentation reviewed. Nevertheless, two aspects of funding that the state should consider are (a) whether the funding determined by the individuals level of need at the facility will sufficiently fund the services needed in the community (e.g., a factor when community providers considered serving Individual #97), and (b) whether success in the community will result in lower funding for a provider that in turn may result in fewer services to an individual. The monitoring team will examine these questions further on subsequent visits to SASSLC.	
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	The state policy on most integrated setting practices included sections regarding the transition and discharge processes as required by this provision item. Possible revisions are noted in this report, and implementation, as noted above, was not yet fully in place. Numerous staff participated in the processes. Some of the staff and some of their roles and responsibilities are listed below.	

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	processes. Such policies, procedures, and practices shall require that:	• The Director of Admissions and Placement played the lead role in implementation of the policy on most integrated setting practices. This included keeping track of individuals referred for placement, community living discharge plans (CLDPs), post-move monitoring, and educational activities. • The newly hired post-move monitor had started to attend every PSP meeting and had started to conduct post-move monitoring visits. • QMRPs had responsibility for completing skills assessments of individuals, leading the PSP meeting and community living options discussion, and for developing a plan to overcome obstacles. • The local contracted Mental Retardation Authority (MRA) had staff assigned to complete the Community Living Options Information Process (CLOIP) and to attend every PSP meeting. MRA (either contracted or designated) staff were also involved in the transition process, including development of the CLDP, visiting the new site prior to the individual's move, and conducting post-move monitoring. These staff all had other responsibilities at SASSLC and senior management of the facility should ensure that they have the support and resources to meet the requirements of this provision item. Of most concern was the QMRP's role. The QMRP had many other tasks not related to this provision item and it appeared that more training, support, and guidance were needed if they were to remain in this important role regarding most integrated setting practices, especially regarding the leading of the living options discussion at the PSP meeting.	
	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	Thirteen PSPs were reviewed for the individuals listed in the Documents Reviewed list at the beginning of this section of the report. Twelve of these individuals resided at SASSLC. One individual had transitioned to a community residence in November 2009. The comments below refer to the 12 individuals who resided at SASSLC. The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at SASSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion Record section of the PSP. Typically, this section of the PSP was less than one page long and indicated to the monitoring team that there was little comprehensive discussion about most integrated setting options for individuals. Nine of the 12 living option discussions included some indication of what the individual would need if a community placement were to be sought. The lists, however, were very	

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	annually, and shall identify, and implement, strategies intended to overcome such obstacles.	similar, if not almost identical, across all of the reports. For example, for Individual #141, the list included having a primary care physician, a nurse, a health care plan to address a number of medical issues, a PNMP, OT and PT services, transportation, 24-hour staff, QMRP case management, and a psychologist to be involved in the PBSP. For some of the individuals, the list of needed supports appeared to be merely a listing of general SASSLC services. For example, for Individual #77, the PSP noted that he would need 24-hour staffing, medical services, specialist consultations, specialized equipment, and specialized transportation. The process indicated little individualization in the thinking and envisioning of possible future environments. One of the 12 individuals (Individual #140) expressed a desire to move, but the PST determined that any referral could not occur until the individual's behavior problems were controlled. No other discussion about components of a most integrated setting was evident. The record indicated, however, that the individual would be allowed to go on visits to community providers. In this case there was an involved family member, but no one appointed as LAR. Thus, SASSLC did not identify 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 as per this provision item. The living options discussion should include discussion about the ideal optimistic vision of the components of an environment that would best suit the needs and preferences of the individual, ensure safety, and provide adequate habilitation (including habilitative services, skill development and maintenance, and quality of life activities, such as leisure and recreation activities). This type of discussion can occur while still acknowledging the LAR's preference and role in determining whether or not a referral for placement should occur. State policy on most integrated setting practices was very clear that referral and placement could not occur without consent from the LAR and individual (paragraph III.B.5.). Moreover, the LARs for all 12 individuals indicated that they did not want to move ahead with any placement changes for the individual. Nevertheless, this type of discussion can occur even given LAR preference and the multiple and complicated medical and behavioral needs of many of the individuals at SASSLC. That is, it should not be assumed that by entering into this type of discussion, the PST members, including the LAR, have made, or are making, a referral. Successfully facilitating this type of discussion will require specialized training of the person responsible. SASSLC should consider whether this should continue to be the QMRP, or whether it should be assigned elsewhere. PSP meetings were attended by a number of staff, including the MRA staff who completed the CLOIP and the facility's post-move monitor. There may be resources and skills that the facility can develop and utilize	

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		among this group of professionals. For example, the post-move monitor attended every annual PSP meeting and used one or two checklists to monitor and record activities at the meeting that were reported to DADS central office. The tools included a Living Options Discussion Meeting Monitoring Checklist. Perhaps the post-move monitor can play a more participatory role during this part of the meeting. Moreover, the checklist had space for a notation for whether there was discussion of an optimistic vision, but no detail regarding what should be included or how to lead this type of discussion. None of the 12 PSPs indicated any discussion of obstacles to placement or any strategies to overcome any obstacles (although one referred to the need for behavior problems to be controlled). The Settlement Agreement and the state policy required that obstacles be identified and a plan be developed. A few points are worth noting regarding this activity. First, it was not yet occurring at SASSLC. This was acknowledged by facility management, and the monitoring team was told that there were plans to address this soon. Any plan to identify and overcome obstacles should include strategies that: • are measurable, • identify a person(s) responsible for their implementation, • identify expected time frames for completion, and • are reviewed regularly and modified as necessary. Second, as appropriate and as required, consideration was given to LAR preferences. In the opinion of the monitoring team, however, the reference to LAR opposition to placement as an obstacle that requires a strategy is likely to compete with the goal of having a collaborative team effort in envisioning and perhaps developing optimal most integrated setting alternatives. Third, LARs and PST members must be knowledgeable and be assured that the community has the resources to support individuals in these individualized ways. Safety, medical care, independence, and socialization are of the most importance to most family members and LARs. For example, the monitoring team attended the annual PSP meeting for Individual #132. His mother was his LAR and during the living options discussion of the meeting she gave an impassioned and detailed description of why she wanted her son to remain at SASSLC. She said she felt it was the safest place for him. She said that when he was in a group home, he was hurt many times. Once, she said, he was hit with belts and ended up in intensive care at the hospital. She found out that the accused staff were fired from the agency, but that she did not have any recourse. She felt that there were many staff always around at SASSLC and that made it a safer place and less likely that there would be a conspiracy to hide allegations of abuse. She described how she had looked at many	

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		other providers in the community and none were satisfactory. She would not consider a foster family option; she would take care of him if she could. Her point was, she said, that she had finally gotten him into a stable environment and that he liked the staff at SASSLC. When asked for her opinion regarding an optimal living situation, she said she would like it if her son could live with her and have another person who could live with him when she could no longer do so; someone who actually and really cared about him. Fourth, planning and discussing possible most integrated settings and addressing obstacles to placement may improve when other areas of service provision improve, including, as noted elsewhere in this report, thorough evaluations and assessments across all disciplines, integration of services, and thorough assessments of preferences.	
	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.	SASSLC was engaged in a number of activities to educate individuals and their families or guardians to make informed choices. The Director of Admissions and Placement participated in a quarterly meeting with representatives from the relevant MRAs called the Continuity of Services meeting. For SASSLC, this was primarily Bexar MRA and Camino Real County MRA. The group planned for the provider fair and discussed other trainings for interested individuals, families, and community members. The plan was for the provider fair to be an annual event. Planning included meeting, developing a one-page flyer advertising the event, and using available mailing lists to send out the information. For this first fair, SASSLC used the MRA's list of individuals who were on their list of people interested in community services. At SASSLC, the flyer was sent to all LARs and other interested family members or advocates. Also, SASSLC provided staff with a one-page guide of information and tips to help them support individuals to talk with community provider agencies, and also for the staff to learn more about the community providers. The guide provided eight questions to ask, or have the individual ask, the providers about what they do and how they do it; and also to help the individual talk to providers about himself or herself. The fair was held on 10/8/09 from 1:30 to 4:00 p.m. The Director of Admissions and Placement reported that many individuals and staff attended and walked around the different displays. Unfortunately, few family members or LARs attended, perhaps only two or three. Another activity was an arranged presentation regarding microboards. A microboard is one way of structuring community services for an individual. The presentation was held on 8/17/09 at SASSLC. It was unclear as to how many people attended and if there was any follow-up activity as a result of the presentation. Although not solely related to education about community placements and providers,	

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		SASSLC had an active self-advocacy group. A list of nine activities conducted since 7/1/09 was given to the monitoring team. It included SASSLC on-campus self-advocacy meetings, a Texas advocates conference, the provider fair, and two San Antonio self-advocacy group meetings. It was possible that community placement and providers were discussed at the meetings and conference. In addition, each individual was supposed to go on at least one outing to a community provider each year. This process had recently begun and a solid system for tracking and scheduling had not yet been implemented. There were 90 providers in the county of all sizes and with different areas of expertise. Finally, the Community Living Options Information Process (CLOIP) was implemented for every individual at SASSLC. The process was intended to provide information to individuals and LARs. The CLOIP was also considered to be an assessment and is discussed in more detail in the next section of this report. In summary, SASSLC was in the early stages of developing and implementing a plan to educate individuals and their families and guardians. Further work will be needed to meet its own policy on most integrated setting practices, section III, paragraphs 1-7.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	This provision item required the facility to assess individuals for placement. Thus, during the on-site tour, the monitoring team attempted to find out how SASSLC assessed an individual for placement. There did not seem to be a simple description of how SASSLC assessed an individual for placement. The Director of Admissions and Placement stated that the process was handled through the PSP process, and that placements and discharges were choice- and rights-driven and thereby not done through an assessment. The DADS Continuity of Services Coordinator told stated that the assessment was the living options discussion component of the PSP process and meeting. Further, the CLOIP was often referred to as an assessment (e.g., "the CLOIP assessment"). The facility and the state need to determine how individuals are to be assessed for placement. This will likely require the development of a tool for this purpose. The assessment would need to include the individual's needs, strengths, and preferences. It should include what is required to address the individual's needs, support his or her strengths, and meet his or her preferences. The context of the assessment should be the PST's vision of the components and characteristics of an ideal living setting for the individual. The assessment should draw on PST members and family members/LARs. As noted above, some aspects of this process exist at SASSLC, such as some of the components of the PSP process, the living options discussion, and parts of the CLDP.	

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		The CLOIP should not be considered an assessment for placement. Its primary purpose was to document that attempts were made to inform the individual and LAR about community placement options and to document the individual and LAR's preferences for placement. The CLOIP was in place for approximately three years and, as a result, documentation existed for all individuals reviewed for this report. MRA staff reported that there was not much change from year to year for most individuals. The MRA staff obtained information for the CLOIP from the QMRP and from direct care staff, however, direct care staff were usually quite busy and not able to meet regarding CLOIP information. The MRA staff also tried to gather information from the family/LAR. Over the past year, this was done by telephone for all but one individual. The monitoring team found that only four individuals were on the active referral list at the time of the on-site tour. Of those four, one was scheduled for placement within four weeks and one other was on hold due to changes in the family's ability to have him transition to the family's home (this referral was discontinued a few weeks after the on-site tour). Thus, there were only two active referrals in this facility of approximately 285 individuals. This appeared to be a very small number and indicated that SASSLC needed to evaluate its systems regarding most integrated setting practices. Possible explanations for such a small number might include one or more of the following: • PST members not having a good understanding of the referral process, • PST members' fear that once a referral was made it could not be not rescinded, even if an appropriate new setting could not be found or if the individual's needs changed, • a need for more effective education regarding community options, • limited service availability for specialized needs in the community, • provider capacity and competence in successfully supporting individuals with challenging needs, • a need for more comprehensive method for envisioning the type of setting that might be an appropriate most integrated setting for an individual, and • PST member satisfaction with services at SASSLC. SASSLC maintained a list of individuals who had expressed interest in moving to the community since 7/1/09. Ten individuals were on this list. The reason given for their not being referred for placement was LAR choice for four of the individuals and behavioral, psychiatric, or medical reasons for another four. Below are listed the individuals and the reason why each was not referred for placement. • Individual #304 LAR Choice • Individual #63 LAR Choice	

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		• Individual #194 LAR Choice • Individual #303 LAR Choice • Individual #274 Behavior/Psychiatric • Individual #319 Behavior/Psychiatric • Individual #276 Behavior/Psychiatric • Individual #22 Medical • Individual #4 Prefers Only Family/Family Not Available • Individual #160 Exploring Community Options As far as the monitoring team could determine, no special attention or actions were devoted to supporting these individuals or their LARs. During interviews with the MRA staff, eight other individuals were identified as having indicated a preference to move to the community or to explore community placement options. The differences between individuals on the SASSLC and MRA lists indicated inadequate communication between the facility's placement staff and the MRA staff. Further, it was unclear if an expressed preference by the individual for exploring placement falls under the state policy on most integrated setting practices section III paragraph 7. The facility and state should clarify the policy in regard to individual expression of preference or interest as it applies to individuals who do, and who do not, have an LAR appointed. The eight individuals are listed below. • Individual #41 • Individual #185 • Individual #150 • Individual #201 • Individual #97 • Individual #142 • Individual #140	
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	The new DADS policy on Most Integrated Setting Practices, dated 10-30-09, included a section regarding the CLDP and an attachment outlining the components of the CLDP. At the time of the on-site tour, five individuals had transitioned since 7/1/09. A CLDP existed for each of these. A sixth individual was in the transition process and his CLDP was in development.	

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	community living discharge plan in a timely manner. Such a plan shall:		
	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 policy on most integrated setting practices provided detail on the development of the CLDP. The policy directed the PST to work in coordination with the MRA to develop and implement the CDLP in a timely manner. It also directed that a representative of the individual's PST to submit a current assessment and/or discharge summary for inclusion in the CLDP. Each of the five CLDPs completed by SASSLC since 7/1/09 were reviewed. Each of the CLDPs followed the format required by the state. The five individuals ranged in age from 14 to 51 years old. Three of the five individuals transitioned to a community provider into a community group home. The other two individuals transitioned to live with family members. A key part of the state process was the identification of essential and non-essential supports. Essential supports were those program components that were required to be in place, that is, those that were essential to the success of the individual's transition. Non-essential supports were those that were very important, but would not serve to prevent a move from occurring. Even so, the expectation was that all non-essential supports needed to be in place and addressed. Non-essential did not mean not needed. Each of the five CLDPs had a single-page table that listed out essential and non-essential supports, the person responsible for making sure the support was in place, and the target date for putting these supports in place. The table listed 10 areas of supports (e.g., residential, vocational, safety). These support pages were similar in their brevity and lack of detail. There were approximately 10 essential supports listed for each individual and a number of these referred to basic logical or bureaucratic processes (e.g., submit a change of residence form, notify SSI, enroll in HCS, have 30-day supply of medication). Other supports were very vague and although important there was no definition of any detail regarding how one would assess the quality of the support put in place. For example, an essential support for each individual was "primary physician." Although one could determine whether a primary physician was or was not in place, the unique needs of many of these individuals required the physician be appropriate for the individual's needs. Similarly, some of the CLDPs merely said "Day program" or "Nursing." The CLDP process should be modified to: • define each of these essential and non-essential supports in more detail, • specify the support in a manner that can be measured or verified, and • ensure that all needs identified in the individual's current assessment are indicated as essential or non-essential supports.	

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		The above is not meant to indicate that SASSLC and the staff responsible for placement and transition were not engaged in thoughtful and meaningful work. Moreover, the records of the five individuals who moved since 7/1/09 indicated individualization in placements sought and developed. Below are some brief comments regarding each of the five individuals. - Individual #202: The PST worked to transition him back to live with his family. The family and the individual had requested reunification. - Individual #237: After many years of institutionalization, he moved to live with family members. - Individual #153: She moved to a community group home closer to her family in a residential neighborhood. - Individual #210: She was very involved in her transition. Her goals included pursuing additional education, such as at a local college. She visited four or five different providers and expressed her preference for supports and for one provider over another. - Individual #44: She presented a variety of challenging behavioral and medical issues. She also participated in choosing a provider. She visited three different providers (only three were considered capable of handling her behavioral and medical disorders). The documentation reviewed by the monitoring team indicated that there was a lot of planning and discussion between facility staff and provider staff. Assessments were updated and shared with the provider. One indication of the planning that went into this transition was a detailed behavior support plan that was in place for the new setting. The monitoring team also had the opportunity to observe a CLDP meeting. It was for Individual #162 and it was led by the Director of Admissions and Placement. Many people attended, including the new provider (an adult foster care provider), the supervising agency, the guardian/LAR, MRA staff, and about a dozen SASSLC staff. The meeting was upbeat, included the individual's participation throughout, and covered a lot of details, such as move dates and amount of monitoring to occur following the move. The individual was going to live in a foster family home with one other individual who received support services from DADS. Unfortunately, the individual had to give up his part time job in the community because the new residence was too far away from the current employer. There was discussion about a new agency working towards finding new employment. Discussion also focused on the day program, a new physician and psychiatrist, and the monitoring period. The last portion of the meeting involved the MRA leading a discussion about what he liked, his strengths, and what was important to him.	

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	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDP essential and non-essential supports page indicated the persons responsible and the timelines for completion. There was, however, no documentation as to whether these timelines were or were not met. Further, many of the actions were designated to be completed by community provider staff rather than facility staff. Although this may be appropriate and expedient, a facility staff must also be assigned to each action as required by this provision item.	
	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.	Signatures on each of the five CLDPs indicated that guardians or LARS were informed of the CLDP and participated in the process. Signatures of individuals were on each of the CLDPs, too.	
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.	As per the state policy, current comprehensive assessments were provided to the receiving agency or provider. The documents for one of the five individuals was reviewed in detail.	
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.	There did not appear to be a process for verifying that supports identified in the comprehensive assessments were included in the list of essential and non-essential supports. That is, it was unclear as to how it was determined that all relevant information from each assessment was included in this listing of supports. For example, it appeared that important information from Individual #153's PSP was not included in her CLDP. Her PSP indicated a history of flipping tables, a team desire to not have her go to bed so early in the evening, and her use of a voice output communication album and a communication dictionary. There were no references to these needs in the CLDP list of supports. Perhaps the essential supports "BSP Inservice" and "Residential Inservice" included information related to the behavioral issues, but the list of essential supports should have included specific communication supports, most likely in the essential supports category. There was, however, a process for the MRA to do a site visit prior to the move-in date to ensure those essential and non-essential supports listed in the CLDP were in place. At SASSLC, the Director of Admissions and Placement reported that she also makes sure that these are in place. It is recommended that there is documentation clearly indicating that all essential supports are in place on the move-in date. This can be done by the MRA	

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		or by the Director of Admissions and Placement. At least two individuals at SASSLC had returned to the facility after failed placement in the community (Individual #155, Individual #49). SASSLC should assess the reasons for these failed placements and determine if anything in the CLDP process might have played a role. Neither of these two individuals was on the current active referral list at the facility.	
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.	A quality assurance process was not in place at SASSLC to ensure that CLDPs were developed and implemented consistent with this Section T.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to 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	This information was not gathered and the processes to address the requirements of this provision item were not yet in place.	

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	be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The facility had a list of individuals who were referred for placement (four individuals) and a list of individuals who were placed in the community during the previous six months (five individuals). In addition, the facility kept a list of individuals who had expressed interest, but whose PSTs had not referred them for placement.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate**		

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	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.	As noted above, SASSLC had very recently hired the post-move monitor (she was only in her second month in the new position during the week of the on-site tour). Fortunately, the post-move monitor had experience with this population and had previously worked at a local MRA. Thus, she had experience with the placement process, CLOIP, and most integrated setting practices. Moreover, she already knew a number of the individuals living at the facility. Due to the recency of the hire, the post-move monitoring process had only recently been initiated at SASSLC. Therefore, as might be expected, all components were not in place, some of the processes were not being implemented thoroughly, and documentation was just beginning. Even so, SASSLC had done some post-move monitoring. All of it was done by the Director of Admissions and Placement, and all of it was done over the telephone. The required documentation was not created. This did not meet the requirements of this provision item, but indicated an attempt to initiate post-move monitoring prior to the hiring of the post-move monitor. Since late December, the post-move monitor completed one post-move monitoring checklist for each of the five individuals who had moved to the community since 7/1/09. One of these, however, was conducted over the telephone. These occurred the following number of days following the individual's move: • Individual #202 61 days • Individual #237 69 days (via telephone) • Individual #210 68 days • Individual #44 44 days • Individual #153 43 days These must be considered the first post-monitoring visits to have occurred and, therefore, did not meet the requirements of this provision item. The documentation of this post-move monitoring was done on the state's standard checklist form, including a listing of all essential and non-essential supports. The monitoring team's review of these completed post-move monitoring checklists, however, raised a number of concerns. First, for two of the five individuals, essential supports were found to not be in place (and as noted in below in section T2b some supports were not in place even though the checklist indicated they were in place). This was particularly concerning given that post-move monitoring had not occurred within the	

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		earlier timeframes. Second, the follow-up for some missing essential supports was vague (e.g., follow-up in one month) or merely indicated that the support was not in place. Thus, the facility did not appear to use its best efforts to ensure such support was implemented. Third, not all supports were correctly transferred from the CLDP to the post-move monitoring checklist. For example, obtaining a local psychologist was listed as an essential support for Individual #202, however, it was listed as a non-essential support on the post-move monitoring checklist (and, moreover, it was not in place 61 days after his move). In another example, two essential supports in the CLDP were entered into the post-move monitoring checklist as a single item. This was for Individual #210 and the checklist indicated it was in place, but it was not clear if this referred to one or both of the items (one was a 30-day supply of medication, the other was counseling therapy). Fourth, a number of non-essential supports were not in place either. Although non-essential supports were labeled as such in order to not delay the move, the supports were important to the likelihood of success in these new placements. Examples of non-essential supports that were not in place included a supported home living worker to assist the individual and family, transportation, and psychological services and a behavior support plan. These are the kinds of supports that, if absent, can lead to a failed community placement. Fifth, it was impossible to determine from the checklist documentation the manner in which the post-move monitor determined that a support was or was not in place. For example, the post-move monitor might have observed the support, observed documentation of the support, or received a verbal report from the provider that the support was in place. These are three very different levels of assessment (direct observation is the recommended procedure). The post-move monitoring process would benefit from a revision that required the post-move monitor to provide more detail regarding his or her assessment of the presence or absence of each support. Some specific comments are below: • Individual #202: Three essential supports were not in place: a SHL (supported home living) worker to work in the home, and a lack of transportation because his aunt moved away and she was going to do his transportation. The third essential support was improperly labeled as a non-essential support on the checklist and it also was not in place (psychologist). There were three other non-essential supports not in place, and a fourth was unlikely to be available (a day habilitation setting for school breaks). Also, his support plan was not updated, there was no documentation of staff training, and other appointments were not kept. Overall, there appeared to be many problems with this monitoring session. Unfortunately, the response only indicated that there would be follow-up in one month.	

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		• Individual #237: The post-move monitoring occurred over the telephone making all information suspect. An important essential support was not in place: a SHL provider. Two non-essential supports were not in place. These appeared to be important to the individual and to the likelihood of his success in this placement with his family: attending a variety of social events, and attending activities separate (away) from usual family members. Further, his sister (guardian) indicated that she was not happy with service provider agency. The note on the form indicated that follow-up would occur in four to six weeks (too long a period of time in the opinion of the monitoring team). • Individual #210: All of her essential supports were marked as having been in place. One non-essential was not in place. It was regarding guardianship, however, there was a reasonable explanation provided. The form also indicated that her psychologist was still developing a behavior plan. This was, however, more than two months after her move to the community. • Individual #44: All essential and non-essential supports were in place according to the checklist. There was no follow-up required. This looked like the best transition across all five of these individuals. • Individual #153: The checklist indicated that all essential and non-essential supports were in place. This was not in line with the findings during the in-home observations described below in T2b. Further, the item regarding staff having received training in the individual's medical needs was marked as N/A. This was a concern to the monitoring team, that is, that the process allowed for an individual to transition to a new provider without there being a requirement that the new provider document that staff were trained on the individual's medical needs.	
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 monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of one of the five individuals who had moved to the community within the previous 90 days, Individual #153. The monitoring team wishes to thank the post-move monitor and the community agency for making arrangements for this visit to occur. The actual post-move monitoring visit that was documented on the post-move monitoring checklist was conducted on 12/31/09. The purpose of the visit during the on-site tour was to see the home, meet the individual, learn about her transition and services, and see the status of some of the essential and non-essential supports. The individual had moved in on 11/19/09, about three months prior to this visit. The individual was the only person living in the home, but there were plans for two other individuals to move in at some point (neither were individuals from SASSLC or any other SSLC). The home was single-story and beautifully furnished. The individual had her own	

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	the 90th day following the move date.	bedroom and the home had an open floor plan. It was located in a nice residential neighborhood. One staff member was present. She reported that she was a regular staff member there and worked five evenings per week. Unfortunately, numerous components of the program did not appear to be in place as indicated by the following: • A Person Directed Plan or a PSP could not be found (although the PSP from SASSLC dated 9/09 was in the individual's active program book). • A PBSP could not be found. The staff member did not know anything about a PBSP or how to address behavior problems other than to direct her to another activity. This was especially concerning because the individual exhibited a behavior problem during the visit (she threw a basket of fruit) and she had some bruises on her arm, possibly from self-injury. Both of these behaviors were indicated in her SASSLC documentation. Further, training on a behavior plan was indicated as an essential support that was in place, but discussion with the staff and observation of the individual's behavior indicated that this likely did not occur, or was implemented ineffectively. • There was some documentation that a meeting with a psychologist was scheduled for later in the month, but this was months after she had moved. Moreover, the documentation indicated that the purpose of the visit to the psychologist was to complete a behavior support plan. It is also unlikely that a comprehensive behavior support plan can be created for an individual as complicated as this individual in a one-day appointment. • There was no collection of data occurring at the home regarding her challenging behaviors. • There were no skill acquisition plans and no skill acquisition training occurring. • The individual went to bed at 6:15 p.m. This was indicated as an issue at SASSLC, but there was no plan to address at this placement. Coincidentally, during this visit to the individual's home, two state DADS HCS Waiver Survey and Certification reviewers came to the home to do an assessment for certification. The process was called a comprehensive evaluation. The reviewers, however, were at the home for 20 minutes and quickly ran through a list of questions with the staff member. The reviewers reported that all items on their checklist were scored as present and correct and did not indicate any of the concerns listed above regarding lack of follow through on the individual's transition and programming. The monitoring team later learned that indeed the program had been cited for failure to implement the behavior support plan and to utilize adaptive equipment. It is unknown as to whether these citations and the above-listed concerns have been corrected.	

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		The monitoring team requested documentation of the MRA's monitoring of this placement. After more than 24 hours, the documents were received by the monitoring team. Only two monitoring activities were noted: a brief phone call on 1/27/10 and a face-to-face visit on 1/29/10. It noted that a behavior support plan was not yet developed for this setting. Thus, even with SASSLC monitoring, DADS monitoring, and MRA monitoring, not all of the important components of Individual #153's program were in place. This one case may or may not be representative of the transition and programming experience of the other individuals who moved from SASSLC. The monitoring team will look at the post-move monitoring process during subsequent on-site tours and will plan to do accompany the post-move monitor on a post-move monitoring visit on some of these future tours.	
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.	There were no individuals to whom this provision applied at the time of the on-site tour. There were, however, five individuals who were committed by the court under the Code of Criminal Procedure and/or Family Code. These court actions occurred between 2002 and 2008. All five individuals were fully committed and placed at SASSLC.	
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:	This provision did not apply to any individuals at SASSLC. The state policy on most integrated setting practices directed the facility to follow these content of this provision item.	

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	(a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

Recommendations:

1. Fully implement the new state policy.

2. Ensure that staff assigned to the many activities required by this provision have the necessary resources, time, and training to meet their responsibilities.

3. Review and modify how the living options discussion occurs at the PSP meeting so that it meets the requirements of provision item T1b1.

4. Include a discussion of obstacles and strategies to address obstacles in the living options discussion of the PSP meeting. Reconsider how to refer to LAR preferences so that the discussion of most integrated settings can be done in a collaborative manner.

5. Create an assessment for placement as required by the provision item.

6. Make sure the individuals who have expressed an interest in moving are tracked and supported, as appropriate for the individual. This may require review and modification of the policy on most integrated setting practices.

7. Ensure information from assessments is included in the lists of essential and non-essential supports in the CLDP.

8. Improve the way essential and non-essential supports are identified and described. These supports should be described in a manner that is specific, detailed, and measureable.

9. Assign facility staff to all actions in the CLDP essential and non-essential support list. Facility staff can be in addition to non-facility staff.

10. Ensure all essential supports in place on move-in day.

11. Develop a quality assurance process.

12. Complete the post-move monitoring processes as per state policy.

13. Revise the post-move monitoring checklist to include detail regarding (a) how the presence or absence of supports was assessed, and (b) follow-up activities for both essential and non-essential supports.

SECTION U: Consent	
	Steps Taken to Assess Compliance: Documents Reviewed: o List of individuals who have an appointed guardian o List of persons who did not have the functional capacity to render a decision and who also did not have an appointed guardian o A draft document titled, Consent Process, standard operating procedure #300-12 for this facility, dated 2005, revised 2009 o The facility's Rights Assessment form o A document titled: Competency Status Legal Status For CARE Forms o A document titled: Consumer Rights and Services Program Description o Position description for Ombudsman: Program Specialist II o List of activities to recruit volunteer advocates and guardians, dated 1/21/10 Interviews and Meetings Held: o Candace Jennings, Ombudsman o Interview and discussion with a group of about 20 individuals Observations Conducted: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The state had not yet issued a policy to address this provision. Nevertheless, SASSLC had taken some initial actions to list individuals' need for guardianship and to recruit guardians and advocates.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision	The state had not yet issued a policy regarding consent as it applied to this provision of the Settlement Agreement. SASSLC and its staff responsible for this provision were awaiting guidance and direction from the state. Nevertheless, SASSLC made some initial attempts to address this provision of the Settlement Agreement. Specifically, the facility created a list of individuals who had an appointed guardian (136), and a list of individuals who lacked both the functional	

#	Provision	Assessment of Status	Compliance
	regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	capacity to render a decision and an appointed guardian (143 individuals). These two lists accounted for all but a handful of the individuals at SASSLC. Further work will be needed to ensure the accuracy of the lists. For example, the PSPs of a number of individuals indicated that they had an LAR/advocate, but their names appeared on the list of individuals who needed an LAR or guardian. They were Individual #41, Individual #313, Individual #302, Individual #211 and Individual #145. It was possible that the PSP named an advocate who was not an LAR. Further, the PSP did not indicate any meaningful discussion regarding the individual's need for an LAR or guardian. Candace Jennings, Ombudsman, had responsibility for developing and maintaining these lists. She looked to the PST to determine the individual's need for guardianship. As indicated by the above lists, almost every individual at SASSLC either had a guardian, or was on the list in need of a guardian. It was somewhat unclear as to how an individual was assessed to determine if guardianship should be pursued. One piece was the Rights Assessment that was completed by the QMRP. It included questions regarding whether the individual advocated for himself or herself, and whether the individual could give or withdraw consent. Overall, however, rather than an assessment of rights, the tool was more of a listing of the types of possible restrictions an individual might have imposed in the course of his or her programming. The determination of competency and the appointment of a guardian are typically done through the legal system. SASSLC should develop a meaningful way to assess whether an individual lacks the capacity to render a decision regarding his or her own health or welfare. For many of the individuals, the outcome of this type of assessment will be clear and reliable; there will be little disagreement among team members. For others, it may be more difficult to assess and to reach PST agreement. Either way, it is not SASSLC's responsibility to determine competency, but to determine whether the individual lacks the capacity to make these types of decisions. It is likely that the state's new policy on consent will provide the facility with the procedures to make this determination. SASSLC might also improve its training of individuals to make these types of decisions. Problem-solving and decision-making training programs exist for individuals with disabilities and it is possible that many of the individuals at SASSLC could benefit from this type of training. The current self-advocacy activities at the facility may provide one opportunity to provide this type of training and experience to individuals. The ombudsman helped to coordinate the self-advocacy group and was in a good position to support these types of learning activities.	

#	Provision	Assessment of Status	Compliance
		The second part of this provision item directs the facility to prioritize the individuals identified based upon a number of criteria. This was not yet in place and, again, the state policy is likely to provide guidance to the facility in this matter.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	SASSLC is also likely to be guided by the forthcoming state policy on consent. The facility took the initiative and began engaging in a number of activities to recruit volunteer guardians and advocates. The ombudsman presented a list of 10 different activities that occurred over the six months preceding the on-site tour. These seemed to be activities designed to recruit volunteers for a variety of activities and needs at SASSLC of which positions as a guardian and/or an advocate were two. Two other activities not on the above list were a letter to a local charity group that already had experience providing guardians requesting assistance, and a training of SASSLC QMRPs on guardianship and how to talk with parents and family members about becoming a guardian for their family member.	

Recommendations:

1. Develop a policy and set of procedures to guide the facility in meeting this provision, including, but not limited to:
   - a process, including tools and criteria, to determine whether an individual needs a guardian,
   - a process to prioritize individuals in need of a guardian as per the provision item criteria, and
   - expected ways to seek out, and educate, people who might serve as guardians.

2. Consider ways of teaching individuals to problem-solve, make decisions, and advocate for themselves. Some of these skills might be addressed with a formal instructional teaching plan.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: Documents Reviewed: o Texas DADS SSLC Policy: Recordkeeping Practices, #020, dated 9/28/09 o Examples of three record binders that followed the draft table of contents; prepared by the Unified Records Manager Interviews and Meetings Held: o Janet Prince-Page, Records Manager o Naomi Cardenas, Unified Records Manager Observations Conducted: o Not applicable
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: SASSLC had made some initial steps to prepare for implementing the new state policy on record keeping practices. The facility was waiting for more guidance from DADS regarding implementation of a new record order, including a new table of contents and guidance on how to create the new records. The facility records managers appeared eager to begin this new project and had taken some initial steps to prepare, including working up some samples of what the new records would look like, and beginning to assemble documents for the master record.

#	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 monitoring team looked to see if SASSLC had established and maintained a unified record for each individual consistent with the guidelines in Appendix D of the Settlement Agreement. At the time of the on-site tour, SASSLC was in beginning to make plans to implement and address this provision. Thus, the current records did not meet all of the criteria listed in Appendix D. An extensive review of the records was not conducted during this on-site tour because the records were going to be revised and reorganized Moreover, the state had recently clarified some of the definitions of the components of	

#	Provision	Assessment of Status	Compliance
		the unified record. It was not clear if this would result in a revision and update to the state policy. The facility, as noted above, had taken some steps to prepare for meeting this provision. First, they recently hired a unified records manager who will have responsibility for overseeing the new systems, including conducting the review of records as required in section V.3. She worked under the quality enhancement department of the facility, but also very closely with the facility's records manager. The records manager had many years of experience at the facility and supervised the clerical staff who worked in each home. The clerical staff who worked in each home were responsible for maintaining the active records in the home, including the purging of documents as per the current purge and retention schedule (which is likely to be revised when the new procedures are put into place). Second, the unified records manager and the facility records manager created three binders with a table of contents, tabs, and sample documents that followed the new and proposed format. This was very helpful to them and to the monitoring team because it allowed for an examination of what the active record and individual notebook might look like. Third, the facility records manager had begun to prepare for creating the new master record. This record will contain important documents that need to be stored centrally and do not need to be in the active record, such as the birth certificate, commitment orders, guardianship papers, and other historical information. The facility records manager had developed a listing of documents for this master record, and although the specific items might change once the state finalizes the policy for content of this record, they were well on their way to creating an appropriate master record for each individual. Below are presented some considerations for the facility as it develops and updates its record keeping practices. The comments are based upon the monitoring team's review of the current records, a review of the sample binders, and discussion with the two records managers. • In the active record, the PBSP was in the psychology section and does not need to be duplicated in the section for Specific Program Objectives. • Within the Specific Program Objectives section, further subdivide the section into service objectives and training objectives. • Consider whether the entire PBSP needs to be in the individual notebook or whether only the essential components would be sufficient. This will require a discussion with the psychology department, residential management, and the	

#	Provision	Assessment of Status	Compliance
		training department. • It appeared that the individual notebook will contain some original documents (e.g., data sheets, daily observation notes from direct care staff) that will only be removed and filed at the end of each month. The facility needs to consider, and plan for, the possibility of loss of an individual notebook or the disappearance of data or observation notes. This might be especially problematic if important data or critical observation notes were to go missing, especially if, for example, an investigation of an allegation of abuse was being conducted.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Over the past few months, DADS wrote and distributed new policies to address many, but not yet all, of the provisions of Part II of the Settlement Agreement. More work will be needed to complete the additional policies, and to develop a regular process for the review, updating, and modification of each policy.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	A quality assurance procedure to ensure a unified record was not in place.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four	This provision item cannot be addressed until the records are organized under the new updated format and the new policy is fully implemented, including section IV of the policy.	

#	Provision	Assessment of Status	Compliance
	years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.		

Recommendations:

1. Implement the new policy, including, but not limited to:
   - modify records following new record guidelines order (table of contents)
   - develop and implement quality assurance process
   - ensure records are used in making care, medical treatment, and training decisions.

2. Review and consider the comments made above regarding aspects of the proposed new record keeping practices at SASSLC.

Health Care Guidelines

SECTION I: Documentation		
		Steps Taken to Assess Compliance:
		Facility Self-Assessment:
		Summary of Monitor's Assessment: Below additional comments are provided regarding documentation as it related to items in this health care guideline section.
#	Item Summary	Assessment
I1a	Documentation: active problem lists (4 items)	Nursing used NANDA diagnoses (active problem list) most consistently, but there were problems with consistency between active and chronic problems in medicine and the identification of nursing problems. Under-identification was an issue, particularly with oral hygiene, GERD, aspiration risk, and other problems, particularly where interdisciplinary collaboration was required.
I1b	Documentation: acute medical problems (7 items)	Acute health issues were not followed to resolution in nursing, particularly injuries.
I1c	Addressing chronic problems (3 items)	No additional comments are provided.
I1d	Documentation: integrated progress notes (7 items)	Documentation in nursing progress notes did not meet professional standards
I1e	PCP orders (4 items, including Appendix A)	No additional comments are provided.
I1f	Documentation: consultations (2 items)	There was reference to consultations in the annual and quarterly nursing assessments as a point of reference.
I1g	Hospitalizations, transfers, readmits (8 items)	Documentation was evident in annual and quarterly assessments, but often missing for transfers and readmits. There was a new hospital liaison who monitored and managed individuals who were in an acute care setting and that process had assisted in preventing the skin breakdown and nutritional issues often seen due to lack of adequate care in the hospital.
I1h	Annual plan of care (4 items)	Everyone had an annual plan of care, but quality was an issue for a number of individuals
I2a	Nursing documentation consistent with standards	Assessment, planning, and documentation did not meet generally accepted professional standards.
I2b	Nursing entries are legible etc.	Nursing entries were often difficult to read.
I2c	Nursing entries fully completed	Nursing assessment were often missing and incomplete.
I2d	Follow-up documentation from integrated prog. notes	Acute illness and injury frequently were not followed to resolution
I2e	Nursing documentation of IDT	There was some evidence of interdisciplinary collaboration, but it was seldom documented in the progress

	communication	notes.
I2f	Late entry notes only acceptable if labeled	This was occurring at SASSLC.
I2g	Integrated prog. Notes in SOAP or DAP format	This was occurring at SASSLC.
I2h	All nursing actions promptly documented	Nursing actions were often not documented at all.
I2i	Documentation of new treatments includes 4 items	Often not evident in the integrated progress notes.
I2j	Nursing documentation regarding new treatments	See above.
I2k	Nursing quarterly review contents	This was, for the most part, very good, with the exceptions discussed throughout in the above report, such as for GERD, respiratory needs, and positioning.
I2l	Documentation of completion of treatment	This was not occurring as noted above.
I2m	Nursing review quarterly and ann. contents (4 items)	This was occurring for the most part, but annual and quarterly assessments missed important health issues and did not lead to a complete set of nursing diagnoses.
I2n	Skin integrity assessments and responses	Skin integrity assessments and responses were done according to current professional standards

Recommendations:

1. Provide training to nurses in the area of physical and nutritional management. These were the missing components in most of the health care plans.
2. Provide clerical support to nursing to allow monitoring of MARs and documentation daily and free nursing for mealtime and dental hygiene monitoring.
3. Individuals with insidious weight loss were not being picked up if they were high or within their IBW. Weight trends over time should be monitored by nursing against a set of standards for nursing and for dietary. Unplanned weight loss in adults, even those who are within their IBW, may be a sign of a disease process, such as reflux esophagitis or cancer, until proven otherwise.

SECTION II: Seizure Management	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The management of seizures at the facility was generally managed with a high level of professionalism. Much of the system of care was consistent with generally accepted professional standards of care. Each record reviewed contained a detailed summary, within the annual medical summary, completed by the PCP, of a neurologic history, including a comprehensive review of prior treatment efforts and their outcomes.

		Seizure occurrences, presumably all of them, were documented as noted in II1a below, however, as noted in section M above, more work needed to be done to provide a description of each seizure that is much more detailed than the facility was documenting. The available information was summed up by month in the quarterly medication review. This document also carried forward gross totals of seizures by year, which was a good way for the physicians to remain aware of the course of the seizure disorder over time. It appeared that neurology consultation was a precious and spare resource, and that more cases were deserving of this consultation. Perhaps further reflective of a premium on the neurologist's time, the PCPs were writing the consult note and signing on his behalf. In one case reviewed, an administrative problem had compromised the quality of care and this was of serious concern. In Individual #36's record, the medical director note on 5/13/09 stated, "Neurology Clinic: VNS will not be implanted secondary to coverage issues." The monitoring team did not find evidence that there were any attempts made to overcome this obstacle. Below additional comments are provided regarding seizure management as it related to items in this health care guideline section.
#	Item Summary	Assessment
II1a	Documentation of seizure freq., dur., characteristics	The "seizure record" was in place and, with few exceptions, completely filled out, presumably for each episode of seizure. This record included a checklist of descriptors of behaviors noted during the seizures; there was also a space for a narrative description, which was usually filled out. There was also good compliance with the documentation of duration of seizures. Greater detail, however, would improve the depth of information given to the physician.
II1b	Evaluation of initial or change in seizure pattern	There was documentary evidence that the PCPs, in concert with the consulting neurologist, were thorough in the evaluation of seizures, both upon admission to the facility and upon change in the pattern of seizures. The PCPs wrote the note for neurologic consultation for the record, and then signed them, as for instance, "for John Doe, M.D." (on behalf of the neurologist.)
II1c	Neurologist is involved	See comment below.
II1d	See neurologist at least 1x year if poorly controlled	The records demonstrated that poorly controlled individuals were generally seen in neurology clinic more often than once a year.
II1e	See neurologist at 1x every 2 years if controlled	In the case of Individual #347, who had a seizure history but was both seizure-free and off anticonvulsants for years, the documentary evidence had records of neurologist visits less frequently than every two years.
II1f	PCP and pharmacist evaluate medical regimen	This was occurring at SASSLC.
II1g	Monotherapy is preferred mode of treatment	All three PCPs at interview expressed their interest in optimal treatment of seizures, which included the value of using monotherapy if it were demonstrated to effect optimal seizure control.
II1h	Rationale provided if more than 1 anticonvulsant used	This was occurring at SASSLC.

II1i	Consideration of other treatments if not controlled	There was documentary evidence that poor control of seizures was treated as an indication for neurology consultation, in order to consider alternative treatments.
II1j	Medication is consistent with type of seizure	The record demonstrated medication usage appropriate to the kind of seizure. In a subsequent site visit, the monitoring team will assess whether this is the case for those treated with one or two anticonvulsants.
II1k	Seizure classification follows Epilepsy Fdn.	This was occurring at SASSLC.
II1l	Blood levels at six months	This was occurring at SASSLC.
II1m	Blood tests for medication side effects at six months	This was occurring at SASSLC.
II1n	More frequent blood levels for new meds	This was occurring at SASSLC.
II1o	Diagnostic and treatment regimen in PSP	In the case of Individual #347, this goal was addressed in the nursing section of the Health Management Plan, but not in the PSP.
II1p	Cluster seizures identified and treated	This was occurring at SASSLC.
II1q	Status epilepticus defined	
II1r	Status epilepticus treated as emergency	There was documentary evidence of appropriate intervention (IM medication administration and emergency hospitalization) for one episode of status epilepticus.
II1s	Weaning of medications if 5 years seizure free	This was occurring at SASSLC.
II1t	Medication reductions done slowly and monitored	This was occurring at SASSLC.
II1u	If side effects impact life, PST will consider rationale	There was evidence on the quarterly medication review of consideration of such rationale.

Recommendations:

1. Policies should be in place to provide guidance to the facility regarding this healthcare guideline. Given the general high quality of approach to the treatment of seizures, the state may benefit from seeking input from the facility on standards of care.
2. The neurologist should be directly signing the note from his or her consultations. Without this, there is no way to confirm that the neurologist endorsed the note.
3. There should be an increase in neurologist consultation time.
4. If the PCPs addressed the administrative barrier to care, but did not document it, they should document outcome on such matters. If on the other hand it remained unaddressed, the PCPs should discuss with administration how to handle such circumstances so they do not compromise care.
5. All prescribing physicians should consult each other about any planned changes in the medication regimen of individuals, in advance of making any change.
6. Nurses and direct care staff need training to document seizures in a way that is more helpful to the managing physician.

SECTION III: Psychotropics/Positive Behavior Support		
		Steps Taken to Assess Compliance:
		Facility Self-Assessment:
		Summary of Monitor's Assessment: Below additional comments are provided regarding psychotropics and positive behavior support as they related to items in this health care guideline section.
#	Item Summary	Assessment
III1a	Initial psychiatric eval contents (7 items)	There was evidence of recent adoption of the use of an "admission comprehensive psychiatric summary." For example, such was present in the record of Individual #211. This note included history of present illness, target behaviors, current psychiatric medications, past psychiatric history, previous psychiatric medication trials, family medical and psychiatric history, substance use history, past medical history, allergies, developmental history, social history, pertinent physical exam findings, lab and medication monitoring, mental status exam, a five Axis multi-axial assessment, a diagnostic assessment, and recommendations. Prior to starting to use this format, the "annual psychiatric summary" was the closest approximation and included far less information, such as the first three diagnostic Axes, current medications, a cursory list of previous medication trials, an annual summary of course of treatment, and a brief medication discussion. This was not an adequate means of documenting the initial psychiatric evaluation.
III1b	General monitoring documentation (3 items)	Rationales for medication changes were briefly documented in the "psychiatric clinic progress note, comments/assessments/formulations" section. All individuals on psychotropic medications were seen monthly, and psychotropic medications were reviewed and updated at that time. The "comments" section of the quarterly medication reviews, present in all records, was sometimes, but not always, used to note medication effect and side effect. This was not an adequate means of documenting general monitoring.
III1c	Monitoring for anti-epileptics used for psych	This was occurring only some of the time at SASSLC. In the case of Individual #113, for example, there were records of an annual, not semi-annual CBC and metabolic screen.
III1d	Monitoring for lithium	Eight individuals were prescribed lithium. The monitoring team did not review their records in more detail during the next on-site tour.
III1e	Monitoring for tri-cyc anti-depressants and trazadone	There was documentary evidence of this occurring at SASSLC. In the case of Individual #166 who received trazodone, for example, there were annual CBCs and EKGs.
III1f	Monitoring for betablockers when used for psych	There was documentary evidence of this occurring at SASSLC. In the case of Individual #250 who received propanolol, for example, there were annual blood sugars (although the monitoring team could not establish that these were drawn while fasting) and EKGs.
III1g	Monitoring for antipsychotics (6 items)	This was occurring only some of the time at SASSLC. In the case of Individual #211, for example, who was taking Abilify and Haldol, the recommended admission labwork was collected, but none thereafter. There was no eye exam, MOSES, or DISCUS in the record.

Recommendations:
No additional recommendations are presented.

SECTION IV: Management of Acute Illness and Injury	
	Steps Taken to Assess Compliance: <u>Documents Reviewed:</u> o Hospitalization and emergency room data to determine the type and intensity of injuries and the types of admissions made to acute care o Injury rates for the 25 records reviewed and listed in section M above. o Acute health care plans for persons returning from ER or Hospitalization
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The acute care plans were quite good. They were no longer active once the reason for hospitalization was resolved. If the condition was ongoing, the facility converted to a Health Management Plan that was filed in the record on the living unit. There was a hospital liaison nurse who visited individuals in acute care and worked with the hospital staff to assure the person was receiving good service and that nutrition and repositioning to prevent skin breakdown were occurring. Individuals with disabilities often return from acute care with significant weight loss and skin integrity issues, so this was good to see. This was an important position and protected individuals from returning with the untoward consequences of lack of adequate care that often occurs in a tertiary care facility. The wound investigation process was very comprehensive and the skin breakdown rate was quite low, but still existed. The fact that more persons did not have active breakdown was a function of the competent care provided. Any person who required assistance to move was at high risk for breakdown, but the list of individuals at risk did not reflect this. Nursing needed training and practice writing health care plans that addressed physical and nutritional management issues that impacted the GI tract in particular. There was not enough interdisciplinary collaboration between nursing and the therapists where the following conditions were involved: GERD, aspiration, gastric emptying, and weight instability. Below additional comments are provided regarding management of acute illness and injury as it related to items in this health care guideline section.

#	Item Summary	Assessment
IV1a	PCP assess individual when acute health problem	
IV1b	PCP assess problem, diagnose, and plan of care	
IV1c	PCP inform nurse of plan, prognosis, and follow-up	
IV1d	PCP will follow-up on individual, evaluate, etc.	
IV2a	Nurse assess individual if acute illness	Nursing assessments were most often focused on presenting symptoms, rather than the generally accepted professional standard of care for head-to-toe assessment whenever symptoms were present. Vital signs were consistently documented in a timely manner.
IV2b	Nursing staff informs PCP in timely manner	In the sample reviewed, this was sometimes not well documented, although subsequent orders indicated that the physician was informed.
IV2c	Information to be communicated to PCP (6 items)	See above.
IV2d	Nursing staff closely monitor individual	There were many examples where tracking to resolution was not done.
IV2e	Nursing staff knowledgeable and comm. with PCP	The problems in the process for the identification of risk noted in this report may be indicative of communication issues between medicine, nursing, and other disciplines.
IV2e	Nursing staff inform other nursing and direct care staff	There were a number of meetings where conditions were communicated from shift to shift.
IV2f	Nurse monitoring of acute episode (3 items)	Documentation to resolution was often problematic.
IV3a	Head injuries	The head injury protocol was difficult to track in the record.
IV3b	Temperature elevations	These were tracked and documented well.
IV3c	Antibiotic therapy	Not consistently documented to resolution,
IV3d	Fracture and/or cast in place	
IV3e	Vomiting or diarrhea	
IV3f	Major choking episode	
IV3g	Suturing/stapling/ dermabond	
IV3h	Human bite	

IV3i	Insect/animal bite	
IV3j	Respiratory distress	There were many hospital admissions for respiratory distress. Overall, there was good information recorded in many instances on respiratory patterns, but it needed to include the locus (location) of respiratory effort.

Recommendations:

1. Injury rates, particularly falls, need to be evaluated relative to the use of psychoactive medications, and particularly, the relationship between the use of sedating medications with individuals who are also on other types of potentially sedating drugs. For example, many individuals were receiving benzodiazepines PRN for seizures, quarterly dental appointments, or for behavioral crises.
2. Every incident of illness or injury should include, in addition to vital signs, a head-to-toe assessment. For example, there were instances where constipation was an admitting diagnosis to the ER, but the discharge diagnosis was pneumonia.

SECTION V: Prevention		
		Steps Taken to Assess Compliance:
		Facility Self-Assessment:
		Summary of Monitor's Assessment: No additional comments are presented.
#	Item Summary	Assessment

Recommendations:

No additional recommendations are presented.

SECTION VI: Nutritional Management Planning	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The NMC met monthly to address nutritional and physical management concerns with well documented meetings, however, the breadth of review by this group was more limited than that identified in the Health Care Guidelines. Many of these elements would require participation by the MD to make appropriate review and recommendations. Below additional comments are provided regarding nutritional management planning as it related to items in this health care guideline section.

#	Item Summary	Assessment
VI1	Screen for nutritional risk, factors (5 items, a-e)	All individuals received a Nutritional Management Screening on an annual basis completed by the NMC in preparation for the PSP meeting the following month.
VI3	Diagnostic workup: diagnoses, tests, consults	The NMC met monthly and reviewed individuals with aspiration pneumonia, choking episodes (though none were reported during 2009), and significant weight loss (planned and unplanned). Others reviewed were based on scheduled reviews based on risk level or annual PSP meeting. There was no evidence of routine review of those referred for recurrent ear, nose and throat infections, GI bleeding, GERD, iron deficiency, wheezing in non-asthmatic, chest x-ray evidence of restrictive lung disease, recurrent dehydration, chronic underweight status, or recurrent emesis. For all that were reviewed for any reason, however, these concerns were generally reported as indicated. It appeared from the meeting minutes that only a portion of those with enteral nutrition were reviewed annually by the NMC (less than 50%).
VI3a	Possible treatments	Recommendations by the NMC for diagnostic testing was generally limited to modified barium swallow studies only. The lack of MD participation likely as issue with this.
VI3b	Supportive care, PNMP	A PNMP was provided to all individuals living at SASSLC which addressed the following, at a minimum: Diet texture/restriction, assistive mealtime equipment, physical alignment and positioning and mealtime guidelines as indicated. Special precautions, pace, and bolus size were not always specific in nature.
VI3c1	Treatment: dysphagia or aspiration / tubes	Position and alignment was addressed for all individuals with GERD precautions and enteral nutrition via the PNMP. Implementation of the PNMP in this regard was not adequate, however, for many as identified in Sections O and P above. There was insufficient evidence that the PSTs had reviewed the continued medical necessity of enteral tube use for those in the sample reviewed including: There was no objective data used comparatively to make this determination and was not documented in the PSP.
VI3c2	GERD	See above

Recommendations:

1. Consider MD participation in the NMC and ensure that these indicators of PNM risk guided routine review of those at highest risk through to resolution or stabilization of specific concerns based on stated objective measures or thresholds.

SECTION VII: Management of Chronic Conditions	
	Steps Taken to Assess Compliance:
	Facility Self-Assessment:
	Summary of Monitor's Assessment: Seizures, respiratory events, injuries, urinary tract infection, and constipation and bowel function accounted for the majority of admissions to the ER or hospital. There were 27 hospital or ER visits in October, 23 visits in November, and 25 visits in October. This was rich territory for preventative steps, but a more comprehensive and integrated interdisciplinary approach will be required if strategies are to be

		developed to improve management of these chronic conditions. The rate of UTIs was very high and the source of this problem, particularly in women, was usually poor technique in perineal care, particularly if the infection involved E. Coli, which was likely indicative of fecal contamination. Respiratory issues, particularly if they involved aspiration or reflux, could often be prevented or modified with meticulous positioning before, during, and after mealtimes, as well as with proper nighttime positioning for emptying. There was inadequate attention to these facts in the health management plans. Oral care was poor and it most likely contributed to the respiratory infection rate. The interdisciplinary problem solving process was unable to do a thorough examination of the root cause of some of these major health issues. Below additional comments are provided regarding management of chronic conditions as it related to items in this health care guideline section.
#	Item Summary	Assessment
VII1a	Diabetes management (3 items)	The care plans reflected management of high risk individuals when the individual was not stable. There was evidence that, for the most part, direct care staff was trained to alert nursing staff if signs and symptoms of secondary complications occurred.
VII2	Role of nurse in diabetes mgmt (5 items)	Screening for risk was not evident in the records. Monitoring of complications of diabetes was not as vigorous as it could have been.
VII1b	Aging (3 items)	This was addressed by the physician.
VII1c	GERD (5 items)	Positioning modifications were not understood and not implemented thoroughly. Behaviors associated with this condition, such as pica, hands in mouth, and agitation within 30 to 60 minutes of mealtime were often not considered in the assessment of GERD. The connection between GERD and aspiration was also not well understood.
VII1d	Hypertension (6 items)	Hypertension was fairly well managed.
VII1e	Incontinence (4 items)	This area was managed via the physician's orders and not through primary action of nurses.
VII1f	Urinary tract infections (4 items)	Same as above.
VII1g	Bowel management (11 items)	There was fairly comprehensive management of this condition.
VII1h	Chronic respiratory illness (4 items)	The care plans reflected a basic understanding and implementation of this condition, but did not reflect and the relationship between GERD and reactive airway disease, which may often be treated as asthma.
VII1i	Skin integrity (5 items)	This condition was well managed, although breakdowns from injuries were often not tracked to resolution.

Recommendations:

1. Prevention plans for respiratory and GI issues must be interdisciplinary and include plans for positioning the individual for intake and emptying. There must be recognition of the normal flow through the GI tract, and individuals on extended drip feedings should be moved

towards bolus feeds. The stomach is designed to operate through a complex mechanism of fill and empty. Nurses will need to do this by working jointly with therapists to find the most effective emptying position. 2. Health prevention and management plans must have measureable outcomes.

SECTION VIII: Physical Management		
		Steps Taken to Assess Compliance:
		Facility Self-Assessment:
		Summary of Monitor's Assessment: Below additional comments are provided regarding physical management as it related to items in this health care guideline section.
#	Item Summary	Assessment
VIII1	Screening for physical mgmt needs (7 items)	All individuals were provided a PNMP to address proper lifting and handling, use of assistive equipment, address joint contractures and muscle tone and to promote and/or maintain comfort and good health. While assistive equipment was generally included to optimize independence when appropriate, supports provided by the clinicians did not focus sufficiently on skill acquisition but rather more acute concerns. These plans were reviewed annually by the clinicians and the PST and changes were made to the plans as indicated throughout the year.
VIII2	Screening for nutritional mgmt needs (5 items)	The PNMP included diet texture and liquid consistency, position and alignment, adaptive mealtime equipment and assistance strategies including physical assistance and verbal cues and prompts.
VIII3	PNM techniques appropriate and all day	Plans were intended for use throughout the day, however, as noted in section O above, strategies and equipment for mealtimes was not used appropriately in the day program.
VIII4	PNM Plans easily understood, implemented	PNM plans were comprehensive and generally accessible. Staff were familiar with the format, however as described in Sections O, P and R above implementation of plans was inconsistent and in some cases, individuals were at risk of harm as a result.
VIII5	Ensure PNMPs accessible and include (7 items)	Dining plans were readily available in the dining rooms. The PNMPs were supposed to be maintained on the individual's wheelchair when appropriate. All plans had sections to address adaptive supports, behavioral concerns impacting on PNM, safety mealtime, communication, physical supports and diagnoses and health/medical concerns including: dysphagia, aspiration, nutritional health, circulation and history of fractures and skin breakdown.
VIII6	Data on PNM activities (5 items)	While not assessed in an interdisciplinary manner across all disciplines, OT, PT and SLP generally collaborated to assess and support issues related to aspiration, choking, pneumonia , need for specialized positioning, alteration of diet texture, problems and other related issues. The PNMP itself represented the collaboration with other team members based on their discipline-specific assessments conducted on an annual basis. The plans were reviewed to make modifications in supports based on changes in the individual's health status or on assessment of new strategies that provide more appropriate supports. PNM strategies to provide integrated supports for swallowing, bedtime, bathing and repositioning were

		included, however, as described above, implementation of these plans was not always appropriate and the system to monitor implementation was not effective in identifying and resolving this problem.
VIII7	Systems for reporting need for re-eval or plan changes	There was not a clear review of each individual's risk indicators and what specifically was provided to them via the PNMP in a well-organized manner. Most of these concerns were listed in the health status review as a part of the annual OT/PT update and in the annual NMC review. The selection of strategies was not, however, consistently linked back to a specific risk indicator as in an analysis of findings. While some were associated in the body of the report it was not easy for the clinician(s) to ensure that each concern was effectively addressed via interventions and supports outlined in the plan.
VIII8	Overall monitoring plan for PNM plans	See section P
VIII9	Regular meetings held of the PNMT	The NMC/PNMT met monthly during 2009

Recommendations:

No additional recommendations are presented.

SECTION IX: Pain Management		
		Steps Taken to Assess Compliance:
		Facility Self-Assessment:
		Summary of Monitor's Assessment: Pain was managed fairly well, primarily with NSAIDS. One possible area of exception was regarding those individuals who could be using SIB and other behaviors to indicate gut pain or other types of discomfort. Below additional comments are provided regarding pain management as it related to items in this health care guideline section.
#	Item Summary	Assessment
IX1a	Treatment plan for pain management	Pain as a chronic condition was seldom identified, and individuals exhibiting gut pain from reflux or chronic esophagitis might have been overlooked.
IX1b	Consider pharmacologic and non-pharm treatments	Repositioning should be an option for individuals with immobility.
IX1c	Non-pharm txs supplement not replace pharm	No additional comments are provided.
IX1d	Follow WHO three-step hierarchy for analgesics	No additional comments are provided.
IX1e	Around the clock pain management	No additional comments are provided.

IX1f	Oral and non-invasive routes of administration	No additional comments are provided.
IX1g	Opioid doses individualized	No additional comments are provided.
IX1h	Dosages adjusted over time	No additional comments are provided.
IX2a	Nurse ensures direct support staff are trained	No additional comments are provided.
IX2b	Signs and symptoms of pain promptly reported	This occurred when they were recognized.
IX2c	Promptly assess indiv, document via DAP or SOAP	This occurred when they were recognized.
IX2d	Nursing evaluation contents (7 items)	This was not occurring. Pain, when recognized and documented, often disappeared from the record without any indication of follow-up to resolution.

Recommendations:

1. Always consider the possibility that certain types of behavior, such as hands in mouth, SIB, or crying and agitation within an hour after a meal or during the night could be directly related to gastric discomfort.
2. Individuals with issues relative to immobility who are also aging are likely to be experiencing arthritis and its accompanying discomfort. This can often be relieved by repositioning or with the use of specific supplements to assist the joints.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABC	Antecedent-Behavior-Consequence
ABLLS-R	Assessment of Basic Language and Learning Skills-Revised
ADR	Adverse Drug Reaction
AED	Anti-Epileptic Drug
AIMS	Abnormal Involuntary Movement Scale
ANE	Abuse, Neglect, Exploitation
AOD	Administrator on Duty
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BS	Bachelor of Science
CBC	Complete Blood Count
CCC	Clinical Certificate of Competency
CIT	Comprehensive Investigator Training
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapy Assistant
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curriculum Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Data, Analysis, Plan
DARS	Texas Department of Assistive and Rehabilitative Services
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	U.S. Department of Justice
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association
EEG	Electroencephalography
EKG	Electrocardiogram
ER	Emergency Room
ESC	Education Service Center
FAOTA	Fellow, American Occupational Therapy Association
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
H&H	Hemoglobin and Hematocrit

HCG	Health Care Guidelines
HCS	Home and Community-based Services
HIP	Head Injury Protocol
HRC	Human rights committee
HST	Health Status Team
IBW	Ideal Body Weight
IBWR	Ideal Body Weight Range
ICAP	Inventory for Client and Agency Planning
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
LAR	Legally Authorized Representative
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBS	Modified Barium Swallow
MD	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MOT	Master's, Occupational Therapy
MRA	Mental Retardation Authority
NANDA	North American Nursing Diagnosis Association
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NPO	Nil Per Os (nothing by mouth)
NSAID	Non-Steroidal Anti-Inflammatory Drug
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PA	Physician Assistant
PALS	Positive Adaptive Living Survey
PAP	Papanicola Test
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PEG	Percutaneous Endoscopic Gastrostomy
PMAB	Physical Management of Aggressive Behavior
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	Per Os (by mouth)
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PST	Personal Support Team

PT	Physical Therapy
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
QSO	Quality System Oversight
RD	Registered Dietician
RN	Registered Nurse
RNP	Registered Nurse Practitioner
SA	Settlement Agreement
SASSLC	San Antonio State Supported Living Center
SHL	Supported Home Living
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SMRF	State Mental Retardation Facility
SSLC	State Supported Living Center
SPO	Specific Program Objective
SSI	Supplemental Security Income
ST	Speech Therapy
TD	Tardive Dyskinesia
TSHA	Texas Speech Language Hearing Association
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulation
VOCA	Voice Output Communication Aid