United States v. State of Texas

Monitoring Team Report

San Angelo State Supported Living Center

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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 (SA) 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 Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center. In addition to the Settlement Agreement, 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 Angelo State Supported Living Center (SGSSLC).

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 Angelo 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, integrated protections, services, treatments and supports, and consent;

Dwan Allen reviewed nursing care and dental services; Russell Livingston reviewed psychiatry services, medical care, and pharmacy and safe medication practices; Gary Pace reviewed psychological care and services, and habilitation, training, education, and skill acquisition programming; 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, record keeping, and quality assurance. 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) **On-site review –** During the week of May 10 through May 14, 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 on-site 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 on-site 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 on-site 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 according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on). The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. 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 and thank the individuals, staff, clinicians, managers, and administrators at SGSSLC for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the on-site monitoring tour. It was evident that the facility took the visit from the monitoring team seriously. Facility staff made themselves available for interviews and for observations. Throughout the week of the on-site tour, SGSSLC staff assisted monitoring team members with scheduling meetings, interviews, and observations; obtaining documents and reports; getting around campus; and answering a myriad of questions. The monitoring team also acknowledges the willingness of many individuals to talk about their lives at SGSSLC and to be observed in their daily day, work, and home activities. The monitoring team also appreciated the efforts of Penny Bivens, Settlement Agreement Coordinator, and Marsha Jones, Unified Records Coordinator for their availability and assistance throughout the entire week of the on-site tour.

The facility director, Philip Baugh, set the tone for the on-site tour during the opening meeting on the first day of the tour. He gave a brief history of the facility and invited the monitoring team to learn everything possible about SGSSLC. He made himself available for questions and assistance if needed throughout the week. 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 professionals eager to learn and to improve upon what they do each day to support the individuals at SGSSLC. 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, below, some general themes found by the monitoring team are discussed.

Settlement Agreement

- The facility and its administrative staff were responsive to questions and to suggestions throughout the week of the on-site tour. They were eager to receive comments from the monitoring team. Most, if not all, staff were aware of the Settlement Agreement. On the other hand, many staff, at all levels, were not very familiar or knowledgeable about the details of the provisions of the Settlement Agreement. Many managers told the monitoring team that they had been waiting for the on-site baseline tour to receive feedback and then to get started working on meeting the many requirements in the agreement. Although the monitoring team was surprised that many possible actions had been delayed until this visit, team members were encouraged by the positive statements heard throughout the week.

Special Population

- Individuals with a wide variety of needs lived at SGSSLC. A majority of the individuals had mild to moderate developmental and cognitive disabilities. Many of these individuals also had histories of exhibiting serious challenging behaviors, such as violent outbursts or sexual offending behaviors. Some had come into contact with law enforcement and had criminal charges pending. Many individuals at SGSSLC also had co-occurring diagnoses of mental illness, such as depression or schizophrenia. In addition, the facility supported individuals with developmental disabilities who did not exhibit challenging behaviors, as well as individuals with more profound multiple disabilities who were medically fragile. As the facility moves forward to meet the requirements of the Settlement Agreement and improve upon its services, it will need to keep in mind the variety of populations of individuals served and supported. That is, the design of treatments, interventions, activities, and systems will need to take into account the special needs of each of these broad groups of individuals.

Restraints

- Restraint procedures were implemented at SGSSLC to intervene during emergencies, and/or as a part of a planned approach in an individualized safety plan. A priority area for SGSSLC is to address the usage of restraints at the facility. The monitoring team found that some restraints were being used that were not in line with state policy. Moreover, the activities of a restraint reduction committee had somewhat languished over the past year and had only recently been re-started. The monitoring team expects that the facility will move forward in addressing this issue in a thoughtful manner that reduces the likelihood of injury to individuals and staff while following state policy. More detail is presented throughout this following report.

Programming

- SGSSLC implemented a variety of treatment, instructional, and intervention programs and procedures. Most of these processes required an improvement in the designation of objectives and outcomes that were measureable.

This was particularly true in the programs that the facility referred to as Dual Diagnosis Programs. These were instructional groups, and individual and group therapies.

- The facility should consider exploring the incorporation of Dialectical Behavior Therapy into its program. Adapted DBT procedures may be appropriate and useful for many of the individuals at SGSSLC. Further, many of the clinicians at the facility spoke about DBT and appeared to be interested in learning more about it. If SGSSLC moves forward in exploring DBT, it should be prepared to do so in a thorough and comprehensive manner. That is, it will require a great deal of staff and clinician training, much more than can be accomplished by attending a single workshop. Nevertheless, it may prove to be a functional program for many of the individuals.

Staffing

- A theme heard throughout the week of the on-site tour was the need for more direct support professional staff to be available to work in the homes and day programs. This need was due, primarily, to the need to fill positions that were funded, but remained vacant. Facility administration was aware of this need and had been struggling with ways of effectively recruiting and retaining competent staff. Most of the direct care professionals observed by the monitoring team appeared to care about the work they were doing and about the individuals with whom they worked. The lack of sufficient numbers of staff, however, led to (a) experienced staff being pulled from their regular assignment to work in another home or day program with individuals and programs with whom they were not familiar, and (b) staff being required to stay over an additional four hours if sufficient staff could not found. In addition, the rotating schedule of weekends off had been changed within the previous few months to a system that was cumbersome, inconsistent, and with fewer weekend days off than a previous rotation had been. These factors, especially the four hour holdover requirement, led many staff to seek employment elsewhere. For example, one of the direct care professionals at the community home visited by the monitoring team had worked at SGSSLC for many years, but resigned from her job due to this holdover requirement, even though the new job paid a lower hourly rate. SGSSLC management should explore this further and perhaps create a performance improvement team that includes direct care professionals and middle managers to try to address and improve this problem.

Collaboration

- SGSSLC demonstrated many practices that other facilities might find useful. Similarly, other facilities face many of the same challenges as does SGSSLC. Therefore, it was surprising to find that SGSSLC had little interaction and engaged in little collaboration with other facilities in the state and around the country. This type of activity might be especially useful for SGSSLC administration and management given the unique characteristics of the population served at the facility.

Integration of Services

- Throughout this report, there are comments regarding a need to improve the integration of services. That is, that teams need to ensure that information from various sources, including, but not limited to, assessments and evaluations, data from previous goals and objectives, the preferences and strengths of the individual, knowledge of staff and family members about the individual, and so forth is synthesized into a plan that comprehensively addresses the individual's preferences, personal goals, and needs. Further, integration of services also requires that the many disciplines of services at SGSSLC have effective systems for communication and collaboration with each other.

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:
  - usage of restraints,
  - proper positioning during meal times,
  - presentation of proper food textures, size, and pacing,
  - medication administration,
  - communication programming,
  - ensuring that all required supports are in place prior to transition to the community and that all post-move monitoring visits include a visit to the individual's residence, and
  - improving the numbers of direct care professional staff in order to reduce the need to pull staff from one home or program to another.

Fourth, a summary regarding each of the Settlement Agreement provisions is provided below. Details, examples, and an understanding of the context of the monitoring of each of these provisions can only be more fully understood with a reading of the corresponding report section in its entirety.

Restraints

- Of particular concern to the monitoring team was the frequency of restraint use at SGSSLC as well as the use of mechanical and supine restraints. The monitoring team was able to observe a demonstration of the use of mechanical restraints by training instructors during the monitoring visit. The facility had a Crisis Intervention Team (CIT) in place. This team was specifically trained in behavioral crisis intervention and restraint applications. DADS policy regarding restraints prohibited the use of both prone and supine restraints. SGSSLC,

however, utilized a 6-point Posey net that placed the individual in a supine position. There had been 10 incidents in the past quarter where staff had restrained an individual using this method. The facility had a Restraint Reduction Committee that met monthly. A review of committee meeting minutes for the past year indicated that the committee did not have a plan in place to focus on aggressively reducing the number of restraint incidents at the facility. Reduction efforts need to focus on any obvious trends and also upon strategies that may prevent behavioral situations from escalating in specific situations. The current facility policies were fragmented in terms of addressing restraint use at the facility. SGSSLC needs to develop one comprehensive policy that governs the use of restraints at the facility.

Abuse, Neglect, and Incident Management

- All staff interviewed were familiar with reporting procedures and had received training consistent with state policies, though employee refresher training was not always provided annually as required. 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, local law enforcement, OIG, and DADS Regulatory. The facility investigators reported having a good relationship with DFPS, local law enforcement, and OIG. There was not a quality assurance system in place to address facility trends in regards to incidents and injuries. A log of investigations listed 491 investigations at the facility between 7/1/09 and 3/30/10. Many of those investigations involved multiple allegations. Fifteen investigations (3%) resulted in confirmed allegations of abuse and neglect. Due, in part to the characteristics of the forensic population at the facility, there were numerous spurious allegations. Some individuals at the facility were on a DFPS Frequent Caller List due to the number of false allegations they reported. The facility had a policy in place regarding spurious allegations.

Quality Assurance

- SGSSLC had two experienced and dedicated professionals managing the facility's quality enhancement activities: the Director of Quality Enhancement, and the Settlement Agreement Coordinator. Unfortunately, their work was not coordinated or integrated. Both offices collected data, but it was not summarized, analyzed, or reported in any comprehensive or organized manner. The facility was operating without a quality enhancement plan. Even so, a number of QE-related activities were occurring at SGSSLC, including the observation and monitoring of various areas by program auditors. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the department's data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report.

Integrated Protections, Services, Treatment, and Support

- The facility was only in the beginning stages of addressing this provision; the state policy was still in draft format. A majority of the PSPs reviewed did not include a summary of services and supports that the individual received. PSPs should clearly address all of the supports that an individual will receive, including a description of the residential, day, medical, and 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. More recent PSPs developed at the facility, however, contained objectives that were individualized based on the individual's interests. Though it was not evident that needed supports identified in assessments were incorporated into objectives. There was not a focus on providing supports in the most integrated setting in the PSPs reviewed. Community placement was considered at each PSP meeting, but plans to achieve community integration were not developed with a focus on actual achievement. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct care professionals responsible for implementing the plan.

Integrated Clinical Services and Minimum Common Elements of Clinical Care

- State policy was not developed or implemented at the time of the on-site tour for either of these provisions. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have 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. Discussions with senior clinicians indicated a good working relationship between the medical, psychiatric, and rehabilitation departments. Discussion also indicated good working relationships within the psychology department. There was a desire for the psychology department to be more integrated and communicative with the medical and psychiatric departments. The facility, however, lacked direction in how to obtain these outcomes. This was due in part to the recency of attention to this provision, great confusion as to who was responsible for each component and the monitoring of each component of this provision, and a plan of improvement that did not provide guidance or direction regarding specific actions to be taken. Clinicians across the facility were not familiar with these provisions.

At-Risk Individuals

- State policy had been developed to address assessing risks for individuals and included standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. SGSSLC had developed additional guidelines in a policy titled Health Status Team Rating Guidelines. Risk statements in PSPs, however, were general and often conflicted with information included in the PSP by specific disciplines. There was consensus

among staff at the facility that contributing factors to challenging behaviors at the facility were low staffing ratios and grouping of individuals with challenging behaviors. The facility did not have a plan in place to address any of these factors. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction. Further, the system of the assignment of risk levels required modification and improvement.

<u>Psychiatric Care and Services</u>

- The staffing of the psychiatric service department was recently improved and resulted in psychiatry staff having adequate time to engage in multiple quality improvement initiatives. The psychiatry staff had training and experience commensurate with capably performing their duties. It was evident that the psychiatrists were focused on the goal of using psychotropics only when the evidence base supported it, and only at the lowest doses needed to attain optimal therapeutic effect. Even so, there were multiple compromises in professional standards of care. For example, in psychiatric clinics, target behaviors were generally presented as an aggregate for the month, and were not presented in suitable graphic form. SGSSLC had been underutilizing medical and psychiatric expertise resulting in many instances of missed opportunity and bad outcome. Psychiatry had little contact with the STACS program. This was true in both the conceiving of the service and in dialoging about the service provision for individuals with dual diagnoses. The absence of DBT as a therapeutic modality for the dually diagnosed was a glaring omission. Further, there did not appear to a mechanism (e.g., regularly scheduled meeting) for psychiatry to provide input to administration.

<u>Psychological Care and Services</u>

- Seven psychologists were enrolled in course work to become certified behavior analysts. Nevertheless, several areas of service required improvement, including data collection and presentation, and the overall quality and comprehensiveness of the functional assessments and Positive Behavior Support Plans (PBSPs). Additionally, the facility lacked the use of several critical behavioral systems, such as inter-observer agreement of target and replacement behaviors, peer review, and a system to ensure that all staff had been trained in the implementation of each individual's PBSP. Psychological assessments that contained all of the required components were not implemented for any individuals, however, some of these components were found for many individuals. More work needed to be done to integrate the program for individuals with dual diagnoses with other treatment disciplines, such as medical and psychiatric services.

<u>Medical Care</u>

- The physicians were competent and committed, and struck a warm, collegial tone among themselves and with their psychiatric colleagues. Dr. McKown, the medical director, lived on campus during the week, and took call at all times when on campus. At the current staffing level, however, the PCPs were not able to conduct all of

their clinical and administrative duties and they were not able to participate in the annual PSP meetings. There was no facility-wide medical review system, nor a medical quality improvement program. While, as noted below, the facility had not established policies and procedures pertaining to quality assurance or medical quality of care consistent with the Settlement Agreement (including the Health Care Guidelines), medical services appeared to be meeting, in general, the needs of the individuals.

Nursing Care

- The Nurse Managers demonstrated a team spirit and willingness to augment the nursing shortages. Quality Enhancement monitoring tools were in the process of being developed and refined to meet required compliance with the Settlement Agreement and Health Care Guidelines. The Nursing Department did not have formalized nursing policies and procedures for monitoring nursing practices. Most Annual and Quarterly Nursing Assessments were completed as scheduled according to the PSP calendar. The Annual and Quarterly Nursing Assessments and Nursing Summaries failed to consistently contain substantive information documented in their respective comment sections for items checked in boxes. Information documented in the comment sections usually related to diagnoses and treatments failed to consistently summarize health status outcomes. Chronic health conditions contained on the Medical Active Problem List did not consistently have Health Management Plans, even if those conditions were stable, to ensure they remained stable or to prevent exacerbation of the conditions. There were many problems observed during medication administration pass times.

Pharmacy Services and Safe Medication Practices

- The facility had two FTEs of pharmacists, and three FTEs of pharmacy technicians. A doctoral level pharmacist was due to start full time employment in June 2010. This will likely help the facility attend to some areas where the pharmacy was lacking. Specifically, there was neither policy in place nor organized practice regarding the identification, reporting, and follow up remedial action for adverse drug reactions. The pharmacy controls report was only one minor element shy of a 100% score. The facility's Nurse Case Managers routinely participated in the Psychiatrist 90 Day Combined Reviews. They prepared and presented relevant information related to individuals' response to psychoactive medication. Annual and Quarterly Nursing Assessment and Nursing Summaries did not consistently summarize individuals' therapeutic response as described in the HCG.

Physical and Nutritional Management

- Recently, PNMP coordinators had been hired/assigned to conduct PNMP monitoring and will require extensive training, supervision and re-validation of competency to monitor and train others to be successful. The existing monitoring and training was inadequate as the monitoring team noted numerous examples of noncompliance with the PNMPs and Dining Plans with regard to position, alignment, and support, as well as food texture, liquids consistency, adaptive equipment, and assistance strategies across a number of homes. As a result SGSSLC failed

to ensure the safety of many who had been identified at greatest risk, particularly for choking and aspiration. It was of concern that these issues had not been identified and addressed appropriately via the extensive assessment and review process in place. The PNM Clinics appeared to be well organized, but were not run as an interdisciplinary process. There did not appear to be a plan for training all NMC members and/or PNM clinic team members beyond the DADS sponsored instruction. The NMC met weekly which enabled them to see a significant number of individuals and spend greater time reviewing the status of each case and developing a plan for PNM supports. The meeting minutes were brief, but each individual reviewed received a review note that was more detailed and person-specific. There was some inconsistency of follow up review by the NMC as well as follow up related to issues identified via the PNMP monitoring system.

Physical and Occupational Therapy

- The Director of Rehabilitation Therapies was a strong leader and was very knowledgeable. The therapists did an excellent job of linking risks to interventions, though the process of justification was somewhat rote rather than a true clinical analysis for selecting one intervention over another. It will be important to ensure that they examine the interrelatedness of the assessment findings and have considered all the viable options to address each individual uniquely based on his or her specific needs. The PNMP Clinic appeared to work well though interventions were largely foundational in nature rather than with a focus on skill acquisition. Implementation was very weak, however, as evidenced by the numerous errors cited throughout this section as well as in section O. This reflected poorly on the staff training and monitoring aspects of their system. The department seemed to focus more on assessment and less in these important areas and, as a result, placed individuals at risk of harm.

Dental Services

- The dental department's staff were comprised of a dentist, dental hygienist, dental assistant, and a contract dentist/anesthesiologist. The dental department planned to add another dental hygienist. The dental clinic was well equipped, organized, and clean. It projected a user-friendly atmosphere. The dental department staff stated they would begin using suction toothbrushes as soon as the nursing staff were trained. Individuals most at risk for aspiration had been identified. Annual dental examinations were completed on 19 of the 21 individuals reviewed within their anniversary month of admission and/or the last dental examination. New admissions received their initial dental assessments within 30 days of admission. Although numerous refusals and/or cancellations for annual and routine dental services were noted in the individuals' records, there was evidence that appointments were tracked, rescheduled, and kept. The dental department maintained a comprehensive computerized database tracking appointments, pre-treatment sedation and/or restraint use, and desensitization programs. There was no trend analysis completed for dental services that tracked, trended, and analyzed the use of sedation/restraints and desensitization plans. The dental department was working

collaboratively with the PSTs and the psychology department to develop and implement desensitization plans for individuals who were resistive to receiving dental care.

Communication

- SGSSLC was soon to have only one part time speech clinician attempting to meet the many communication needs of the individuals living there. Adequate and appropriate supports and services will then not be possible. There was inconsistency in the number of completed screenings and/or assessments reported by the clinicians as well in two of their databases with regard to assessment tracking. The current evaluations were weak in format and substance and will need to be redone. This will be a monumental task and serious thought must be given to the logistics of this to ensure that the re-evaluations are thorough and accurate, and that appropriate recommendations are brought forward with timely implementation. This must be considered to be of the highest priority. Of the 69 individuals listed with a communication evaluation or screening, only 12 were listed with devices, another nine individual's devices had been discontinued, and one individual's was pending. Four were listed with devices being investigated for use. There was a serious deficiency in the provision of communication supports at SGSSLC. Many individuals had communication dictionaries serving as one important aspect of support, but, for most, the clinicians had not moved beyond this to ensure that individuals who required them had systems that were functional and meaningful. A few great systems were in place, but the individuals only had access to them during therapy sessions rather than throughout their day.

Habilitation, Training, Education, and Skill Acquisition Programs

- The skill acquisition programs at SGSSLC contained some of the components necessary for learning and skill development. They did not, however, contain all of these components and the training methodology was limited to training one step at a time, and using only least-to-most prompting. The skill acquisition programs at SGSSLC would benefit from expanding the training methodology, including graphing of acquisition data, and adding assessments of treatment integrity. Additionally, the selection of specific training objectives should be based on each individual's needs identified in the functional assessment or PBSP, psychiatric assessment, language and communication assessment, Personal Support Plan (PSP), or other habilitative assessments. Replacement behaviors were included in PBSPs, however, no training instructions for replacement behaviors were presented. Programs specifying the acquisition of replacement behaviors need to contain all of the components necessary for learning and skill development. The facility was involved in establishing active treatment. The actual measures of individual engagement collected by the monitoring team, however, indicated that improvement in individual engagement was needed in many settings. Although there was evidence of many community activities, no individuals were employed in the community at the time of the on-site tour. Additionally, there was no evidence that training in the community was developed to address individuals' needs for service or their preferences.

Most Integrated Setting Practices

- SGSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. Overall, very few individuals were in the referral process, however, that number appeared to be increasing over the past few months. An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. 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. Some of the discussions appeared to be brief and/or done in a rote manner, however, others appeared to be individualized and to begin to refer to optimistic visions for the individual. The CLOIP was implemented for every individual reviewed. SGSSLC conducted a number of educational activities and participated in regular meetings with local MRAs. The facility also had the opportunity to add to the content of the self-advocacy groups and home meetings to include community placement, decision-making, and problem-solving as regular topics for discussion. Modifications were recommended for improvements to the post-move monitoring process, including ensuring that an on-site face-to-face visit occurs at the residence for all three of the post move monitoring periods.

Consent

- The state policy addressing guardianship was developed in January of 2010 and was in draft format at the time of this on-site tour. The facility planned to adopt the state policy that addressed assessing each individual for the need for guardianship and referring individuals for guardianship. SGSSLC had begun developing a list of individuals in need of a guardian. There were only eight individuals identified on the list as Priority I for guardianship. There were 10 identified as Priority II and 13 as Priority III. PSTs at the facility determined the need for guardianship and made referrals to the Guardianship Coordinator.

Recordkeeping and General Plan Implementation

- SGSSLC 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 Director of Client Records and the Unified Records Coordinator were both very experienced at SGSSLC, as well as with SGSSLC operations, and the record keeping functions of the facility.

The comments in this executive summary were meant to highlight some of the more salient aspects of this baseline review of SGSSLC. 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 SGSSLC.
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 Restraint Checklist Form 4012008R o Administration of Chemical Restraint Form o SGSSLC Policy: Management of Inappropriate Behaviors, rev. 2/10/06 o SGSSLC Policy: Management of Conduct Between Staff and Persons Served, rev. 7/10/09 o SGSSLC Policy: Medical/Dental Restraint and Sedation Minimum Guidelines, 9/9/05 o SGSSLC Policy: Crisis Intervention Guidelines for Implementation of Body Wraps, Transport Jacket, & Posy Body Net, rev. 7/30/08 o SGSSLC Policy: Individual Risk Evaluation, Related Actions and Supervision Levels, rev. 10/12/01 o SGSSLC Policy: Protection of Individuals from Serious Self-Harm in Acute Situations, rev. 12/18/09 o SGSSLC Policy: Consumer Emergency Relocation, 12/30/04 o SGSSLC Policy: Restraint Reduction Plan, 3/14/08 o SGSSLC Policy: Physician's Notification and Orders for Use of Restraint, 12/1/09 o Restraint Data and Trends, 7/09 to 2/28/10 o Log of all restraints, 7/09 to 2/10 o Restraint usage, by Individual, 4/9/10 o Restraint Reduction Task Force Committee Notes since July 2009 o Restraint Reduction Plan for San Angelo State School FY 2009 o Sample of eight Restraint Reviews due to resulting injury or allegation of abuse o Log of medical restraints 9/09 to 3/10 o Log of emergency psychotropic medications 7/1/09 to 4/9/10 o Sample of 20 Restraint Debriefing, Review, and Face-to-Face Assessment for Crisis Intervention o List of Individuals with Safety Plans o Restraint documentation for last three chemical restraints o Training transcripts and background checks for three employees: an LVN, a Clerk, and a Direct Care Professional o A Sample of Daily Incident Management Team Meeting Summaries from 7/09 through 3/10 o Sample of PSPs including: • Individual #146 5/26/09 • Individual #243 2/26/10 • Individual #389 2/11/10 • Individual #107 2/25/10

	• Individual #396 2/3/10 • Individual #318 2/25/10 • Individual #345 2/16/10 • Individual #390 2/24/10 • Individual #273 3/10/10 • Individual #148 2/17/10 • Individual #26 2/12/10 o Safety Plan for Crisis Intervention (SPCI) for: • Individual #48 Interviews and Meetings Held: o Informal interviews with various staff in homes and day programs throughout campus o Interview with Charles Njemanze, Assistant Director of Programs, and Chair, Restraint Reduction Committee o Jalown McCleery, Program and Management Support Director o David Ponce, Applying Mechanical Restraint Instructor o Nancy Flores, Home Manager; Celia Warrick, PMAB Instructor; Melanie Flores Training and Development; Charles Rivers, Training and Development. Observations Conducted: o Residence 516 Morning Unit Meeting 5/13/10 o Demonstration of mechanical restraint use o Daily Incident Management Meeting 5/10/10 and 5/13/10 o Human Rights Committee Meeting 5/13/10 o Annual PST meetings for Individual #146 o Residences 501, 502, 505, 509, 511, 516 o On-campus workshop
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Restraint data were provided to the monitoring team from FY09 to FY10 (1st half). There were a total of 880 emergency and programmatic restraints for FY09. For the first half of FY10, there had been 290 restraints in these two categories, indicating a decrease in restraint use at the facility. The facility had restraint data trended by individual, type of restraint, location of restraint, when the restraint occurred, and behavioral cause of the restraint. In the quarter prior to the review (12/1/09 to 2/28/10), there had been 122 behavioral related physical

	restraints, including 47 that involved self-injurious behavior, 41 that involved aggression towards staff, 17 that involved aggression to peers, nine that involved property destruction, and four that involved elopement. The restraints involved 42 individuals. Of the last 122 documented restraints for crisis intervention included in trend reports, 12 were mechanical and 70 were horizontal physical restraint (often implemented following a less restrictive restraint, such as when the individual may have dropped to the floor), indicating that the most restrictive restraint methods were used in 67% of the incidents. There were an additional 51 chemical restraints used during this quarter for crisis intervention, bringing the total to 173 restraints for the quarter. There were 170 restraints used for crisis intervention in the previous quarter (9/1/09 to 11/30/09), thus indicating a slight increase in the use of restraints over the past two quarters. There was a 31% decrease in the use of mechanical restraints and a 47% increase in the use of chemical restraints. Of particular concern to the monitoring team was the frequency of restraint use at SGSSLC and the use of mechanical restraints at the facility. The use of mechanical restraints has not been a widely accepted practice in this field for a number of years due to the risk associated with restraint application and the dehumanizing aspect of this method of behavioral intervention. SGSSLC had put several practices in place to try to minimize the dehumanizing aspect of the procedure, such as, trying to move the individual to a private area more comfortable area (e.g., the individual's bedroom). The monitoring team was able to observe a demonstration of the use of mechanical restraints by training instructors during the monitoring visit. The facility had a Crisis Intervention Team (CIT) in place. According to facility policy, this team was specifically trained in behavioral crisis intervention and restraint applications. Members of this team were the only staff approved to apply mechanical restraints to an individual at the facility. A positive aspect of the CIT was that it set the occasion for additional staff to assist with attempts at de-escalation as well as with restraint application. Moreover, these additional staff were not involved in the initial behavioral incident (e.g., aggression towards the staff) and thereby were less likely to be tired, angry, or otherwise emotionally involved in the situation. The use of prone and supine restraints is controversial due to the risk of injury and death associated with these types of restraints. The DADS policy regarding restraints prohibited the use of both prone and supine restraints. SGSSLC utilized a 6-point Posey net that placed the individual in a supine position. There had been 10 incidents in the past quarter where staff had restrained an individual using this method. The state policy, however, needed more clarity in guidelines for the use of prone and supine restraint. While both were prohibited in physical restraint incidents, the policy did not specifically state whether supine mechanical restraint was or was not prohibited. The monitoring team recommends that this be addressed in an explicit manner throughout restraint usage policies. The facility had a Restraint Reduction Committee that met monthly. A review of committee meeting minutes for the past year indicated that the committee did not have a plan in place to focus on aggressively reducing the number of restraint incidents at the facility. Charles Njemanze, Assistant Director of Programs, chaired the Restraint Reduction Committee. He stated that one of the positive steps the facility

	was taking towards restraint reduction was in providing better support for direct care professionals, including relaxation and stress reduction classes, and facilitating support and training for DCPs from psychology staff. Psychology staff was slated to receive additional training, as well. In order to have a clear picture of where restraint reduction efforts need to continue, the committee should review restraint data for any significant trends and develop a plan to review trends and make specific recommendations in regards to restraint reduction. Reduction efforts need to focus on any obvious trends and strategies that may prevent behavioral situations from escalating in specific situations. Trends were not available regarding the use of medical and dental restraints at the facility. The facility should trend that restraint data also and develop plans to reduce the use of medical and dental restraints to the extent feasible. PMAB instructors at the facility reviewed any restraint that resulted in injury to the individual or an allegation of abuse and neglect. A sample of restraint reviews was reviewed by the monitoring team. These reviews included specific findings and recommendations that could be used in reducing restraint use. The facility may want to expand these reviews to include all mechanical restraints or a review of multiple restraints in a limited period of time. This may assist the facility in reducing the number of restraints. The current facility policies were fragmented in terms of addressing restraint use at the facility. SGSSLC needs to develop one comprehensive policy that governs the use of restraints at the facility.

#	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	Assessment of this item required review of policies and an examination of implementation of those policies. State 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 several policies and procedures in place addressing various aspects of restraint use, but no comprehensive policy addressing the use of restraints. The facility needs to develop a restraint policy that meets the provisions of the Settlement Agreement within the guides of state policy. Nine different policies provided to the monitoring team addressed different aspects of restraint usage (see list included in documents reviewed). Having all of the information included in one general restraint policy would give staff one point of reference when referring to restraint policies. The use of prone and supine restraint was prohibited by the state policy. The facility was using supine restraints in the form of a 6-point restraint/Posey net. Additionally, according to a restraint review triggered by an abuse allegation, a restraint incident involving Individual #152 on 4/5/10 noted that the individual was held on her back during the restraint. Although a restraint monitor was present, the monitor did not attempt to correct the improper restraint.	

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	governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	SGSSLC needs to ensure that restraints prohibited by DADS are not being used at the facility. The facility policies did not address prohibited restraint techniques. Facility administration will need to work closely with program managers to meet the DADS policy in a manner that ensures safety of individuals and staff. Restraint documentation by direct support professionals indicated that a series of least restrictive measures was attempted prior to restraint in most cases. Staff interviewed throughout the facility stated that restraints were a last resort measure in behavioral intervention. The adequacy of behavioral support strategies is addressed further in this report. As noted in the summary, there had been an increase in the number of chemical restraints used for crisis intervention in the past two quarters. There had been 106 incidents of chemical restraints involving 37 individuals since 7/1/09. In a majority of these incidents (84), a 20 mg intramuscular injection of Geodon was administered for agitation, aggression, or self injurious behaviors. In the remaining 22 incidents, another medication, including Benadryl, Ativan, Haldol, Zyprexa, and Klonopin was administered, and in two instances Geodon 80 mg was administered. Ten individuals had three or more chemical restraints in a rolling 30 day period. Of these ten, all had Positive Behavior Support Plans in place. Eight of the 10 individuals had Safety Plans for Crisis Intervention (SPCI) in place. Two of the individuals each had five chemical restraints within a 30 day rolling period, but did not have an SPCI in place, as required by state policy. In upcoming monitoring visits, the monitoring team will review the effectiveness of behavior support strategies, whether chemical restraints are being used as a last resort measure in crisis intervention, and how medication and dosage is determined for each individual.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	Restraint checklist and Restraint Debriefing, Review, and Face-to-Face Assessments completed for each incident of restraint indicated that restraints were terminated as soon as the individual was no longer a danger to himself, herself, or others. The facility restraint data included the duration of each restraint in the data collected. A review of data from the 36 restraint incidents in February 2010 indicated that: • 9 of the restraints were implemented for five minutes or less, • 20 of the restraints were implemented for 15 minutes or less, and • 6 restraints lasted longer than 15 minutes, including one incident where the 6-point Posey net was used for 70 minutes.	
C3	Commencing within six months of the Effective Date hereof and with	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	

#	Provision	Assessment of Status	Compliance
	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.	policies. The state policy described the types of restraints that were allowed to be used and listed restraint types that were specifically prohibited. Supine restraints were in use at SGSSLC. As noted above, the state policy should be revised to be more explicit about the allowance or prohibition on supine restraint. The facility's quality assurance reviews of restraint incidents did not support that the least restrictive intervention was always attempted by staff in a crisis situation. Restraint reviews often found that specific intervention strategies included in behavior support plans were not attempted prior to restraint use to deescalate aggressive behavior. For example: • the review of a restraint used with Individual #162 on 2/4/10 indicated that the restraint may have been avoided if staff were carrying out the assigned level of supervision appropriately, • the review of a restraint for Individual #252 on 2/28/10 found that staff failed to follow steps of her SPCI prior to restraint, and • the review of a restraint on Individual #322 on 12/23/10 indicated that the restraint may have been avoided if staff had altered the situation by backing off after the first prompt, and/or waiting until later to prompt him again, or by asking different staff to come in and work with him as written in his behavior intervention program. In order to reduce the use of restraints, it will be imperative that all staff are familiar with individual behavioral intervention strategies and that all staff are consistently utilizing these strategies. Additionally, a system must be in place to evaluate and revise strategies as necessary. Staff were required to complete initial training and were to be retrained at least annually on the use of restraints and positive behavioral intervention. This training included RES0105 Restraint: Prevention and Rules for Use of Restraints at MR Facilities, RES0110 Applying Restraint Devices, and Competency Based PMAB training. Training transcripts were reviewed for three staff: an LVN, a clerk, and a direct support professional: • Only one of the three employees had completed the required training within the required timelines. • One employee had not completed annual refresher courses in PMAB or RES0110. • One employees had completed refresher training, but not within 365 days of the previous training. A larger sample of employee training records will be reviewed during upcoming on-site monitoring visits. Informal interviews with staff confirmed a basic knowledge of policies regarding restraint, including prohibited restraints and required documentation and	

#	Provision	Assessment of Status	Compliance
		follow up. The facility needs to ensure that all employees receive training in restraint techniques and behavioral intervention strategies at least annually.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	There was no indication that restraints had been used at the facility other than for crisis intervention or medical reasons. The facility had a policy in place titled, "Medical/Dental Restraint and Sedation Minimum Guidelines" that mandated a PST review of the need for restraint and/or sedation prior to routine medical or dental procedures and the development of a plan focused on reducing the need for sedation or restraint. The facility had a Restraint Reduction Team that met quarterly. The team reviewed restraint trends, but had not developed meaningful restraint reduction objectives for the facility. The Restraint Reduction Team should use data collected by the facility to make recommendations on reducing restraint in specific areas and develop outcomes and action plans for reducing restraints in those areas. A list of medical and dental restraints used from July 2009 through April 2010 indicated that dental restraints had been used with 11 individuals during that time period. During a PSP meeting observed for Individual #243, the team discussed her need for dental restraints and stated that she had a dental desensitization plan in place to reduce the need for restraints. Her new PSP draft plan dated 5/11/10 did include a medical/dental desensitization plan. The facility had a Human Rights Committee (HRC) that met weekly. The committee reviewed restraint incidents, as well as other rights restrictions. It was noted during the PSP meeting observed for Individual #146, that a seatbelt was being used to restrain this individual in her wheelchair due to pica behavior. There was no documentation that this had been approved by the Human Rights Committee. All programmatic restraints should be approved by the HRC prior to implementation.	
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	Staff were required to complete a Restraint Debriefing, Review, and Face-to-Face form for each incident of restraint applied for crisis intervention. A sample of 20 Restraint Debriefing, Review, and Face-to-Face forms were reviewed by the monitoring team. All of the forms indicated that a face-to-face assessment was conducted of the individual within 15 minutes from the start of the restraint. All Restraint Checklists reviewed also indicated that a health care professional monitored and documented the individual's vital signs and mental status, however, five of the forms (25%) indicated that this review did not take place within 30 minutes of the start of the restraint. Details are provided below.	

#	Provision	Assessment of Status	Compliance
	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.	• Restraint documentation for Individual #292, dated 4/5/10, indicated that the first assessment by the nurse was at 12:23 pm. The restraint was initiated at 10:41 am. • Restraint documentation for Individual #152, dated 4/5/10, indicated that the first assessment by the nurse was at 1:40 pm. The restraint was initiated at 12:37 pm. • Restraint documentation for Individual #243, dated 3/21/10, indicated that the first assessment by the nurse was at 11:23 am. The restraint was initiated at 9:47 am. • Restraint documentation for Individual #170 dated, 4/16/10, indicated that the first assessment by the nurse was at 4:20 pm. The restraint was initiated at 3:20 pm. • Restraint documentation for Individual #168, dated 4/25/10, indicated that the first assessment by the nurse was at 3:15 pm. The restraint was initiated at 2:40 pm. The facility needs to ensure that a health care professional does a face-to-face assessment of each individual within the guidelines of this provision and state policy.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one	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. The state policy addressed safety and supervision during restraint. One-to-one supervision during physical restraint and following medical or chemical restraints was documented in all incidents reviewed.	

#	Provision	Assessment of Status	Compliance
	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:	The facility had guidelines in place that addressed this section of the Settlement Agreement requiring the Personal Support Team (PST) to develop and implement a Behavior Support Plan and a Safety Plan for Crisis Intervention (SPCI) for any individual placed in restraint, other than medical/dental restraint, more than three times in any rolling 30 day period. According to a list provided to the monitoring team, there were 38 individuals with SPCIs in place at the time of the monitoring visit. Five individuals (Individuals #165, #346, #154, #247, and #304) had three or more physical restraints within 30 days in the period between 1/1/10 and 2/28/10. None of these individuals were included on the list indicating that any of them had a SPCI in place. 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 Assessments, Positive Behavioral Support Plans, and Crisis Intervention Plans is addressed elsewhere in this report. The facility will need to focus on behavioral assessments and recommendations to effectively reduce the number of restraints used for crisis intervention.	
	(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 provoking restraints;	See note C7 above.	

#	Provision	Assessment of Status	Compliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	See note C7 above. See section K for additional comments on PBSPs.	
	(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 days of the start of each instance of	The Restraint Checklist had a place to indicate review by the Restraint Monitor and Psychologist, and a place to document the Unit Review date. Documentation from a sample of 13 restraint incidents indicated that all were reviewed within three business days by the Restraint Monitor, Psychologist, and Unit. Additionally, PMAB instructors at the facility reviewed any restraints that resulted in an injury to the individual or an allegation of abuse or neglect. They reviewed the restraint	

#	Provision	Assessment of Status	Compliance
	restraint, other than medical restraint. ISPs shall be revised, as appropriate.	documentation and any related injury reports, as well as interviewed staff involved in the restraint. Recommendations from these reviews were submitted to the Incident Management Meeting. Restraints that had occurred the prior day were reviewed at Daily Incident Management meetings observed during the on-site review week. The team reviewed each restraint and discussed possible contributing factors to the behavior. A review of Incident Management Review Team Minutes indicated that the team reviewed all incidents of restraint during the meeting following the incident.	

Recommendations:

1. Develop a comprehensive restraint policy that meets the requirement of this Settlement Agreement and complies with state policies regarding the use of restraints. Revise state policy to be more explicit regarding under what conditions supine restraint is and is not prohibited.

2. Ensure that all employees receive training on the use of restraints and positive behavioral approaches at least annually.

3. Complete behavioral assessments as often as needed to determine precipitating factors to restraint use and develop Positive Behavior Support Plans that offer direct care professionals a graduated range less restrictive interventions to manage behaviors in the least restrictive manner.

4. Psychology staff should provide individual specific training to staff on strategies for behavioral intervention and request frequent feedback from staff on which strategies are effective. Plans should be reviewed and modified when strategies are not effective in deescalating aggressive or self injurious behavior.

5. The Restraint Reduction Team should use data collected by the facility to make recommendations on reducing restraint in specific areas and develop outcomes and action plans for reducing restraints in those areas.

6. Continue to focus on developing desensitization programs for individuals currently using medical and dental restraints and develop written plans to support consistent implementation of desensitization efforts.

7. The facility needs to ensure that a health care professional does a face-to-face assessment of each individual as soon as possible following release from restraints.

8. Ensure that all programmatic restraints are approved by the HRC prior to implementation.

9. All disciplines need to work together to identify behavioral interventions that may reduce the use of restraints and ensure that interventions are consistently used.

10. Decrease the use of mechanical restraints.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed</u>: o State Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management o Unusual Incident Report Coding and Reporting Matrix o SGSSLC Policy: Client Management –Abuse/Neglect Prevention Team, rev. 10/10/08 o SGSSLC Policy: Spurious Allegations of Abuse/Neglect/Exploitation, 10/11/02, rev. 3/19/10 o SGSSLC Policy: Individual Levels of Supervision, 1/14/05, rev. 6/12/09 o SGSSLC Policy: Individual Well-Being Check, 2/11/05, rev. 3/13/09 o Memorandum of understanding between DADS, the Department of State Health Services, DFPS, the office of the independent ombudsman for the SSLCs, and OIG, 5/28/10 o Training transcripts for Facility Investigators o Abuse and Neglect ABU0100 Training Curriculum o Log of all unusual incidents since 7/09 o List of all abuse/neglect/exploitation investigations since 7/1/09 o Client Injury Reports for three most recent injuries resulting from peer-to-peer aggression. o List of individuals requiring sutures/Dermabond since 7/09 o List of individuals with fractures since 7/09 o List of individuals with unauthorized departures since 7/09 o Human Rights Committee Meeting Summaries from 10/29/09 to 3/4/10 o Proof of background check for 18 Direct Care Professionals o Training transcripts for Four Direct Care Professionals o Sample of PSPs including: • Individual #146 5/26/09 • Individual #243 2/26/10 • Individual #389 2/11/10 • Individual #107 2/25/10 • Individual #396 2/3/10 • Individual #318 2/25/10 • Individual #345 2/16/10 • Individual #390 2/24/10 • Individual #273 3/10/10 • Individual #148 2/17/10 • Individual #26 2/12/10 o A Sample of Daily Incident Management Team Meeting Summaries from 7/09 through 3/10 o Sample investigations completed by the facility investigator: • #281 2/4/10

	• #2930 3/9/10 • #2882 2/15/10 • #2574 10/10/09 o Sample of Closed DFPS Investigative Reports • #35070077 1/30/10 Neglect Confirmed • #35214611 2/11/10 Abuse/Neglect Confirmed • #35586189 3/15/10 Neglect Unconfirmed • #35531689 3/10/10 Abuse/Neglect Unconfirmed • #35614269 3/17/10 Neglect Unconfirmed • #33973389 11/2/09 Neglect Unconfirmed • #33965511 11/1/09 Sexual Abuse Unconfirmed • #35185193 2/10/10 Neglect Confirmed • #34109173 11/14/09 Neglect Confirmed • #34225409 11/23/09 Sexual Abuse Unconfirmed Interviews and Meetings Held: o Mary Holmes, Investigator o Four Direct Support Professionals o Informal interviews with DCPs, QMRPs, Unit Directors, and Psychology Staff Observations Conducted: o Residence 516 Morning Unit Meeting 5/13/10 o Demonstration of mechanical restraint use o Daily Incident Management Meeting 5/10/10 and 5/13/10 o Human Rights Committee Meeting 5/13/10 o Annual PST meetings for Individual #146 o Residences 501, 502, 505, 509, 511, 516 o On-campus workshop
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: SGSSLC had adopted the state Protection From Harm Policy without revision. All staff interviewed were familiar with reporting procedures and had received training consistent with state policies, though employee refresher training was not provided annually as required by state policy. 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, local law enforcement, OIG, and DADS Regulatory. The facility investigators reported having a good relationship with DFPS, local

	law enforcement, and OIG. The facility provided the monitoring team with logs of incidents and injuries at the facility. The facility trend analysis did not focus on facility wide trends for incidents and injuries, but rather on trends for individuals. There was not a quality assurance system in place to address facility trends in regards to incidents and injuries. A log of abuse, neglect and exploitation investigations listed 491 investigations at the facility between 7/1/09 and 3/30/10. Many of those investigations involved multiple allegations. Fifteen investigations (3%) resulted in confirmed allegations of abuse and neglect. Due, in part to the characteristics of the forensic population at the facility, there were numerous spurious allegations. Some individuals at the facility were on a DFPS Frequent Caller List due to the number of allegations they reported. The facility had a policy in place regarding spurious allegations. An individual was identified as making spurious allegations if there were at least three unconfirmed or unfounded allegations as determined by DFPS within a four week period or a pattern was identified. If identified, the individual's PST was required to develop a formal program to address the behavior with a behavior support plan.

#	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 state policy was titled, "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. The facility had adopted the state policy. The state policy #002.1 regarding abuse and neglect 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 at most facility sites visited and all staff interviewed were able to relay this information. All employees interviewed were aware of reporting procedures consistent with the state policy. A log of confirmed abuse and neglect investigations and follow up employee disciplinary action indicated that abuse and neglect were not tolerated. There were 15 confirmed abuse and neglect allegations at the facility since 7/1/09. The following table shows the disciplinary action taken in each case.	

#	Provision	Assessment of Status	Compliance

Date	Allegation	Disciplinary Action Taken
7/8/09	Physical Abuse	The employee was terminated during the probationary period.
7/11/09	Sexual Abuse	The employee had resigned by the time this case was opened by DFPS.
7/12/09	Physical Abuse	Dismissed
9/5/09	Neglect	Dismissed
9/13/09	Physical Abuse	Dismissed
11/5/09	Physical Abuse	Dismissed
11/23/09	Neglect	Employee was given a written reprimand because there was a breach of supervision with no injury. The breach of supervision was that the employee was required to do 15-minute checks on the one side of the home. After completing the checks as required, the employee went to the other side of the home to get supplies and while there, one individual pushed another. There were no injuries to the either individual.
12/16/09	Physical Abuse	Resigned
1/2/10	Neglect	Resigned
1/5/10	Neglect	Employee was suspended for two days for not following PMAB in response to verbal aggression from individual.
1/14/10	Physical Abuse	Dismissed
1/26/10	Neglect	Written reprimand was given for breaching supervision. Employee was assigned to an individual who was on enhanced supervision. The employee left the individual to go inside at food services to get an item. The individual was left outside and out of line of sight. The employee was also trained on providing proper supervision. No injury occurred to the individual.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td><table>
<tr><td>1/27/10</td><td>Neglect</td><td>Performance Counseling.
Data provided to monitors showed an "inconclusive" finding resulting in a performance counseling for an employee and a finding of "confirmed" for an unknown.</td></tr>
<tr><td>2/10/10</td><td>Neglect</td><td>Written Reprimand. Employee was seen sleeping while assigned to a one-to-one supervision. Circumstances included employee medication side effect and having been asked to stay over past the required eight-hour shift. No injuries occurred to individual.</td></tr>
<tr><td>2/11/10</td><td>Physical Abuse</td><td>Dismissed</td></tr>
</table></td><td></td></tr>
<tr><td>D2</td><td>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:</td><td></td><td></td></tr>
<tr><td></td><td>(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</td><td>The state 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.

All incidents reviewed documented notification to the facility director as required. A review of incidents also indicated that DFPS, DADS regulatory, and OIG were typically notified of incidents within required timeframes when appropriate.

There were posters at most facility sites that provided basic instructions on intervening to stop abuse, as well as reporting abuse. The 1-800 number to call to report suspected abuse was posted on bulletin boards and near phones around the facility.</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
	official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.		
	(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 state policy mandated immediate action and reporting of all allegations of abuse and neglect. 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 removing alleged perpetrators, increasing staffing ratios, or requesting other additional supports as needed. The facility followed the state policy addressing the reassigning of alleged perpetrators. It was evident that alleged perpetrators were routinely reassigned until investigations were completed. Daily Incident Management Meeting minutes and investigation documentation indicated that staff were removed from positions providing direct support to individuals and reassigned to jobs not requiring client contact or remained in direct support positions with monitoring in some cases. In most instances, staff were not returned to regular duties until DFPS notified the facility that the allegations were not confirmed. The facility, however, had a system in place to release staff to return to positions with client contact, plus monitoring by a supervisor, when allegations were made by individuals with a significant history of making spurious allegations. It was reported at the 5/10/10 Daily Incident Management meeting that there were 19 staff members assigned to no client contact positions and nine released back to client contact positions with supervision. This represented a significant number of displaced support staff. One concern resulting from the significant number of staff reassigned was that according to staff interviewed, this often resulted in a shortage of staff trained to the specific residence available to work. On the other hand, the monitoring team was impressed with the arrangements made by SGSSLC and the local DFPS to get staff back to work as soon as possible. DADS should consider exploring this further and perhaps applying or adapting these procedures at other SSLCs, as appropriate. In most instances, individuals were also placed on one-to-one supervision following an allegation until the PST determined that it was no longer necessary thus providing further protection and support to the individual.	
	(c) Competency-based training, at least yearly, for all staff on	Initial staff in-service training included training on recognizing and reporting incidents of abuse and neglect (Course ABU0100) that was to be provided upon initial hire and	

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	recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	annually for tenured staff. A review of training transcripts for staff members revealed that: • Only one of the three employees had refresher training in ABU0100 within the required 365 days • One of the employees completed refresher training late • One had not had refresher training. The facility needs to ensure that all employees have training on recognizing and reporting incidents of abuse and neglect initially upon hire and annually thereafter. 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 of training records will be reviewed 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 state policy addressed mandatory reporters. All staff who were interviewed were aware of their obligation to report. A sample of staff personnel records was not reviewed during this initial review to verify the existence of these signed statements regarding reporting obligations, however, this will be verified during future reviews. In most 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	The state 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. A sample of PSPs reviewed indicated that this resource guide was provided to individuals and their families annually. Clear reporting information was posted in most buildings at the facility.	

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	LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	A review of abuse and neglect investigations indicated that at least some of the individuals and their LARs were aware of reporting procedures and had reported suspected abuse and neglect incidents to DFPS.	
	(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.	Most 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 violations of rights. Information on the poster was clear and easy to understand, including pictures for individuals who could not read. These posters, however, were missing in some of the residences at the time of the monitoring visit. Staff reported that individuals living in the home often remove the posters. This problem has been addressed in other facilities with the use of Plexiglas covered bulletin boards. The facility may want to consider purchasing some of these for homes in which the individuals routinely remove such postings.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The state policy addressed the referring of allegations of abuse and/or neglect to law enforcement. The state was working with OIG to clarify their role in investigations. It was found during the baseline monitoring tour that the process for referring cases to local law enforcement or OIG and the handling of criminal cases was not consistent from facility to facility. The monitoring team will continue to work with the state to develop clear guidelines for facilities and OIG to ensure that all reported incidents of criminal activity are followed up on and investigated in a consistent manner. The monitoring recently became aware of a Memorandum of understanding between DADS, the Department of State Health Services, DFPS, the office of the independent ombudsman for the SSLCs, and OIG regarding the investigation of abuse and neglect in SSLCs. The monitoring team looks forward to the implementation of these procedures. The monitoring team was pleased to hear from the facility investigator that SGSSLC has a good working relationship with OIG and local law enforcement agencies. Documentation supported that investigations involving criminal activity were routinely referred to OIG by the facility and DFPS.	
	(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,	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.	

#	Provision	Assessment of Status	Compliance
	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.	There was no evidence found that reporters of suspected abuse and/or neglect had been subject to retaliatory action.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	According to information provided prior to the monitoring visit, there had been no injuries of unknown cause reported to DFPS for investigation at the facility since 2008. There was no evidence that a procedure was in place to determine whether significant injuries were reported for investigation. This will be reviewed further at upcoming monitoring visits.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The state 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. A review of training transcripts confirmed that a number of administrative staff were qualified to complete investigation and had completed the three required courses. Having numerous trained investigators on campus ensured that investigations could begin promptly.	

#	Provision	Assessment of Status	Compliance
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The facility policy mandated that staff were required to cooperate with DFPS and law enforcement agencies in conducting investigations. An interview with the facility investigator, and review of a sample of completed investigations indicated investigations were a cooperative effort with DFPS investigators. The lead facility investigator was interviewed and was able to describe incident types and the process for reporting to DFPS, OIG, local law enforcement, and DADS regulatory. As noted in section D.2.g. the state is working with OIG to clarify their role in investigations.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	It was evident in documentation that the facility investigators completed preliminary steps to ensure the safety of the individual (e.g., medical evaluations, removing APs), and then allowed appropriate entities to complete investigations as necessary. The facility investigator stated that the facility had a good working relationship with local law enforcement agencies and OIG and worked cooperatively with them. There was no evidence that this was not the case.	
	(d) Provide for the safeguarding of evidence.	The state policy described procedures for safeguarding evidence in the event of a serious incident.	
	(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 state policy required that investigations commence within 24 hours, but allowed for investigations to be completed within 14 days (10 days after 6/1/10). All investigations handled by facility investigators reviewed by the monitoring team commenced within 24 hours of notification and were completed within 10 days of the incident. Investigations by DFPS commenced within 24 hours of notification for all incidents reviewed, but were not always completed within 10 days. DFPS had required investigations to be done within 14 days of notification. This was being changed to within 10 days according to the presentation to monitoring teams on 11/16/09. Of the DFPS investigations reviewed, all but one was completed within 14 days with the exceptions of DFPS investigation #34109173. It was completed in 27 days. An extension was filed because witnesses were not available for interview. All investigations reviewed included a summary of the investigation and findings and relevant 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	The state policy mandated consistent investigation procedures and recordkeeping including elements listed in this provision item. Investigation files were consistently compiled in a clear and easy to follow format. Investigation reports included a list of previous allegations and incidents involving the individual or the alleged perpetrator as	

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	basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	required by this item in the settlement agreement.	
	(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.	A review of investigations completed by the facility investigators indicated that final investigations were reviewed in the Daily Incident Management Meeting and by the facility director. DFPS investigation reports were signed by the investigator. It was unclear if supervisory staff at DFPS reviewed the investigations to ensure they were thorough, complete, accurate, and coherent, however, this was not required until 6/1/10. Status of ongoing investigations and completed DFPS investigations were reviewed at the Daily Incident Review Meeting.	

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	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	A sample of Unusual Incident Investigation forms was reviewed by the monitoring team. Each written report was written in a clear and consistent manner. Reports included a 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.	It was evident that the facility followed up on individual incidents by immediately removing APs from contact with individuals, taking disciplinary action when warranted, and holding PST meetings to review incidents and take corrective action as needed. Action taken in each case was documented by the facility on the Unusual Incident Investigation form. Corrective action was discussed and reviewed at Daily Incident Management Meetings. The facility reviewed APs reassigned during investigations at the daily incident management meeting. APs were assigned to positions within the facility that required no contact with individuals served at the facility during investigations unless it was determined that they could return to a position with client contact under increased supervision and monitoring (as per the procedures for individuals who made frequent spurious allegations). A review of Unusual Incident Reports documented that there was usually a level of supervision increase, immediately and at least temporarily, for individuals involved in any type of unusual incident. The increased level of supervision remained in place until either the PST or the incident management committee recommended a return to routine supervision.	
	(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 a sample of investigation records confirmed that files were maintained and were easily accessible for review.	
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	The facility was able to provide the monitoring team with multiple logs of injuries and other incidents as requested. There was no indication that injuries and other incidents were trended by individual, home, location, date and time, staff involved, cause and incident type.	

#	Provision	Assessment of Status	Compliance
	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 needs to develop a quality assurance system to trend injuries and incidents and address any trends identified with a quality improvement plan.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	Criminal background checks were reviewed for four current employees. Background checks were in place for all four employees. Employees were also required to complete a form disclosing all arrests, indictments, and convictions immediately upon employment. A sample of this form was not reviewed. A log provided to the monitoring team for 18 new hires documented criminal background checks and signed disclosure forms prior to employment. Additional review of this system for both employees and volunteers will occur during future monitoring visits.	

Recommendations:

1. Ensure that all employees have training on recognizing and reporting incidents of abuse and neglect annually.

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

3. 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/quality enhancement plan.

4. Continue to take every allegation of abuse seriously. Take steps to further address the occurrences of false accusations. Even though the monitoring team was pleased with the procedures in place at SGSSLC, it is recommended that SGSSLC and DADS:
    a. Explore what has been done at other facilities around the country and state,
    b. Focus on this problem via a QA or program improvement project.
    c. Involve staff and individuals in coming up with possible solutions.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Documents Reviewed: o DADS policy #003: Quality Enhancement, dated 11/13/09 o SGSSLC policy list, dated 4/9/10 o Various policies from SGSSLC policy and procedure manual, various dates o Facility Support Performance Indicators, dated 11/12/99 o Organizational chart, dated 4/7/10 o History of SGSSLC, document presented to monitoring team members o List of meetings scheduled for week of 5/10/10 o PIC monthly meeting notes and agenda, December 2009 through April 2010, except March 2010 o Restraint reduction committee notes, dated 4/22/10 o SGSSLC plan of improvement, 8/09 o SGSSLC set of blank audit tools • Abuse neglect monitoring form, questions for staff, 1 page • Unusual incident monitoring form, questions for staff, 1 page • Documentation audit for AN concerns or UI that had not been reported, 1 page • Program audit, regarding PSP and other documents in record, 6 pages • PNMP and nursing audit, 7 pages • Environmental checklist, 1 page • Meal observation, 2 pages • Active record review, 13 pages o Some tables, bar graphs, and narratives describing the results of use of some of the audit tools o Quarterly Trend Analysis (data, tables, and reports that were required by DADS central office): • Unusual incidents, abuse and neglect allegations, injuries, and restraints o Notes from weekly home group meetings for individuals, 4/22/10 through 5/6/10 o Descriptions and forms from Cultural Diversity Committee and EMPACT Committee regarding recognition of outstanding employee performance Interviews and Meetings Held: o Philip Baugh, Ph.D., Facility Director o Angela Kissko, Director of Quality Enhancement o Penny Bivens, Settlement Agreement Coordinator o Roy Smith, Rights Officer o Individual #172 o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. Observations Conducted:

	- Many residences and day programs - Self-advocacy meeting - Home meetings: 505B, 511B
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: SGSSLC was fortunate to have two experienced and dedicated professionals managing the facility's quality enhancement activities: the Director of Quality Enhancement, and the Settlement Agreement Coordinator. Unfortunately, their work was not coordinated or integrated. Both offices collected data, but it was not summarized, analyzed, or reported in any comprehensive or organized manner. The facility was operating without a quality enhancement plan. Therefore, SGSSLC needs to develop and implement an organized, systematic, meaningful, functional, QE program that is useful to administrators, managers, clinicians, and staff. Even so, a number of QE-related activities were occurring at SGSSLC, including the observation and monitoring of various areas by program auditors. It is expected that the quality enhancement program will develop and mature over the next few years at SGSSLC. Improvements and developments will be needed in the breadth of the quality enhancement activities, the validity and reliability of the department's data collection activities, the thoroughness of the QE Plan, the use of graphic presentations, and the writing and disseminating of a regularly produced quality enhancement report. Other comments are detailed below in this section of the report. The monitoring team looks forward to continued development of SGSSLC's quality assurance program.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	A review of this section of the Settlement Agreement required the monitoring team to look at policy, processes, and outcomes related to quality assurance activities at SGSSLC (these are referred to as quality enhancement (QE) in this report). A policy was developed by the state DADS regarding quality assurance titled "Quality Enhancement." It was labeled policy #003 and was dated 11/13/09. The facility had adopted this policy in full. 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 Quality Enhancement plan, corrective action plans, tracking of these plans, and operation of the performance improvement council.	

#	Provision	Assessment of Status	Compliance
		SGSSLC, however, was not implementing or following the components of this policy at the time of the on-site monitoring tour. It did not have a comprehensive, organized, or systematic quality enhancement process in place. There were, however, a number of quality enhancement-related activities going on at the facility. Nevertheless, as a result of the absence of any quality assurance system or quality enhancement plan, there was little upon which the monitoring team could comment. The monitoring team expects to see a more formal and comprehensive quality assurance and quality enhancement program initiated and in place at SGSSLC when it returns for the next on-site tour. <u>Policies</u> The Director of Quality Enhancement told the monitoring team that the state policy on quality enhancement (policy #003, dated 11/13/09) was the policy used by the facility. Little activity, however, had occurred at SGSSLC to implement the policy. In addition, at SGSSLC, there were no policies or processes related to quality enhancement that were specific to the facility or that referred to the state policy. Only one related policy was found in the policy manual. It was called "Facility Support Performance Indicators" and was dated 11/12/99. It noted that there were 18 to 20 self-audit modules that were to be completed every other year and that the results were to be submitted to central office. The monitoring team did not hear anything about this process during the on-site tour and, therefore, it appeared that this was not an active policy. SGSSLC should ensure that its policies are up to date and are in line with any state policies. Any facility policies related to QE should be reviewed and approved by DADS central office. <u>Quality Enhancement Plan</u> The DADS policy required the development of a quality enhancement plan (QE Plan). A QE plan did not exist at SGSSLC. <u>QE Department</u> Angela Kissko was the director of the QE department. She had 15 years experience at SGSSLC and had been in the role of QE Director for more than 10 years. She supervised the QE department staff (nine FTEs according to the organizational chart), client records (two FTEs), and investigations (one FTE). The organizational chart needed to be updated because it did not include the unified records coordinator or campus administrators, and did not reflect the actual number of FTEs working in each of these areas.	

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		Penny Bivens, the Settlement Agreement Coordinator, also played a role in quality enhancement activities. She had two years experience as SAC at SGSSLC. Moreover, she was very experienced with the SSLC system having worked for more than 15 years in a variety of positions at two other facilities. Thus, both the Director of Quality Enhancement and the Settlement Agreement Coordinator were experienced at SGSSLC and had handled QE-type activities for many years. SGSSLC was fortunate to have two experienced professionals in these roles. It was surprising, therefore, to find that they were engaged in separate, somewhat parallel, activities. One of the documents reviewed by the monitoring team indicated that it was the Settlement Agreement Coordinator's responsibility to manage the data related to the Settlement Agreement, and it was the Quality Enhancement Director's responsibility to manage the data related to ICFMR regulations. The facility, with support from senior administration, should ensure that both of these activities are coordinated into a single well-designed quality enhancement plan. Both the Director of Quality Enhancement and the Settlement Agreement Coordinator reported directly to the facility director. This was a reasonable organizational structure for SGSSLC given the amount of work needed in quality enhancement. It set the occasion for administration to support a full integration of the QE and SAC departments, Settlement Agreement activities, and Quality Enhancement into the overall operation of the facility. Moreover, the QE department and the SAC appeared to have a good working relationship with the many departments at the facility. This, too, made it likely that quality enhancement activities could be integrated across all facility services and operations. The monitoring team learned that a statewide meeting with QE directors and SACs from all of the SSLCs was being scheduled to occur in the near future. Perhaps the topic of integration and coordination of these two roles can be put onto that agenda. Other types of professional development for quality enhancement staff should be considered, including, for example, quality assurance in the field of developmental disabilities and those with dual diagnoses. <u>QE Activities</u> To reiterate, numerous QE activities were occurring at SGSSLC even though a coordinated, comprehensive QE plan was not in place. Some of these activities are listed below. Overall, some important and useful information was being collected. The absence of a QE plan, however, resulted in the activities being fragmented, isolated, and, to a large extent, appearing to be random in their selection, design, application, and usefulness. Some of these activities were done for the Quality Enhancement department, others for	

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		the Settlement Agreement Coordinator's department.
		
		There were two program auditors at SGSSLC, and both were new to their positions, however, both were experienced at SGSSLC having worked previously home managers. In addition, a QE nurse RN conducted audits. Thus, there was a total of three staff who conducted routine monitoring activities at SGSSLC.
		
		The program auditors engaged in the following activities:
		• Conducted four to five record audits per month. The records chosen for audit were based upon incidents that had occurred for those individuals, such as medical or behavioral incidents.
		• Engaged in follow up activities to incidents and incident management meeting as directed by the Director of Quality Enhancement
		• Conducted reviews of observations notes made by DCPs. These were somewhat randomly chosen.
		• Engaged in follow up to ICFMR surveys, such as participating in ICFMR plans of correction and implementation of action steps.
		• Engaged in medical review activities, such as
		    o four to five medical record audits, including the records of any individuals who had died,
		    o review of medication administration, and
		    o attendance at skin integrity committee meetings.
		
		The auditors had a set of monitoring tools. Some of these tools were developed at other facilities and some by DADS central office. It did not appear that SGSSLC developed any of its own monitoring tools. The tools were not tied to the Settlement Agreement or to the checklist tools used by monitoring team members. The tools and the data collected were not part of a facility-wide organized quality enhancement plan. The tools given to the monitoring team were:
		• Abuse neglect monitoring form, questions for staff, 1 page
		• Unusual incident monitoring form, questions for staff, 1 page
		• Documentation audit for AN concerns or UI that had not been reported, 1 page
		• Program audit, regarding PSP and other documents in record, 6 pages
		• PNMP and nursing audit, 7 pages
		• Environmental checklist, 1 page
		• Meal observation, 2 pages
		• Active record review, 13 pages
		
		One tool was not listed, but was apparently being used because data and results were reported. It was called Individual Observation/Interview Item Analysis and included	

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		observations and recordings of individual's engagement in activities and a reference to CAPs. The data and comments were very appropriate and can be useful to the facility as it addresses individual engagement in activities (see section S below). SGSSLC collected and reported data on a number of areas as was required by DADS' central office. Again, these data were not incorporated in any useful manner or into any type of overall facility QE plan or report. Some of the data were presented to the monitoring team for the period of July 2009 through February 2010. The data on client injuries was accompanied by narrative paragraphs for each incident. These measures are described below. • Unusual incidents: data collected by the Director of Quality Enhancement • Abuse and Neglect: data collected by the Director of Program and Management Support • Injuries: data collected by the Risk Management department • Restraint: data collected by the Director of Quality Enhancement Incident Management Meeting: this was a daily meeting during which senior management reviewed the previous day's incidents, emergency restrictions, restraints, injuries, and aggression between individuals. Although this meeting was not a QE meeting, it might be used by facility administration (in addition to the PIC described in section E2 below) as a way to incorporate QE activities into the daily operation of the facility. <u>Other Comments</u> QE Tools: As SGSSLC develops tools and processes for the QE department, it should consider having the contents of the facility's tools line up with the monitoring team's checklist tools. This would ensure that the activities engaged in by facility managers and staff, and the actions that are monitored by QE staff, are in line with the actions of the monitoring team. The Monitors have discussed this with DADS' central office staff. Of note, however, is that the monitoring team checklist tools are likely to be revised somewhat following the completion of the set of baseline reviews. QE Data: The DADS policy called for "an integrated, reliable and valid data information system that compiles relevant individual and organizational data…" (page 2); the facility to "review and monitor the integrity and validity of the data…" (page 6); and that "data must be tracked to identify trends across, among, within, and/or regarding program areas; living units; work shifts; protections, supports and	

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		services; areas of care; individual staff; and/or individuals receiving services and supports." (page 7). The QE system at SGSSLC was not meeting this requirement. These clear directives from the policy require that the QE department:
		• Ensure validity of the items in each tool (i.e., whether the tools actually measure what it is they are purporting to measure). This requires an examination of the definitions that the auditors used to determine if the item was present.
		    o Experts in each discipline area should be involved in this process, both at the facility level, and at the state level (i.e., central office discipline heads).
		    o Detailed definitions are needed for auditors to determine the presence or absence of the indicator.
		• Ensure the tools are reliable; that is, that there is agreement across auditors, that unintentional bias by auditors is reduced, and that observer drift does not occur (a change, over time, in what is accepted to indicate presence of the indicator).
		
		Committees:
		The policy required a minimal number of operating committees to be in operation at the facility. The policy listed restraint reduction, human rights, health status, incident management, behavior support committee, pharmacy and therapeutics, infection control, and skin integrity. Most of these were in operation (or were soon to be in operation) at SGSSLC.
		
		The policy required a program improvement committee; this was in place at SGSSLC and is described in section E2 below.
		
		Reports:
		The policy also required performance improvement reports. These were to be self-assessments completed on a monthly basis, but there was no evidence of any type of performance improvement report.
		
		Specific SA items:
		The Settlement Agreement, in addition to requiring quality assurance activities for the overall compliance with the agreement, specifically required quality assurance and quality review activities in a number of provisions, including F2g, L3, T1f, and V3. The Director of Quality Enhancement was not aware of the Settlement Agreement detail or of these specific requirements.
		
		Satisfaction:
		A typical outcome measure usually assessed and tracked at facilities, such as	

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		SGSSLC (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 satisfaction across a range of areas, some broad, some very specific. The SGSSLC QE program should include a regularly occurring measurement of these types of satisfaction. Moreover, this was indicated in the policy on page 3, that is, to "...assess individuals satisfaction with services and supports." The monitoring team learned about work done at the facility to recognize exemplary staff performance. It was good to hear about these types of activities and the monitoring team hopes to learn more about this during the next on-site tour. Staff recognition activities can certainly play a role in improving staff satisfaction and the effects might be further assessed by conducting surveys of staff satisfaction. Individual interviews might generate useful information to the facility, as well as identify successes. For example, Individual #92 told the monitoring team about her progress at SGSSLC and her upcoming transition back to the community. She told the monitoring team that, "They've helped me out tremendously. I have my life back again. They helped me out a lot. They really did their job here." The self-advocacy activities of the individuals at SGSSLC can be another way to gauge individual satisfaction and can be part of the QE plan at SGSSLC. The monitoring team had the opportunity to attend the facility's self-advocacy meeting. It was an active and lively meeting, led by the individuals (with guidance from the facility's rights officer), and with much participation from the attendees. Approximately 60 individuals were present and all were attentive (and not disruptive) during the meeting. The rights officer did a nice job of keeping the meeting moving along and guiding the individuals to remain on the agenda. The topics were primarily maintenance and facility operations related, such as lighting, food service, and repairs. These were appropriate topics, important to the individuals, and were ones upon which they've had an impact. In addition, the meeting and discussion set the occasion for other important outcomes, such as individual receiving instruction and practice in group problem solving (e.g., identifying problems, generating possible solutions, considering the advantages and disadvantages of each possible solution, and choosing a solution by a vote) rather than just the identification of problems that were left to the rights officer and other staff to look into or solve. Other topics might include voting, and individual rights versus group rights.	

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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.	This provision item required the facility to analyze the data collected by the QE processes that are implemented at the facility. As indicated above, little analysis of data occurred at SGSSLC and should, therefore, be one of the facility's priorities as it moves forward in developing an active and functional QE system. During the time of the on-site monitoring tour, the facility was not doing anything meaningful with the data collected by program auditors. If anything of importance was noted or found, QE staff apparently notified relevant administrators and managers via an informal process of email or phone calls. Even so, the monitoring team was presented with some information from the Settlement Agreement Coordinator and via the document request submitted prior to the on-site tour. This included: • 1st quarter data: This was a table with numbers in it for some areas that appeared to be related to the Settlement Agreement, such as integrated protections and pharmacy services, but they were not comprehensive, did not align with Settlement Agreement, and did not align with the monitoring team checklist tools. • The forms called Individual observation/interview item analysis. This had many useful comments regarding engagement, but it was unclear as to the definitions used by the observers, and the methodology and frequency of data collection. • Many pages with details from the six-page program audits • Table showing audits conducted done from March 2009 through Jan 2010 for 44 individuals, however, it was not clear as to what was audited for most of the individuals. • Many pages of completed active record reviews (13 pages each). • Many pages of ADSO checklists and environmental checklists. <u>Performance Improvement Council</u> The Performance Improvement Council (PIC) was one component of the analysis of data system as called for by the state policy on Quality Enhancement. Part of the PIC's role is to look at data collected by the QE department. Members of the PIC should review, discuss, and respond to the data via corrective action plans and via other mechanisms that the facility might develop. Notes from PIC meetings were reviewed for the period December 2009 through April 2010 (the PIC did not meet in March, and the April information was the agenda and attachments; the minutes had not yet been prepared). The notes indicated that the PIC committee members reviewed data collected for many of the provisions, based upon the facility's original POI (which was discontinued pending it being updated). April's	

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		attachments included some monthly bar graphs of health related information, such as medication administration errors, pressure ulcers, and polypharmacy. <u>Performance Evaluation Team</u> Performance Evaluation Teams (PET) did not appear to be in place at SGSSLC even though these were required in the DADS policy on Quality Enhancement. Subsequent to the onsite tour, however, the facility indicated that PETs were in place for the individual observation/staff interview, mealtime monitoring, and facility support performance indicators. The monitoring team will review these, and any other, PETs during future onsite tours. <u>Corrective Action Plans</u> There was no organized process for developing, implementing, disseminating, monitoring, documenting, or modifying corrective action plans at SGSSLC. The monitoring team learned that the PIC was beginning to include CAPs. This was evident in the notes from one of the recent meetings that indicated work being done to address pre-treatment sedation. In addition, a CAP tracking form was completed. It listed seven CAPs. All were for nursing-related actions, such as medication administration and treatment of decubitus. This appeared to be tied to activities of the Settlement Agreement Coordinator's department and not integrated with the quality enhancement department.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	See comments above in section E2.	
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.	See comments above in section E2.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	See comments above in section E2.	

Recommendations:

1. Implement state policy on Quality Enhancement.

2. Update facility policies to be in line with newer state policies. If the facility policy is no longer needed, it should be removed from the facility's policy manual. If facility policies are to differ from state policies, provide documentation of approval from the state central office discipline head.

3. Reorganize the manner in which QE activities are conducted at SGSSLC. The work of the QE Director and the SAC should be coordinated, not isolated from each other.

4. Create a facility QE plan that is functional, meaningful, and useful to SGSSLC managers, administrators, and clinicians. The plan also needs to include:
   - all requirements of the DADS policy on Quality Enhancement,
   - a narrative,
   - all of the areas listed on page 4 of the policy, and
   - the Health Care Guidelines

5. Modify and create quality enhancement tools that are in line with the monitoring team's checklist tools. Note, however, that the monitoring team's review tools are likely to be revised following the completion of the baseline reviews at all of the facilities.

6. Ensure reliability of data collected by program auditors.

7. Subject the QE department to quality assurance/enhancement review, feedback, and assessment.

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

9. Ensure self-advocacy groups learn skills of self-advocacy. For example, add a structured problem-solving decision-making component to the self-advocacy group meetings. Utilize these self-advocacy groups as one way of gauging individual satisfaction with services and supports at the facility.

10. Provide program improvement reports as per the policy.

11. Implement CAPs when needed, following all requirements of E2, E3, E4, and E5 above.

12. Develop a QE report that includes a summary of all activities, data, trends, and narrative that describes important points about the data.

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 Personal Support Teams PDP Process Training Curriculum, 9/22/09 o DADS 2009 Your Rights in a State Supported Living Center Booklet o DADS Positive Assessment of Living Skills (PALS) o Training transcripts for four direct care professionals o Human Rights Committee Meeting Summaries 10/29/09 to 3/4/10 o Rights Assessment for Individuals #230, #222, and #21 o Sample of PSPs and corresponding assessments for: • Individual #146 5/26/09 • Individual #243 2/26/10 • Individual #389 2/11/10 • Individual #107 2/25/10 • Individual #396 2/3/10 • Individual #318 2/25/10 • Individual #345 2/16/10 • Individual #390 2/24/10 • Individual #273 3/10/10 • Individual #148 2/17/10 • Individual #26 2/12/10 • Individual #222 2/8/10 <u>Interviews and Meetings Held</u>: o Interview with Charles Njemanze, Assistant Director of Programs o Jalown McCleery, Program and Management Support Director 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 Residence 516 Morning Unit Meeting 5/13/10 o Demonstration of mechanical restraint use o Daily Incident Management Meeting 5/10/10 and 5/13/10 o Annual PST meetings for Individual #146 o Residences 501, 502, 505, 509, 511, 516 o On-campus workshop

	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. The state policy #004 Protections, Services, Treatments, and Supports, dated 2/15/10, was still in draft format. Further, SGSSLC had not yet developed a facility policy to address this section of the Settlement Agreement. A majority of the PSPs reviewed did not include a summary of services and supports that the individual received. PSPs should clearly address all of the supports that an individual will receive, including a description of the residential, day, medical, and 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. More recent PSPs developed at the facility, however, contained objectives that were individualized based on the individual's interests. Though it was not evident that needed supports identified in assessments were incorporated into objectives. There was not a focus on providing supports in the most integrated setting in the PSPs reviewed. Community placement was considered at each PSP meeting, but plans to achieve community integration were not developed with a focus on actual achievement. The cover page of each PSP reviewed that used the new format developed by the state included a list of "what's most important to the person?" and "how is this supported?" These lists tended to be individualized and comprehensive. This information would be a great starting point for the development of individualized outcomes, however, this information was not used to prioritize outcomes for the individual. Outcomes should reflect a plan to provide supports necessary to help each individual achieve his or her individualized vision The plan should describe who will provide and monitor each support, how the support will be provided, and a schedule of when each support will be needed. The overall goal of the plan should be to ensure that each individual develops or maintains skills necessary to participate to the extent possible in daily activities that are meaningful to that individual. All healthcare and behavioral risks should be identified and the team should integrate recommendations from specialists into one comprehensive plan that offers clear guidance to direct care professionals responsible for implementing the plan.

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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 provision had not been developed at the time of this on-site review. SGSSLC did not have facility policies in place addressing the role of Personal Support Teams (PSTs) or the development of Personal Support Plans (PSPs). 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 based on the preferences and vision of the individual.	
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 whose responsibilities included keeping the group focused on an agenda and making sure all sections of the PSP were addressed. QMRPs were also responsible for obtaining assessments, coordinating, and monitoring services for the 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's understanding was that DADS was in the process of revising the state policy regarding Person Directed Planning. The monitoring team will review the implementation of these new policies and procedures during the next on-site monitoring visit.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The monitoring team observed an annual PST meeting for individual #146. The individual was present at her meeting, but her LAR was not in attendance. Others in attendance included her QMRP, Home Manager, Psychologist, RN Case Manager, and MRA. PNM staff was not present at the meeting, though she had a mealtime and positioning plan in place to prevent aspiration, a communication plan, and required positioning in her wheelchair. Additionally, there was no discussion at the meeting regarding her mobility, positioning, and how she transferred. Staff who provided direct support to the individual were present the meeting and given the opportunity to contribute to discussion. Additionally, the following was found in regards to the absence of important team member participation in PSTs: • For Individual #389, there were no Direct Care Professionals or any PNM staff present at the meeting, though he had complex physical, nutritional, and communication needs. • Individual #345 had a Physical and Nutritional Management plan in place to address diet and mobility. There was no PNM staff in attendance at her PST meeting.	

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		• Individual #390 had numerous health care, nutritional, and mobility needs. There was no nursing or PNM staff in attendance at his PST meeting. It was evident from a review of PSPs that documentation from a variety of relevant disciplines was reviewed in preparation of the annual PSP meeting. Additional review of this item will occur during future monitoring visits.	
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.	A wide range of assessments were performed prior to PSP development. It was not, however, evident that these assessments were used to address barriers to each person achieving his or her individualized vision. PALS was the functional skills assessment tool used by the facility and specifically named in the state policy. While this assessment offered a basic checklist of functional skills, it did not include a means of prioritizing skills based on each person's individual preferences. This resulted in generic outcome development rather than individualized outcomes for each person. Additional assessments were completed for each person by specialist and clinicians. Recommendations from these assessments were included in isolated plans rather than being integrated into a comprehensive plan for providing support to each individual throughout his or her day. At the PST meeting observed during the monitoring visit, communication and mobility needs were priorities for the individual. Even so, there was no evidence that the individual's communication and mobility needs had been addressed adequately for planning by the team for integration into the PSP. Assessments were not always in place or updated prior to annual PST meetings. For example: • Nutrition and communication supports were a priority for Individual #389. His PST stated that his annual SLP evaluation was pending. • Individual #107 indicated that he was interested in community employment. There was no indication that a comprehensive vocational assessment had been completed for the team to use in planning. • There was no indication that Individual #390 had a recent neurological evaluation though he was treated in the emergency room on 2/13/10 after "having an hour and a half long seizure episode" after which he became nonresponsive and was taken to the emergency room. • Individual #273 had significant health care and therapy needs. No nursing or therapy staff were in attendance at her annual PSP meeting. 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. Information from assessments should be	

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		included in the PSP body and used to develop supports based on the individual's preferences and needs. 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 the protections, services, and supports to be provided to the individual.	It was not evident that assessment results were used to develop, implement, or revise PSP supports. The PSP included information from specific disciplines in isolated sections of the PSP, rather than integrating assessment information into one plan that staff could use to support the individual. A narrative section in the PSP describing the individual, his or her preferences, how he or she spends the day, and what supports are needed throughout the day may help the team see how services should be integrated into a lifestyle rather than looking at supports from each discipline as isolated interventions. • For individual #146, a speech and language assessment referred to consultation for AAC needs. During her annual PST, the team did not address assistive communication devices or how they might be used to support her communication needs even though the team acknowledged that communication was a barrier for her. • Individual #146 had specific mobility needs that would require support throughout her day. There was no discussion at her PST meeting or in her PSP of what supports she needed to move about including positioning and transferring. The PSP for Individual #222 did contain a brief description of how he liked to spend his day and how his preferences were supported. Hopefully, QMRPs will begin to develop plans that provide a better picture of how the individual prefers to spend his or her day and integrate services into a routine that reflects each individual's specific preferences. PSPs reviewed generally did not address communication needs for the individual. Any indentified communication supports needed should be integrated throughout the PSP. For example, Individual #389's SLP evaluation included a recommendation for augmentative and/or alternative communication strategies. His PSP did not address this recommendation. When comprehensive policies are in place to address PSP development, the facility needs to be sure that QMRPs receive updated training on developing plans. Quality enhancement staff should continue to monitor plan development and provide assistance and training as needed.	
F1e	Develop each ISP in accordance	Community placement was discussed at the PST meeting observed. There was a brief	

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	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).	discussion of supports that would be needed in the community and a visit was scheduled to a community home for the following month. It was not evident that the team had made community placement a priority for this individual, since she had lived at the facility since 1980 and a visit to a community home had not taken place prior to the annual PST meeting. All PSPs reviewed included a discussion of community placement and supports that would be needed if services were provided in the community. Individuals and their LARs were provided with information regarding community placement. Although all of the PSPs reviewed including a Community Living section, this section offered little indication that community living was a priority for individuals. Most PSPs just listed barriers to living in the community without real consideration for movement into the community. PSPs for Individuals #389, #390, and #345 stated that if moved into the community, he or she would "experience the loss of familiar staff and surroundings in exchange for the same type of environment with nothing more to offer." This statement reflects the need for PSTs to receive additional training on community placement and how placement could benefit individuals currently residing in the facility. All of these individuals were without guardians and unable to make informed decisions according to their PSPs, thus, team members were currently their only advocates. There is concern that without an active advocate and team members that feel current placement is the most appropriate placement, the individual will never be considered for placement in a less restrictive environment. Very few PSPs included a description of the individual's current day program. There was, generally, no consideration of community-based day programs, community participation, or supported employment by the team. Although, trips were planned into 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. Community outings focused on specific activities in the community rather than supporting the person to build relationships and become an integrated part of the community. Observation at the sheltered workshops 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 limited vocational program that offered individuals a chance to work on contract work in a segregated setting. There was no evidence that employment was a priority or even a focus of PSTs at the facility. A rights assessment was completed for each individual by the PST and any restrictions of rights for an individual were reviewed by the PST and Human Rights Committee.	

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F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:	This provision will be reviewed in greater detail by the monitoring team following the implementation of 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. It was found that outcomes for most PSPs reviewed were based on this list of preferences for each individual. The PSPs that were 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 attendance at specific events rather than integration into the community. Opportunities for community integration should be addressed at the facility and 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 most integrated setting appropriate to his/her needs;	Most outcomes did not contain enough information to be observable and measurable, and plans were not consistent in addressing supports needed to achieve outcomes. This will be reviewed further in upcoming monitoring visits. For example: • Individual #26 had the outcome, "Remove obstacles to support her to be able to successfully move to a situation in the community." It was not stated what specific obstacles would have to be overcome for her to successfully complete this outcome. There was not a list of supports that staff would need to provide to facilitate achievement of the outcome. Furthermore, instead of looking at obstacles that she may need to overcome, the team should look at what supports she may need in the community and how they could be provided to her so that she could move into the community with appropriate support. • Individual #273 had an outcome that just stated "work." There was one action step listed under this outcome to "continue to participate in the workshop."	

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		There were no additional guidelines to let staff know what level of participation would be considered successful or what supports were needed to accomplish this goal. • Individual #148 had the outcome, "Daily Skills for Independent Living." There were eight areas of functional skills listed in the action steps including helping staff, social skills, money management, and reading. Again, there was not enough specific information in the action steps to guide staff in supporting her to achieve this outcome.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	As noted above, supports identified for individuals were not integrated into plans. The facility needs to put into place specific procedures for developing PSPs that integrate all protections, services, and supports that the individual 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 also a description of how and when those supports will be implemented and monitored.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	PSPs reviewed did not include methods for implementation. Most PSPs specified the person responsible for implementation by discipline. Action plans had a column for identifying when implementation would take place, but interpretation of the purpose of this column varied throughout the PSPs reviewed and sometimes within an individual's PSP. For example, for Individual #273, some action steps specified when the action step should be implemented (e.g., daily, quarterly), some action steps noted ongoing, and others gave a projected completion date. Additional training should be provided to staff responsible for writing outcomes and action steps so that the plan directs support staff in consistently carrying out the plan.	
	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	Outcomes and action steps did not include specific interventions, strategies, and supports individuals might have needed to achieve outcomes. See section F.2.a.2 above.	
	6. Identifies the data to be collected and/or documentation to be maintained and the	Most 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. Plans should specify the data that staff will record for each action step. Data collection	

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	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.	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 full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The facility did not have a process to ensure coordination of all components of the PSP.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The PSPs did not provide clear information that would guide direct care staff in providing necessary supports.	
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	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 professionals responsible for implementation, oversight, and monitoring by plan developers. A larger sample of implementation data will be reviewed during upcoming monitoring visits and additional comments will be made regarding the monitoring and updating of PSPs.	

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	ISP needs to be modified, and shall modify the ISP, as appropriate.		
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	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. 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 or modified. This provision of the Settlement Agreement will continue to be reviewed in upcoming 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.	A sample of new admissions was not reviewed during this on-site baseline visit. All PSPs in the sample were revised annually. One individual was admitted to the facility on 1/27/10 and her PSP was developed on 2/26/10. A sample will be reviewed for compliance with this provision during future monitoring visits.	

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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. 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. PSPs should include a description of all supports that the individual will receive, including a description of residential, day, medical, psychiatry, and 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 to support participation. The PSP should be a genuine team effort with vigorous discussion amongst the members, not simply a report of a templated plan. In this way, each individual can benefit from an approach to treatment that is fully integrated, not simply a paper exercise.

2. PSP should specify the data that staff will record for each action step. Data collection should indicate the individual's level of participation, and supports needed, and describe the individual's response to the activity. Further, individualize treatment plans and specifically behavioral plans and integrate this with psychiatry.

3. Conduct comprehensive assessments that identify the individual's preferences, strengths, and supports needed. Update the diagnoses as the treatment plan changes them.

4. 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.

5. Ensure that requests for moves are followed up on in a timely manner and community tours are scheduled when recommended by the PST.

6. Focus on developing PSPs that address community integration that is meaningful for each individual based on his or her preferences, interests, and supports needed.

7. Provide training to staff responsible for writing outcomes and action steps on developing plans that give clear direction to all staff implementing the plan.

8. Provide training to team members on community placement so that they can support individuals in decision making in regards to community living options.

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:** • Meeting with Philip Baugh, Ph.D., Facility Director • Meetings and discussion with Dr. Becky McKown, M.D., medical director • Meeting with three unit directors, Melinda Gentry, Cedric Woodruff, Vicki Hinojos • Meetings with lead psychologist, Jason Dunham, Ph.D. • General discussions held with facility and department management, and with 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. • Definitions of high, medium, and low risk for nursing and for psychology, dated 1/6/10 • Review of SGSSLC Plan of Improvement, 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. The importance of the provision of integrated services was acknowledged by facility management and clinicians. Moreover, there was an interest and desire to have this occur. Discussions with senior clinicians indicated a good working relationship between the medical, psychiatric, and rehabilitation departments. Discussion also indicated good working relationships within the psychology department. There was a desire for the psychology department to be more integrated and communicative with the medical and psychiatric departments. The facility had not identified a lead manager for this provision of the Settlement Agreement. Clinicians across the facility were not familiar with this provision.

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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	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.	

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	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 number of discussions with the facility director, medical director, chief nurse executive, lead psychologist, and unit directors, as well as with staff at various levels of management, within clinical services, and at the direct care level indicated that meaningful integration of clinical services was not evident throughout the facility. Clinical staff were not aware of the components of this provision of the Settlement Agreement and no one was assigned lead responsibility for this provision. It appeared that the facility was awaiting direction from the state office regarding this provision. There were significant lapses in the facility's efforts to provide integrated clinical services. For example, the prescribers did not share information with each other at times regarding the initiation of a new medication; the psychiatrists were essentially not in dialogue with the psychologists for the dual diagnosis clinical programming; both the PCPs and the psychiatrists praised the nursing line staff, but strove for better communication with nursing services; and psychiatry and medicine were not being optimally utilized by the administration for consultation about systems of care and problem solving regarding highly complex cases. Even so, 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. Achieving integration will be a facility-wide process, that is, it will require that all departments and all levels of staff participate. The facility director had more than 30 years experience at SGSSLC and acknowledged that facility senior management was well aware of the need to put more integrated processes into place. The need for better integration and communication was exemplified during one set of discussions at SGSSLC. The psychology department was trying to deal with a potential obstacle to clinical treatment. According to the lead psychologist, best practice in many treatment programs requires an acknowledgement of wrongdoing by the participant. This, however, was seen as potentially setting the stage for self-incrimination, especially for those individuals whose cases were pending or who had not been charged. This serious treatment issue, however, had not been brought to the attention of the facility director or the facility's attorney. Although the issue was not fully resolved during the on-site tour, conversation occurred during the week of the on-site tour regarding working towards an appropriate solution. Also, various clinicians expressed desire to learn more about the psychology department's treatment programs (e.g., STACS, STEPP) and to have psychology	

#	Provision	Assessment of Status	Compliance
		department leadership more available for meetings, discussions, and problem solving activities, when needed. Even though work will be needed, SGSSLC was not without collaborative work. • The beginnings of clinical integration were apparent in the psychiatry clinic where the psychiatrists and psychologists worked together to attempt to reduce individuals' problem behaviors. This integration, however, was limited by the insensitive data system used by the psychology department (see section K4 below). • The medical director made herself extremely available to her staff and others who needed her at the facility. • The medical director described an excellent working relationship between the physicians and psychiatrists and their equal access and standing at the facility. • The rehabilitation department was seen as helpful, available, and responsive. Examples were given of assisting with obtaining of mobility devices for a number of individuals (e.g., Individual #318). • Nursing staff participated in numerous meetings and served on numerous committees, such as the Personal Support Team Meeting, Health Status Team Meeting, Nutritional Management Team, Transition Meetings, Incident Management Meetings, Psychiatric Medication Reviews, Infection Control Committee, Medication Error Committee, Pharmacy and Therapeutic Committee, and Safety Committee. A number of other activities were occurring at SGSSLC that related to integration of services. • The Health Status Team met every week. Each meeting focused on one home and every home was reviewed two to three times per year. Staff from a variety of disciplines attended this meeting, led by the medical director. Details of the meeting are discussed elsewhere in this report (e.g., sections I). • Any medical or clinical related concerns of direct care professionals were to be brought to the attention of the nurse and the nurse was then responsible for taking that information forward (e.g., injury, medication). • A morning meeting was held at each unit and recent incidents and changes in medical and healthcare status were discussed. • Various notes were kept by clinicians and other staff. Integrated progress notes were used by clinical staff. Another set of notes was kept by the direct care professionals and was called "observation notes." These were running comments describing general and specific information about the individual's day. There was also a home shift log, and a nursing shift report.	

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		The combination of all of these notes, recording systems, and meetings can contribute to an integrated system of clinical supports. A goal for the facility was to ensure that all disciplines could attend and participate in the annual PSP meeting.	
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. 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. At SGSSLC, the PCPs routinely and reliably reviewed the findings and recommendations from the neurologist. The documentation of this review sometimes consisted solely of initialing a consultation note to signify that they had seen it. The monitoring team will review documentation at the next on-site visit to establish whether there is adequate documentation regarding disposition of the recommendations of non-facility clinician	

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. There was a need to do more integrated assessments, particularly in the area of risk assessment (see section I).

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:** • Meeting with Philip Baugh, Ph.D., Facility Director • Meetings and discussion with Dr. Becky McKown, M.D., medical director • Meeting with three unit directors, Melinda Gentry, Cedric Woodruff, Vicki Hinojos • Meetings with lead psychologist, Jason Dunham, Ph.D. • General discussions held with facility and department management, and with 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. • Observation of PSP Meeting 5/11/10 • Review of SGSSLC Plan of Improvement, August 2009 • Review of Active Record of Individual #146 • Review of the Nursing Department's Nursing positions and staffing patterns • Review of SGSSLC Health Risk Assessment Policy, Procedure, and Assessment Tools
	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 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) great confusion as to who was responsible for each component and the monitoring of each component of this provision, 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	A plan was not in place to address this item.	

#	Provision	Assessment of Status	Compliance
	full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Facility senior medical administrators noted that assessments were addressed via a nursing policy for assessments, Health Status team, PSP meetings, and PSPA meetings. Although these forums and processes may set the occasion for assessments to occur and be reviewed, an overall system of managing assessments at SGSSLC was still in need of development. For instance, there were several examples of clinical practices at the facility that were not consistent with generally accepted professional standards of care. These included the absence of psychological evaluations (see section K6) and ineffective functional assessments (see section K5) as defined in the Settlement Agreement.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	The medical director noted that ICD-9 diagnoses were used by physicians and ICD-9 and DSM diagnoses were used by psychiatrists. DSM diagnoses were used by psychologists.	
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.	Provision of timely and appropriate treatments and interventions is often a function of available skilled professional staffing. The medical director described the facility's historical difficulty in obtaining and maintaining a medical staff. She noted, however, that at this point in time, the facility had obtained a medical staff with a broad range of expertise and experience, including an internist, hematologist, pathologist, and pulmonologist. Together, the staff were able to do chart reviews and quarterly summaries more regularly than in the past. The staffing equaled 2.5 FTEs. In the medical records reviewed, and in the clinics attended by the monitor team, interventions were most often both timely and clinically appropriate. As described in section J, however, the care of Individual #95 was not appropriate to the assessment in that he remained in a locked unit for a significant period of time when the clinical circumstance did not appear to warrant it. Facility management should examine the need for a nurse practitioner to be added to the medical staff team. This may be necessary if SGSSLC is to work further towards medical	

#	Provision	Assessment of Status	Compliance
		staff attendance and participation in more integrated activities, such as attending PST, PSP, and PSP addendum meetings. Observation of the nursing department indicated that SGSSLC did not have adequate nursing staffing to provide 24 hours a day, seven days a week, nursing service to meet individual health and safety needs. This was particularly evident in residences 508, 510, and 516 East where individuals with increasingly complex health care needs lived. As a result, when an individual's health status declined to the degree that he or she required nursing care 24 hours a day, seven days a week, the individual was transferred to 516 McKnight West, the only unit that had this level of nursing coverage. In psychology, 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). For example, PBSPs were not consistent with current ABA standards, and skill acquisition plans were incomplete (see section S1).	
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 across all disciplines.	
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. The Health Status Team was operating and reviewing each individual every six months, but, as noted elsewhere in this report, the HST did not look at all aspects of health (it looked primarily at risk) and was reported by some clinical staff to be an onerous task without tremendous clinical merit. Further, SGSSLC's Integrated Progress Notes were separated into Medical and Program sections, greatly reducing the integrated nature of these records and notes.	
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 and without clinical indicators identified (see H4 above), treatments and interventions cannot be modified in response to clinical indicators. The facility referred to the HST as the way health status was monitored at SGSSLC. See comments above in section H5.	

#	Provision	Assessment of Status	Compliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	Policies, procedures, and guidelines were not in place regarding Section H. Facility management also acknowledged that this provision item was not yet being addressed.	

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 an electronic medical record; this may be an effective way to implement clinical indicators and provide for accurate tracking.
4. Facility management, in collaboration with the Chief Nurse Executive needs to critically evaluate the need for providing nursing coverage 24 hours, seven days a week in residential living units 508, 510, and 516 East.

<table>
<tr><th>SECTION I: At-Risk Individuals</th><th></th></tr>
<tr><td>Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o DADS Policy #006: At Risk Individuals
o SGSSLC Policy: Health Status Team Rating Guidelines 2/25/09
o DADS Health Status Team Training Curriculum March 2010
o DADS Risk Assessment Tools, dated 8/31/09
o HST Meeting Notes from 5/12/10
o SGSSLC Log of individuals diagnosed with pneumonia 3/29/09 to 3/29/10
SGSSLC Log of ER visits 3/1/09-3/25/10
o SGSSLC Log of Hospitalizations 3/1/09 to 3/31/10
o List of all injuries by individual since 7/09
o List of 10 individuals with the most injuries
o List of 10 individuals causing the most injuries to peers since 7/1/09
o List of Individuals requiring mealtime assistance
o List of individuals with poor dental status
o List of individuals with G-tubes
o List of individuals with diagnosis of pica
o List of individuals requiring sutures/Dermabond since 7/09
o List of individuals with fractures since 7/09
o List of individuals with unauthorized departures since 7/09
o List of incidents involving individuals with one-to-one or enhanced staffing ratios
o List of individuals rated high or moderate risk in the following areas:
• Aspiration
• Pneumonia
• Chronic Respiratory Infections
• Contractures
• GERD
• Choking
• Dysphagia
• Weight
• Causing Harm to Self or Others
• Pica
• Metabolic Syndrome
• Seizures
• Dehydration
• Osteoporosis/Osteopenia
• Skin Integrity
• Non-Ambulatory/Assisted Ambulation</td></tr>
</table>

	- Constipation/Bowel Obstruction/Impaction - Falls - Cardiac - Urinary Tract Infection - GI Concerns - Polypharmacy - Hypothermia - Medical Concerns - Injury - Diabetes - Respiratory o Sample of PSPs listed in section F of this report o Active Records for: - Individual #214, Individual #215, Individual #69, Individual #59, Individual #127, Individual #301, Individual #346, Individual #102, Individual #25, Individual #78, Individual #385, Individual #281, Individual #247, Individual #94, Individual #146, Individual #222, Individual #122, Individual #124, Individual #203, Individual #112, Individual #137, Individual #40, and Individual #60 Interviews and Meetings Held: o Informal interviews with various direct care professionals, QMRPs, nursing staff, and psychology support staff in homes and day programs throughout campus Observations Conducted: o Residence 516 Morning Unit Meeting 5/13/10 o Demonstration of mechanical restraint use o Daily Incident Management Meeting 5/10/10 and 5/13/10 o Annual PST meetings for Individual #146 o Residences 501, 502, 505, 509, 511, 516 o On-campus workshop
	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. Additionally, the state had developed standardized forms to assess health risks, challenging behaviors, injuries, and polypharmacy. The facility had developed additional guidelines in a policy titled Health Status Team Rating Guidelines, dated 2/25/10. These guidelines were an attempt to further define

	what criteria would be used to categorize each risk level. Risk statements in PSPs were general and often conflicted with information included in the PSP by specific disciplines. 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. The monitoring team recommends that the facility clarify the purpose of the identification of at-risk individuals. There was consensus among staff at the facility that contributing factors to challenging behaviors at the facility were low staffing ratios and grouping of individuals with challenging behaviors. The facility did not have a plan in place to address any of these factors. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The state policy 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. The HST had developed a list of individuals at high risk in each of the following categories: aspiration, choking, weight, cardiac, constipation, dehydration, diabetes, hypothermia, GI concerns, medical concerns, injury, osteoporosis, seizures, skin integrity, urinary tract infections, challenging behaviors, polypharmacy and respiratory. Determining risk levels was 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. As also noted in section M of this report, the monitoring team attended the Health Status Team (HST) Meeting held during the week of the on-site tour. David Ann Knight, RN, MSN, HST Coordinator, Chaired the meeting. Membership was comprised of all clinical disciplines. The meeting was well attended, coordinated, and ran efficiently. Each discipline presented Health Risk Assessment Ratings for 12 individuals. The HST reviewed and discussed recommendations for each risk category. There was active discussion and leadership from the medical director. Even so, findings of the HST did not appear to be discussed or utilized by the PST. PSPs reviewed addressed risk factors, but did not reference specific risk assessments or HST findings. Logs of individuals at moderate or high risk in specific areas were provided to	

#	Provision	Assessment of Status	Compliance
		the monitoring team prior to the review week, but these logs were not consistent with information contained in PSPs or Health Status Team (HST) findings. Please see section M5 and section O2 of this report for details regarding the monitoring team's review of assessment of the facility's processes for health risk assessment.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The 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 be assigned cautiously to ensure proactive measures are taken to monitor each individual's health and safety. Some examples of inconsistencies in risk scores and actual risk factors for individuals are provided below. • Individual #50 had a diagnosis of pica and incidents were documented on 2/19/10, 2/26/10, and 3/11/10 involving her ingesting cigarette butts, but she was not on the high risk list for pica provided to the monitoring team. • Individual #137 had a diagnosis of pica and was taken to the emergency room after ingesting a powder and a chemical cleaner on 1/30/10. • Individual #146's PSP indicated she was at high risk for constipation and skin breakdown. According to the HST meeting notes from 5/12/10, the committee	

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		assigned a moderate risk rating for constipation and skin breakdown, but she was not included on the list of individuals at risk for constipation or skin breakdown even though these were not recent findings. • Individual #389's PSP indicated that he was at moderate risk for aspiration and was on a modified diet to prevent choking, though he was listed as low risk for aspiration on the log provided to the monitoring team. • Individual #396 was rated as low risk in challenging behaviors, though his PSP notes that community placement is not an option for him now due to challenging behaviors. • Individual #390 was not included on the risk list for aspiration or seizures provided to the monitoring team, though his PSP indicated moderate risk for both aspiration and seizures.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The policy established a procedure for developing plans to minimize risks and monitoring of those plans by the PST. The PSPs that were reviewed included limited strategies to address identified risks, but again, not all risks were identified as a risk for each individual. Throughout the on-site monitoring visit, direct care professionals were asked questions by the monitoring team about risks for individuals whom they supported. Staff at SGSSLC could generally list risks for individuals whom they were assigned to provide support to on a regular basis. They were also aware of crisis indicators to monitor for those individuals. An area of concern though, was that staff were routinely pulled to work in homes where they had not received individual specific training to work with those individuals. Several incidents were reviewed that were a direct result of staff not being trained to provide adequate supports to individuals because they did not routinely work at the home they were assigned to at the time of the incident. Direct care professional staff need to be able to identify risk factors for each individual whom they support and know signs of crisis so that they can seek help when necessary. They need to be able to provide support in a manner that will minimize risk to individuals.	

Recommendations:

1. 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. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria in order to determine risk, to eliminate subjectivity, and to ensure that the tool meets accepted professional standards of care as defined in the Settlement Agreement.

2. Risk information should be coordinated between the HST and the PST. Risk levels should be consistent and accurate and reviewed by both

groups when risk factors change.

3. The HST needs to evaluate the Health Risk Screening Tools for inconsistencies between the aspiration and aspiration pneumonia risk screening tools to ensure that individuals' risks for aspiration are accurate.

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 on any given day.

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.

6. Facility management teams need to look at trends around challenging behaviors and address known contributing factors in a plan of correction.

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 psychiatrists, Dr. James Sikes and Dr. William Bazzell and o Curriculum vitae of Clinical Nurse Specialist, Pamela Tanner o SGSSLC Policy/Procedure for Prescribing Psychoactive Medications o SGSSLC Policy/Procedure for Dental and Medical Pre-treatment sedation o Job Description of Psychiatrists o Documentation of CME activities for Psychiatrists from 1/09 through 12/09 o Copy of Materials from an inservice on pharmacotherapy given to staff by Dr. James Sikes in February 2010 o Calendar of Psychiatric Providers, 90 Day Combined Review Form o Notes from Dr. James Sikes' supervision meetings with Ms. Pamela Tanner o Internal Audit Reports/Observation of Psychiatric Consultations, 3/10 through 5/10, o Document: Dual Diagnosis Supports at San Angelo State School o Initial Comprehensive Psychiatric Evaluations for Individual #81, Individual #96, Individual #290, Individual #359, and Individual #381 o Three months span of Psychiatric Interim and 90 Day Review notes for Individual #68, Individual #132, Individual #150, Individual #250, and Individual #301 o February 2010 list of individuals meeting criteria for receiving polypharmacy as defined in the Settlement Agreement o List as of 3/31/10 of individuals meeting diagnostic criteria for tardive dyskinesia o Desensitization Programs for Individual #7, Individual #9, Individual #18, Individual #216, Individual #232, Individual #235, Individual #236, Individual #274, and Individual #312 o All documents that were part of the investigation of the death on 5/10/09 of an individual <u>Interviews and Meetings Held</u>: o Dr. James Sikes (meetings and interviews) o Dr. William Bazzell o Pamela Tanner o Jason Dunham, Ph.D., Clinical Director of the Dual Diagnosis program <u>Observations Conducted</u>: o Dr. Sikes' clinic o Dr. Bazzell's clinic o Pamela Tanner's clinic o Medical/Psychiatry/Pharmacy meeting o Difficult case meeting—Medical/Psychiatry o Supervision of Ms. Pamela Tanner by Dr. James Sikes

	- All residences and day activity sites at least once during the on-site tour - Dual Diagnosis group and site visit
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The staffing of the psychiatric service department was recently augmented, going from one FTE psychiatrist, to the current status of two FTE psychiatrists, one FTE APN, and one FTE psychiatric assistant. As detailed below, this has resulted in Dr. Sikes having adequate time to engage in multiple quality improvement initiatives consistent with expectations in the Settlement Agreement. Drs. Sikes and Bazzell and Ms. Tanner 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. Dr. Sikes, who had been at the facility since January 2006, has been promoting evidence-based prescribing practice since his arrival. In the first month of his employ, he reviewed all cases receiving psychotropic agents in order to establish the scope of polypharmacy at SGSSLC. He documented in 11/07 his efforts to eliminate the use of medications "for which data-based efficacy has not been demonstrated," referencing this effort as being guided by DADS policy. By 11/07, SGSSLC had 196 individuals on psychoactive medication (down from 240 in 1/07). By 3/09, the number was 178. It was evident that Dr. Sikes remained focused on the goal of using psychotropics only when the evidence base supported it, and only at the lowest doses needed to attain optimal therapeutic effect. He indicated that this was an explicit focus in the weekly psychiatry department and supervision meetings. Dr. Sikes also made efforts to improve coordination across disciplines. Two months prior to the monitoring team's site visit, he initiated a change from each discipline documenting its respective 90 day assessments separately to, instead, using a combined assessment and case formulation form, that required the signature of both psychiatry and psychology. This likely increased the conveyance of relevant clinical information among disciplines. Nonetheless, there were multiple compromises in professional standards of care. For example, the prescribers of psychotropic agents were generally not involved in directly obtaining informed consent from guardians. This fell instead to the QMRPs. In addition, in psychiatric clinics, target behaviors were generally presented as an aggregate for the month, and were not presented in graphic form. Phase lines were generally not utilized.

	SGSSLC had been pervasively underutilizing medical and psychiatric expertise, which had manifested in many instances of missed opportunity and bad outcome. Psychiatry had little contact with the STACS program. This was true in both the conceiving of the service and in dialoging about the service provision for individuals. The absence of DBT as a therapeutic modality for the dually diagnosed was a glaring omission; Dr. Sikes indicated that for more than a year, he had been recommending it be added to the service. Dr. Sikes described his efforts to get an individual transferred to an inpatient setting. He thought that she was presenting with escalating aggression, and that she had become an imminent danger to others. He was told that the state psychiatric hospital did not have a bed, and he asked the facility director to request DADS central office to facilitate placement. To his knowledge, DADS did not do so, and he was told to seek hospitalization at a private facility. Having been turned down by every private facility, the individual then, from Dr. Sikes' point of view, acted as a ringleader in the initiation of an aggressive episode that involved participation by a number of other individuals and in which a number of staff and individuals were injured and, moreover, during which another individual committed suicide. Three days after the suicide, regulators from the state came to investigate. While there, they saw the individual described as initiating the incident, who was still out of control. Shortly thereafter the DADS central office was able to intervene, resulting in the transfer of the individual to a state psychiatric hospital. Dr. Sikes estimated that there had been many transfers to the state psychiatric hospitals over the past years. He thought that many of these might have been averted if psychiatry had been engaged earlier in circumstances where an individual was experiencing deteriorating mental status. He also indicated that there was no standing mechanism (most pertinently, no regularly scheduled meeting) for psychiatry to provide input to administration. Leaving the communication to an "as-needed" status skewed the content toward reactive management of crises rather than planned quality improvement.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Sikes was board certified in adult psychiatry. He had worked as a staff psychiatrist in state hospital settings for 10 years, and as a psychiatric consultant to correctional settings for 10 years. Dr. Bazzell was board eligible in adult psychiatry. He had worked in San Angelo as an outpatient psychiatrist for 19 years. For several years, he was the psychiatrist for individuals with mental retardation, autism, and other disabilities living in group homes. Working in a state hospital, Dr. Bazzell also had experience supervising a team for the treatment of a population with developmental disabilities. Ms. Tanner was licensed as a Psychiatric Mental Health Clinical Nurse Specialist with	

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		Prescriptive Authority. She had eight years of prior experience in mental health nursing in state hospitals. Drs. Sikes and Bazzell and Ms. Tanner had training and experience commensurate with capably performing their duties.	
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.	The prescribers generally demonstrated good clinical judgment when interviewed about clinical circumstances and when observed in their respective clinics. The documentation reviewed was also consistent with the contents of this provision of the Settlement Agreement, that is, based on the records reviewed, the individuals were diagnosed and evaluated in a clinically justifiable manner. For example, the comprehensive psychiatric evaluation for individual #381 included: • a detailed review of history of prior hospitalizations and their context, • prior medication trials to the extent the old records were available, • an explicit comment on the absence of a prior trial of a likely agent, • evidence of careful review of medication history, • a detailed family history, • good attention to medical history, • a thorough mental status exam, • a well-reasoned multi-axial diagnosis, and • a coherent formulation and discussion of rationale for chosen treatment approach. Further, the psychiatrist also documented his consideration of TIMA, the Texas Implementation of Medication Algorithms, when rendering his treatment recommendations. In the comprehensive psychiatric evaluation for individual #359, the psychiatrist demonstrated his commitment to making treatment decisions from as solid a base of data as possible: "I am asking her team to obtain additional records for the purpose of a more detailed evaluation and for any carefully recorded mental status exams that would clarify her diagnostic history." He went on to describe his intention to wean medication so as to get her on monotherapy as compared to the four agents she was receiving at time of admission. There were, however, no comprehensive psychiatric assessments available for review that were done by Dr. Bazzell, nor by Ms. Tanner, because Dr. Sikes was the psychiatrist for the homes into which all new admissions occurred and, therefore, he was the only one who had conducted admissions to date.	

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		Regarding peer review, Dr. Sikes kept a running record of cases discussed in their weekly psychiatry staff meetings. Ms. Tanner kept a log of her weekly supervision meetings with Dr. Sikes. One vulnerability in the peer review process was that Dr. Sikes reviewed his own prescribing practice biannually. This could potentially be remedied with the addition of a psychiatry peer review system, or a medical peer review system.	
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.	There was no explicit evidence of usage of medication in any way that was in conflict with the content of this provision of the Settlement Agreement. The data available to the monitoring team pertinent to this question included prescribers' narrative description of care during interviews, observation of prescribers' clinics, record review, and observation of individuals throughout the SGSSLC campus. Nonetheless, unless the facility were to adopt a practice of tracking data about target behaviors in a line graph format that showed daily variance, and with phase lines also graphed to represent occurrences or introduction of variables that might bear on the target behaviors (e.g., medication changes), it will remain difficult to definitively establish that medication is never being used as a substitute for a treatment program or for the convenience of staff. In the case of Individual #68, for example, he had apparently refused to take his lithium eight times in 9/09, and once in 10/09. The psychiatrist described him in his 12/10/09 90 day review note as having been "much more aggressive, hitting and grabbing staff members" when he had refused lithium. The 9/09 tally for physical aggression, however, was one episode, and the October tally was two episodes. Both of these totals were not substantially any different than the prior nine months. The psychiatrist went on to note that, "no major issues have been noted since Lithium was restarted." The tally for 11/09, however, was one episode, essentially no different than the prior two months. In an interim review note on 1/26/10, the psychiatrist noted, "he is beginning to grab at people again." The 12/09 tally was zero episodes. Further, the psychiatrist noted that, "in January, he has been grabbing at people again." A data tally for January (1/10) was not noted in the review note indicating that data may not have been presented to the psychiatrist. Instead, staff verbal reports may have been presented. There were several problems with this process: • The available data did not bear out the assertion that he had more frequent aggression when he was not complying with lithium, nor that the aggression decreased in frequency when the lithium was re-initiated; • It was possible that the individual did have more frequent aggressive episodes	

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		when noncompliant with lithium, and that the increased frequency was not tracked because the episodes did not quite meet the definition of the behavior as established on the PBSP. If this were the case, the notes should have explicitly stated that, and there should have been documentation of a discussion about changing the definition of the behavior so that it could be tracked; • Throughout the notes referenced here, there was no discussion of whether there were any variables that might have been affecting the frequency of the individual's aggressive behavior, other than medication, such as recent changes to the behavior support plan, changes in the individual's home or employment situation, or recent illnesses; and • There was similarly no reference to consideration of a change in the PBSP that might address the observed change in frequency of aggression. One other area of concern was the lack of integration of psychiatry and the nursing services department. For example, psychiatry indicated that they had repeatedly encouraged nurse administrators to attend psychiatry meetings and medical team meetings in order to promote integration of care, communication, and coordinated service. This happened once only, which was inadequate to serve the goals noted above. A good working relationship between psychiatry and nursing is an important condition for both case-based discussion and quality improvement. The monitoring team recommends that facility management explore this further.	
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 interview, Dr. Sikes indicated that psychiatry was, for the most part, not involved in pre-treatment sedation activities, including prescribing, developing strategies to minimize or eliminate the need for it, or in any coordination with other disciplines. Further, the psychiatrists were not part of any desensitization programmatic initiatives at SGSSLC. He reported that individuals received pre-treatment sedation often without their psychiatrists even knowing that it has happened. He also reported that the facility director had been extremely supportive of efforts to promote the use of desensitization techniques. The facility provided lists of 32 individuals who had received pre-treatment sedation during the period 3/1/09 until the on-site visit, and 35 individuals who were awaiting functional assessments in order to initiate a desensitization program. Record review demonstrated efforts to help individuals become desensitized to the medical treatment setting in a way that might result in decreased utilization of pre-treatment sedation. All nine of the desensitization programs were nearly identical, which suggested that the plans were being designed in a way that underutilized the	

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		process of developing a specific plan tailored to the individual, drawing on the outcome of the functional assessment. The templated desensitization program was, however, quite thorough, with clear instructions about its execution. For example, Individual #235's Desensitization Program was structured as follows: • Objective: "The objective of this program is to help Individual #235 receive medical care without becoming overly upset and without having to receive sedation for procedures." • Baseline: "When employees escort Individual #235 to any physician's office…, he becomes extremely upset. He will typically exhibit physical and verbal aggression towards staff as well as the person performing the procedure…" It would be better to frame objectives with a description of specific observable behaviors targeted, than to use a subjective term such as "overly upset." Also, a description of baseline should more specifically define the frequency and topography of the behavior. The desensitization program then described a seven-phase desensitization process that started with the goal of the individual hearing that it was time for his medical appointments without displaying physical or verbal aggression, and culminating in the goal of allowing medical professionals to examine and/or treat him without his displaying of physical or verbal aggression. The procedures for each phase of the program were well described and quite specific.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	The two psychiatrists, the APN, and the psychiatric assistant were sufficient to ensure the provision of services. They were assigned roughly 90 individuals each. In addition, there was consensus among them that they had sufficient time and a reasonable caseload.	
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	The Comprehensive Psychiatric Assessments template used conformed completely to Appendix B of the Settlement Agreement. Each one reviewed, as noted in detail in the comments in Section J2, was completed thoroughly, coherently, and in a fashion that was consistent with the requirements of this provision item. The 90 day combined assessments demonstrated continued fidelity to this provision item.	

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	psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The implementation of these procedures, however, did not always ensure that the psychiatric care was actually carried out in a fashion that was consistent with those same professional standards. For example, at individual #95's 90 day combined assessment in psychiatry clinic, attended by the monitoring team, the individual's team was prepared to continue the current treatment plan, which involved maintaining him in a locked setting. The monitoring team, after listening to the presentation of the clinical data, understood that he had been moved from an open unit to a locked unit in 11/09 and had remained there since. He had had a medication side effect in 11/09 that led to increased aggression, thus, apparently necessitating the transfer. The team realized quickly that the problem was a medication side effect, adjusted his medication, and he quickly returned to approximately the behavioral status he had been at when he was on the open unit. Despite this rapid resolution, the team failed to recognize the obligation to try and transition him back to the open unit, and consequently he remained in the locked unit. In review at the time, when asked why he remained locked, members of the team responded that, "with less supervision, he gets into behavioral trouble." Asked what that meant, they responded that they did a trial of having him unsupervised for two hours per day and they concluded he was not ready to return to the open setting because, although he "did well" with the unsupervised period, he "took off an hour early." When the monitoring team commented that this did not appear to be an adequate rationale for retaining an individual in a locked setting, team members next offered as another rationale for doing so, that he became inappropriate with new staff, especially females. Asked if that had been the case with the same frequency and severity when he was in the open setting, before the medication side effect occurred (behavior that in itself no one saw as an indication for moving him), team members affirmed that this was the case. The psychiatrist then suggested that the team should try to transition him back to the open setting.	
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,	The Reiss scale was not used to screen each individual at the facility as per the content of this provision item. By report, the individual's psychologist and QMRP somehow monitored every individual to see if administration of the Reiss was necessary. This did not conform to this requirement of this provision item. In cases where individuals were admitted with an established psychiatric diagnosis and treatment plan, a lack of a Reiss screen did not stand to deprive them of psychiatric services at SGSSLC. Nevertheless, the Reiss needed to be used as per this provision item.	

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	except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	For the rest of the population at SGSSLC, however, the content and intention of this provision will need to be implemented. It will be helpful to do so in order to reduce the chances that any individual might go without services from a psychiatric perspective.	
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.	As described by the monitoring team's comments in the Summary of Monitor's Assessment at the beginning of this section of the report, psychiatry had highly prioritized improving integration of interventions. At the time of the on-site tour, however, the facility did not have a system to integrate pharmacological treatments with behavioral and other interventions. Further, there were no combined assessment and case formulation processes as indicated in this provision item. Even so, some activities were occurring that provided evidence of the psychiatry department's efforts towards this outcome. The monitoring observed and heard about the close collaboration between the psychiatry staff and the medical staff. For instance, the medical director attended several of the regularly scheduled psychiatry meetings. In addition, Dr. Sikes and the medical director established a weekly meeting to review cases with complex co-morbidity, and cases where the medical and psychiatric care were uniquely intertwined. The monitoring team had the opportunity to observe these interactions and was impressed with the interchange and thoughtful consideration of a variety of aspect of each individual case. Very significant challenges to integrated care remained: • There appeared to exist a need for an improvement in the working and collaborative relationship between psychiatry and nursing administration, and between the medical staff and nursing administration; • Psychiatry was fundamentally not involved in any meaningful manner with the treatment for the individuals participating in the dual diagnosis day and therapy programs; • There appeared to be a lack of coordination amongst prescribers, including psychiatry, medical staff, neurology, and other consultants. This introduced an increased risk of adverse drug interactions and prescribers working at cross-	

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		purposes, although, however, no specific examples of adverse outcomes were observed at SGSSLC; • There was a lack of involvement of psychiatry in pre-treatment sedation decisions also resulting in an increased risk to individuals; and • There was a surprising underutilization of medical and psychiatric expertise by the facility administration and program management. This decreased the potential for learning from the on-campus experience of these professional staff and the likelihood of developing best practices.	
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.	The PST, and the PBSP, did not include psychiatry in discussions of treatment in any meaningful manner. There was little evidence of the incorporation of psychiatry perspective and expertise integrated into the PBSP or the PSP. This will be assessed further during the next onsite tour at SGSSLC.	
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	During all observations conducted during the onsite monitoring tour, there was no indication of any discussion among PST members regarding this specific question, that is, whether the harmful effects of the individual's mental illness outweighed any possible harmful effects of psychotropic medication. The existing mechanism for obtaining informed consent consisted of a description of	

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	psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	potential risks, benefits, and alternatives given or presented to a legal guardian, usually by the QMRP. The QMRPs were not knowledgeable enough about psychopharmacology to meaningfully respond to the questions guardians and LARs may have regarding risks, benefits, and alternatives. As a result, the point of view of the guardian or LAR was not given adequate valence, and almost by definition, thereby resulted in a flawed process for assessing relative risk and benefit.	
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.	SGSSLC did not have a facility level review system to monitor the prescribing of psychotropic medications as per this provision item. According to the psychiatrists, the facility lacked the capability of generating an adequate and useful list from the pharmacy software, but they were working on doing so. During the week of the on-site tour, the facility presented the monitoring team with a document reflective of their system of review of those individuals receiving polypharmacy as defined in this provision. This document was from 2/10, and was described as the most recent accurate list, demonstrating that the facility was not conducting a monthly review. As described by the monitoring team in the above Summary of Monitor's Assessment at the beginning of this section of the report, the psychiatry department had engaged in multiple activities in order to address the issue. Despite the fact that the facility was not generating a document reflective of monthly reviews of polypharmacy, they were, nonetheless, clinically attending to addressing polypharmacy in a fashion that attempted to meet the intent of this provision item. In the 2/10 report provided to the monitoring team, there was sufficient documentation of rationale for continued polypharmacy. For individual #51, for example, the psychiatrist wrote that, "we have done slow taper studies on both of these (clozapine and risperidone). He was also on lithium, but in 2008 we did a successful taper study. He had some breakthrough symptoms in 2010, and rather than a third medication, I chose to optimize Risperdal. We believe this is a minimal effective amount." This kind of thoughtful approach was typical of all cases reviewed. In 1/06, at the time of Dr. Sikes' arrival at SGSSLC, he conducted an audit and determined that there were 22 individuals whose psychotropic regimen met criteria for polypharmacy. On the presumably current, but undated, list the facility provided to the monitoring team, of all individuals on psychotropic medication, again 22 individuals	

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		were on a psychotropic regimen that met criteria for polypharmacy. The monitoring team had the impression that, even though there had been no net reduction in polypharmacy, psychiatry had established clear and convincing rationale for the polypharmacy regimens. Further, it was likely that the current number included some of new admissions that had occurred since 2006.	
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 AIMS was used at SGSSLC for assessing tardive dyskinesia. The psychiatrists appeared to prefer the AIMS to a change to the DISCUS. An overall assessment of all possible side effects, such as the MOSES, was being used at SGSSLC by the nursing department. The psychiatrists indicated that they would prefer "ownership" of the assessment of side effects, and the documentation of same. This indicated another area in which psychiatry and nursing needed to work collaboratively. The DISCUS, in some records simply had written on it "to be done in session," but otherwise was not completed, such as with individual #53 during psychiatry clinic. The psychiatrist's assessment of involuntary movement in that case was cursory and suboptimal.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the	The primary mechanism for documenting the psychotropic treatment plan at SGSSLC was the 90 day review document. In most cases reviewed, there was documentation of a clinically justifiable diagnosis. For example, in the case of Individual #1, the 90 day review dated 5/13/10 stated that, "he has a diagnosis of chronic paranoid schizophrenia 295.30 with mild mental retardation, and physical aggression as a target symptom." The note also described "psychosis and agitation," "physical aggression, verbal aggression, and inappropriate sexual behavior." Regarding treatment with an antipsychotic and a mood stabilizer, the review noted "Individual #1 continued to report that he is feeling better and the medicine is helping him." There was generally not an explicit description of timeline for potential therapeutic effect, but there was explicit description of a timeframe for follow up, which appeared to the monitoring team to be consistent with the clinical need. At the psychiatry clinic visit for individual #51, for example, the psychiatrist increased his lithium and indicated a follow up plan for 6/10. There was not generally clear documentation of what target symptoms would be tracked and who would be responsible for monitoring. In all cases reviewed, however, the	

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	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.	psychiatric monitoring was happening consistent with clinically indicated frequency.	
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.	As described above, the facility was nominally obtaining informed consent in advance of initiating medication, without undue delay. The lack of direct contact between the guardian/LAR and the prescriber rendered it a seriously compromised process.	
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.	In interview, the psychiatrists indicated that they signed off on all neurology consults. They received a list one to two weeks prior to neurology clinic as to which individuals were going to be seen. The medical staff also received this list, and prepared a brief account for the neurologist regarding observed neurologic status since the last consultation, including recent occurrences of seizures. The medical staff then sent this to psychiatry in advance of the neurology visit, so that the psychiatrist had an opportunity to add comment. The neurologist then sent back a brief note with the individual, and faxed a more detailed note within two weeks of the visit. The primary care physician then reviewed and initialed the brief consult note the day of the consultation. If, in the primary care physician's judgment, it required immediate review, he or she wrote "rounds" on it, and made the recommended medication change, as needed. If the primary care physician saw no indication for immediate review, the consultation note then flowed into the nurse's component of the 90 day review. It then was initialed by nursing the next day, and went into the medical record. There were two concerning implications to this from the perspective of psychiatric care:	

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		• In the physicians' estimation, the primary care physician will let the psychiatrist know of the urgent medication change "90% of the time," which left the patient vulnerable to poor coordination of care in 10% of the "urgent" circumstances; • In the non-urgent scenario, the psychiatrist may not learn of the outcome of the neurology visit until the next 90-day review, opening the individual to the same potential for poor coordination of care.	

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. Facility management should attend to improving the integration of services, coordination of care, and communication among disciplines, especially between psychiatry and both psychology and nursing.

3. Psychiatry must be substantially more involved in the interdisciplinary process, including the PSP and the PBSP.

4. Psychiatry needs to be involved in the pre-treatment sedation processes.

5. The Reiss Scale needs to be implemented as per the Settlement Agreement provision above.

6. Regarding the services for individuals with dual diagnoses:
    a. Psychiatry should have a hand in shaping the dual-diagnosis treatment initiatives and be communicating with the dual diagnosis clinicians on a regular basis.
    b. The dual diagnosis program should be driven by the evidence base. In particular, DBT should be explored as a possible cornerstone for this program. The staff for this program will need substantial training (also see section K of this report).

7. Psychiatry should be directly attending to informed consent.

8. Psychiatry should ensure appropriate and thorough monitoring of medication side effects (this is not meant to suggest that nursing should reduce their attention to this same monitoring).

9. Behavioral data should be presented in graphic form, with appropriate frequency, such as daily indices, and with phase lines utilized to highlight variables that may bear on the target behavior being tracked (also see section K below).

10. Decisions should be made based upon data that are available and reliable.

11. The facility should consider the adoption of the usage of an electronic medical record; this may 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.

12. 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, Psychological and Behavioral Services, #008, dated 11/13/09 o Behavior Support Plan Committee minutes for: 10/7/09, 10/14/09, 10/21/09, 11/4/09, 11/18/09, 12/9/09, 12/30/09, 1/6/10, 1/13/10, 1/20/10, 1/27/10, 2/3/10, 2/10/10, 2/17/10, 2/24/10, 3/3/10, 3/10/10, 3/17/10) o SGSSLC Habscan card (undated) o Dual Diagnosis Supports (no date) o Reliability Probe (1/9/09) o Structural and Functional Assessment Report (11/30/09) o Education and Training Roster (4/14/10) o SGSSLC psychology and dual diagnosis program organizational chart o Sample of STEPP summary notes, 2/15/10 through 5/3/10 o Functional Assessments for: • Individual #184, Individual #218, Individual #48, Individual #191, Individual #162, Individual #349, Individual #153, Individual #304, Individual #313, Individual #26, Individual #68, Individual #96, Individual #252, Individual #200, Individual #283, Individual #38, Individual #216, Individual #36, Individual 67, Individual #9, Individual #310, Individual #202 o Positive Behavior Support Plans (PBSPs) for: • Individual #184, Individual #162, Individual #48, Individual #218, Individual #191, Individual #349, Individual #153, Individual #304, Individual #313, Individual #26, Individual #68, Individual #96, Individual #252, Individual #40 (reviewed in chart in Home), Individual #200, Individual #283, Individual #38, Individual #216, Individual #36, Individual #67, Individual #310, Individual #202 o Behavioral/Psychological Summaries for: • Individual #184, Individual #191, Individual #17, Individual #218, Individual #48, Mindy Individual #162, Individual #349, Individual #153, Individual #304, Individual #313, Individual #26, Individual #96, Individual #252, Individual #200, Individual #283, Individual #144, Individual #310, Individual #202 o Personal Support Plans (PSPs) for: • Individual #292, Individual #114, Individual #81, Individual #231, Individual #211, Individual #232, Individual #97, Individual #389, Individual #218, Individual #184, Individual #191, Individual #17, Individual #162, Individual #48, Individual #59, Individual #219 Individual #127, Individual #334, Individual #291, Individual #2, Individual #302, Individual #34, Individual #276, Individual #259 o Six month reviews of Positive Behavior Support Plans (PBSPs) for:

	• Individual #48, Individual #184, Individual #218, Individual #191, Individual #17, Individual #162 <u>Interviews and Meetings Held</u>: o John Church, MA, Associate Psychologist o Dana Roberts, MA, Associate Psychologist o Amanda Rodriquez, MS, Associate Psychologist o Noel Zapata, Vocational Training Director o Jason Dunham, Ph.D., Interim Chief Psychologist o Jacinda Borego, Shift Coordinator o Robbie Potter, Psychology Assistant, Dual Diagnosis Services o Tristi Lee, MS, Dual Diagnosis Services Therapist <u>Observations Conducted</u>: o Specialized Teaching and Education for People with Paraphilias (STEPP) session: • Staff conducting session: Robbie Potter and Tristi Lee, MS., LPC • Individuals participating: Individual #172, Individual #327, Individual #352 o Psychiatry Clinic Rounds: • Staff attending: Dr. Bazzell, Psychiatrist; C. Daniels, RN; Erick Ybarra, MA, Psychologist • Individuals Presented: Individual #1 and Individual #132 o Observations occurred in various day programs and residences at SGSSLC. 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 educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), 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: SGSSLC demonstrated a commitment to achieving the provisions of the Settlement Agreement by arranging for seven psychologists to be enrolled in course work to become certified behavior analysts. Nevertheless, several areas associated with this provision of the settlement agreement required improvement. These areas included data collection and presentation, and the overall quality and comprehensiveness of the functional assessments and Positive Behavior Support Plans (PBSPs). Additionally, the facility lacked the use of several critical behavioral systems, such as inter-observer agreement of target and replacement behaviors, peer review, and a system to ensure that all staff had been trained in the implementation of each

	individual's PBSP. Finally, psychological assessments were not implemented for any individuals at SGSSLC at the time of the on-site tour. Although some components of a psychology assessment existed for many individuals, record review and staff interviews indicated that no assessments contained all components. The facility needs to develop a plan to ensure that all individuals have a current, accurate, and complete psychological assessment.

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K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the on-site tour, no Psychologist at SGSSLC was a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA). Seven of the 10 psychologists, however, were enrolled in a BCBA program. Additionally, the remaining three psychologists have committed to beginning BCBA classes in the fall of 2010. 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 beneficial in enhancing the behavioral skills of the current psychology staff. It was clear to the monitoring team that the facility was working very hard to develop Positive Behavior Support Plans (PBSPs) that promoted growth, development, and independence while ensuring the safety, security, and freedom from undue restraints of the individuals they served. Nevertheless, the monitoring team believed that, in general, the PBSPs were not as effective as necessary to adequately address the behavioral needs of many of the individuals residing at SGSSLC (see K9 below for a more detailed review of PBSPs).	
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.	At the time of the on-site tour, SGSSLC did not have a Director of Psychology. The director of the dual diagnosis component of the psychology department had been appointed as an interim director of the entire psychology department. The interim director's primary responsibility, however, was to direct the dual diagnosis program. This position appeared to be a full time endeavor in and of itself and, not surprisingly, Dr. Dunham indicated that he had very little time to devote to oversight of data systems, psychological assessments, PBSP development and outcome, and restraint management. The management of these other critical components of the psychology department (and as required by the Settlement Agreement) also appeared to require the commitment of a full time psychologist. The facility needs an interim director for the management of the psychology department separate from the management of the dual diagnosis program.	

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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.	The monitoring team could find no evidence that peer review was occurring at SGSSLC. 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, direct care professionals (DCPs) who implement the plans, and those that supervise the implementation of behavior plans. The psychology department conducted Behavior Support Planning Committee meetings that were designed to review and approve new and annual PBSPs. This meeting, however, did not consist of PBSP authors and did not provide an opportunity to present challenging cases for peer discussion and feedback, beyond those that were scheduled for initial approval or annual review. Subsequent to the onsite tour, however, the monitoring team was informed by DADS that these Behavior Support Planning Committee meetings typically included peer review activities, such as discussion of format and content of PBSPs, needed changes or enhancements, discussion of challenging cases, and attendance by the author of the PBSP. The monitoring team looks forward to observing one of these meetings during the next onsite tour. Additionally, the monitoring team recommends that peer review be extended by adding monthly external peer review meetings consisting of, at minimum, other Texas DADS BCBAs and supervisors (perhaps by teleconference). External peer review committees play an important role in the development of the skills of applied behavior analysts and the facility's ability to provide ABA services that meet the generally accepted professional standard of care. External peer review can provide constructive and useful feedback to behavior analysts at the facility. This type of peer review was recently highlighted in an article of the Association of Professional Behavior Analysts (www.apbahome.net, Peer Review for Behavior Analysts, by Jim Johnston, Ph.D., BCBA-D). Operating procedures for these peer review committees will need to be established.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and	Data collection at SGSSLC was accomplished with the use of Habscan cards. Habscan cards were preprinted, containing categories of behaviors that direct care professionals (DCPs) used to record target behaviors. The cards could then be scanned and used to produce graphed data. The simple process from data collection to graphing was a clear	

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	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.	advantage to this system of data collection. A disadvantage, however, was its inflexibility. An adequate data system needs to be sensitive to each individual's needs. That is, it needs to be able to accurately collect behaviors that occur at low rates but may reflect high intensity behaviors (e.g., eloping from the facility, severe physical aggression), as well as behaviors that occur at very high rates (e.g., stereotypies, undesirable verbal behavior, noncompliance). Often very high frequency data require the use of a different system of data collection, such as time sampling or a duration system. Further, the data system did not include the collection of the occurrence or instruction of replacement behaviors. The establishment of replacement behaviors is an important component of an effective Positive Behavior Support Plan (PBSP). There was, however, no way to determine if replacement behaviors were exhibited by individuals at SGSSLC, because they were not included in any of the data sheets examined by the monitoring team. It is recommended that the current data collection methodology be expanded to ensure the accurate collection of the occurrence of replacement behaviors. The rationale for having a flexible data collection methodology is that it is unlikely that any single system will lend itself to accurate data collection across all types of needs. The most direct method for assessing and improving the integrity with which data are collected is to regularly measure inter-observer agreement (IOA). It may be that some data systems are too complex for some DCPs to collect reliably (e.g., ABC systems that require the collection of multiple antecedents and consequences for each target behavior). Under those conditions the data system may need to be modified (i.e., use of fewer target behaviors, or move to a less complex time-sampling procedure) to ensure that the data are reliably collected. At the time of the on-site tour of SGSSLC, data reliability (i.e., IOA) was not collected. It is recommended that the facility ensure that IOA for all target behaviors (including replacement behaviors) is consistently collected in each home and day/vocational site. Additionally, specific IOA goals should be established, and staff retrained or data systems modified if scores fall below those goals. All PBSP target behaviors at SGSSLC were graphed monthly. That is, each datum point represented one month of data. Some target behaviors (and replacement behaviors), however, need to be graphed more frequently to ensure that sufficient data-based decision-making can occur. Monthly data points, for example, would not allow one to identify the effects of a new medication or change in the PBSP for several months. A more sensitive data system (i.e., each datum point representing weekly data or even daily data) that identifies behavioral trends quickly could assist the psychiatrist or psychologist in the most effective use of a medication or treatment intervention modification.	

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		Monthly notes documenting the progress of target behaviors were completed for each individual with a PBSP. None of the monthly notes, however, documented the progress of replacement behaviors. It is recommended that monthly notes include both PBSP behaviors targeted to decrease, as well as desirable behaviors (i.e., replacement behaviors). Review of at least six months of progress was completed for six individuals by the monitoring team. For comparison purposes, one common target behavior (physical aggression) was selected to evaluate progress toward stated objectives. None of the individuals reviewed achieved his or her reduction in physical aggression objective. Additionally four of the six individual's PBSP data indicated no change, or an increase, in physical aggression over the six month review period. Despite this apparent lack of progress of the majority of PBSPs, the monitoring team could find no evidence that any of these PBSPs was modified or reviewed prior to its annual review. It is important when an individual's data trends in an undesirable direction (or continues with no improvement), that hypotheses be developed (perhaps requiring repeating of the functional assessment [see section K5 for additional comments on the use of functional assessments] as well as considering other factors such as staff training, implementation of PBSP, and medical and psychiatric variables), and modifications to the PBSP occur immediately (rather than waiting until the annual PBSP review).	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	Psychological Assessments Standard psychological assessment procedures were not implemented for any individuals at SGSSLC at the time of the on-site tour. Annual Behavioral/Psychological Summaries were completed, however, they reported the results of assessments that were conducted at other programs. Eight of 18 Behavioral/Psychological Summaries reviewed did not report any cognitive and/or adaptive scores, and the remainder reported scores from psychological assessments that ranged from two to 27 (i.e., Individual #304) years old. The facility should conduct standard psychological assessment procedures. Each individual's evaluation should contain, at minimum: • Standardized assessment or review of intellectual and cognitive ability • Standardized assessment of adaptive ability • Screening for psychopathology, emotional, and behavioral issues • Assessment or review of biological, physical, and medical status • Review of personal history Functional Assessments Nineteen of the 22 functional assessments reviewed at SGSSLC used a standard format.	

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		The other three (Individual #17, Individual #191, and Individual #304) utilized different formats. It is recommended that all functional assessments at the facility use the same format. An effective functional assessment should contain the following elements: • Differentiation between learned and biologically based behaviors • Identification of setting events and motivating operations relevant to the undesired behavior • Identification of antecedents relevant to the undesired behavior • Identification of consequences relevant to the undesired behavior • Identification of functions relevant to the undesired behavior • Identification of functionally equivalent replacement behaviors relevant to the undesired behavior • Identification of preference and reinforcers • Direct and indirect measures of targeted behaviors reflecting a process or instrument widely accepted by the field of applied behavior analysis All of the functional assessments reviewed identified antecedents and consequences hypothesized to be relevant to the undesired behavior. The majority of functional assessments attempted to differentiate between learned and biologically based behaviors. All of the functional assessments identified hypothesized reinforcers or functions of undesired behavior, but 10 functional assessments reviewed did not include the individual's most potent reinforcers. All 23 functional assessments reviewed attempted to identify setting and motivating events. The identification of motivating operations in 22 of the functional assessments reviewed, however, was not consistent with the definition of the term. Motivating operations are events that alter (increase or decrease) the reinforcing effectiveness of a stimulus, object, or event. For example, if an individual is thought to engage in disruptive behavior in order to obtain staff attention, the value or effectiveness of attention could be reduced if attention is given frequently in the absence of disruptive behavior. In this way motivating operations could be used to decrease undesired behavior by, in this example, decreasing the value of the reinforcer for the undesired behavior. The one functional assessment reviewed that correctly used the term motivating operation suggested that Individual #162 was more likely to engage in undesired behaviors when she was not receiving staff attention, and she was observing others receive attention. It is reasonable to conclude that under these conditions the value or effectiveness of staff attention had been increased, and therefore the likelihood of Individual #162 engaging in undesirable behavior to access staff attention was also increased. The other 22 functional assessments appeared to interpret motivating operations as conditions under which undesired behavior was least likely to occur. For example, Individual #283's functional assessment stated that target behaviors did not occur when he was receiving ongoing	

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		staff attention, when he was not having demands placed upon him, and so forth. All functional assessments identified replacement behaviors. Replacement behaviors should be functional. That is, they should represent desired behaviors that serve the same function as the undesired behavior. For example, Individual #36's functional assessment concluded that his undesired behavior often served to escape or avoid unpleasant events or activities. One of his replacement behaviors was to allow him to leave an unpleasant situation in an appropriate manner. Many of the replacement behaviors reviewed, however, did not appear to be related to the function of the undesired behavior (although they may have been important skills for the individual to learn). The following are typical examples: • Individual #200's functional assessment concluded that he engaged in physical and verbal aggression to gain tangible objects. His replacement behavior, however, was teaching him problem solving skills. • Individual #153's functional assessment suggested that his undesirable behavior served an escape/avoidance function. His replacement behavior was teaching him which sexual behaviors were inappropriate. • Individual #48's undesired behaviors were hypothesized to be a function of gaining staff attention and avoiding undesired activities. Her replacement behaviors consisted of participation in dual diagnosis sessions, appropriately interacting with others living in her home, and participation in school. Additionally, none of the replacement behaviors reviewed was operationally defined so that direct care professionals (DCPs) would be able to conduct training. For example: • Individual #191's replacement behavior was defined as "teaching Individual #191 better coping skills to facilitate more appropriate responses to staff requests and to frustrating events in his daily routine through modeling and positive social reinforcement…" • Individual #216's replacement behavior was defined as "focus should be on providing Individual #216 with positive attention and reinforcement for utilizing more appropriate means of gaining his desires and more constructive means of escaping an undesirable task or situation." It is unlikely that DCPs could reliably teach these replacement behaviors based on these general explanations. Specific skill acquisition plans should be implemented for replacement behaviors. Moreover, these plans should be integrated into the current methodology, data system, and schedule of implementation as is done with other skill acquisition plans at the facility. These skill acquisition plans should be based upon a task analysis (when	

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		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 for a more complete review and discussion on the use of skill acquisition plans at SGSSLC). All of the functional assessments reviewed reported using indirect (interviews) measures of behavior. The indirect tools included the Functional Analysis Screening Tool (FAST), Motivation Assessment Scale (MAS), and Questions About Behavioral Function (QABF). All of the functional assessments reviewed also reported using direct observation as a method for identifying the function of undesired behaviors. Direct observations should be focused on the measurement and analysis of specific target behaviors, rather than the general observation of an individual. In only one functional assessment reviewed, Individual #48, was it clear that direct observation was of the specific target behaviors, and those behaviors were observed, recorded, and analyzed (e.g., ABC data was collected and analyzed). Ideally, the indirect component of a functional assessment (i.e., interviews of DCPs; completion of the QABF, FAST, and/or MAS) would reveal some common themes that then can lead to working hypotheses concerning the variable or variables potentially affecting an individual's target behaviors. These hypotheses could then be further refined (or abandoned) based on the results of direct observation components of the functional assessment (i.e., direct data collection). If the behavior analyst is confident that indirect and direct measures have suggested clear sources of control of the targeted behavior, then the functional assessment is complete, and the results of the assessment can be used to develop the PBSP. If the results of the functional assessment remain unclear, or the PBSP is not producing the desired results, the behavior analyst should then attempt to use other assessment tools, such as a functional analysis (i.e., experimental investigation of variables affecting the target behavior) to better understand the variables affecting the target behavior. In addressing complex behavior problems, functional assessments are often revised several times (also see K4 above). There was no evidence that the functional assessments at SGSSLC were revised when individuals' behavior failed to meet treatment expectations (see K4). Over subsequent on-site tours, the monitoring team will be looking for: • indirect assessment techniques, • direct assessment techniques that include the collection and analysis of descriptive data (e.g., ABC data) at minimum, • evidence that the functional assessment is reviewed, and revised when the individual does not meet treatment expectations, • the inclusion of a functional analysis, when necessary, and	

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		• evidence that functional assessment findings are incorporated into effective PBSPs.	
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.	At the time of the on-site tour, SGSSLC did not conduct psychological assessments. They did complete annual psychological summaries for each individual. The annual summaries were not based on current, accurate, and complete clinical and behavioral data (see sections K5 and K7).	
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.	SGSSLC should conduct psychological assessments as needed, and at least every five years, for each individual residing at the facility. Additionally, the monitoring team recommends that each individual at the facility receive an annual psychological assessment update. The purpose of the annual update would be to note/screen for changes in psychopathology, behavior, and adaptive skill functioning. Thus, this annual psychological assessment update would comment on (a) reasons why a full assessment was not needed at this time, (b) changes in psychopathology or behavior, if any, (c) changes in adaptive functioning, if any, and (d) recommendations for an individual's personal support team for the upcoming year. Additionally, for newly admitted individuals, psychological assessments should be completed within one month.	

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.	The psychology department at SGSSLC offered a variety of services in addition to behavior support programs. These included:
		• Forensic risk assessments (e.g., violence, sex offending).
		• Fitness to proceed/competency assessments.
		• Individual counseling, including anger management and substance abuse counseling. There was a daily schedule of individual and group therapies. Time slots began at 10:30 a.m. and went through 4:15 p.m.
		• Group counseling.
		  o Women's and men's anger management therapy groups
		  o Men's substance abuse therapy groups
		  o Men's abuse survivors therapy groups
		  o Men's and women's cognitive behavioral therapy groups
		• Specialized Teaching and Education for People with Paraphilias (STEPP). This was to be a licensed sex offender treatment program.
		• Specialized Treatment and Consultative Services (STACS). This program was	

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		designed to work on daily living skills. The staff reported that this program was going to be faded out over time. • Success Center. This program's goal was to focus on community transition and community living skills. Although staff reported that a curriculum was followed, it was unclear as to how topics and goals were determined and how outcomes were measured in any type of objective manner. Although the facility's documents and reports indicated an active program, during observation by the monitoring team, only 17 individuals total were observed in all of these programs combined. In the Success program, three individuals were in one classroom. In the STACS program, 12 individuals were in two classrooms. One individual was in a third classroom and one individual was in the hallway. Three therapists were awaiting individuals for the first day of an anger management group, but no one showed up. The monitoring team looks forward to future observations of these programs at more active programming times. Even so, daily lists of scheduled groups and individuals participating indicated that a substantial number of individuals were involved in these activities. For all of these therapy-type services, it is important that they are goal directed with measurable objectives and treatment expectations. An observation of a STEPP group, however, indicated that this might not be the case. Three individuals participated in discussions involving management of their inappropriate sexual impulses. Conversations with the staff that led the group indicated that a treatment curriculum was used. The curriculum, however, was developed at SGSSLC or possibly at another SSLC more than 10 years ago. It did not appear to be updated and had not taken advantage of incorporating any recent literature or other disseminated work in this field. Further, it was not clear that an assessment of each participant's needs and desired outcomes was developed, or if there was a method established for measuring the outcome of therapy. The staff facilitating the discussion appeared caring, and managed to engage every individual during at least a part of the session. They were not aware of the contents of the Settlement Agreement. One was an unlicensed direct care professional who had been leading these groups for many years, however, she did not have any formal training or credential in this area. The newly appointed licensed therapist was inexperienced with sex offending issues. Clearly, more work must be done to implement processes and outcomes for this type of therapy. Subsequent monitoring team on-site tours will closely review these services to ensure that: • they are identified as a need in each individual's psychological assessment • a service plan includes measurable objectives and a plan of service	

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		• services reflect evidence-based practices • the services include documentation and review of progress • a service plan includes a criterion for review and revision of the intervention • a service plan includes a plan to generalize skills learned to living and work settings • service is identified in each individual's PSP.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Twenty-two PBSPs at SGSSLC were reviewed to assess compliance with this provision item. All of the PBSPs reviewed had the necessary consents and approvals. There are several important components that should be included in every PBSP. Since the functional assessments were consistently presented as a component of SGSSLC's PBSPs, the monitoring team reviewed both documents to determine the presence of these elements. All of the functional assessments and PBSPs reviewed included: • History of prior intervention strategies and outcomes. • Consideration of medical, psychiatric, and healthcare issues. • Operational definitions of target behaviors. • Operational definitions of replacement behaviors (see K5 for a discussion of the quality of those operational definitions). • Description of potential function(s) of behavior. • Treatment expectations and timeframes written in objective, observable, and measureable terms. • Strategies addressing setting event and motivating operation issues. • Strategies addressing antecedent issues. • Strategies that include the teaching of desired replacement behaviors (see K5) • Strategies to weaken undesired behavior. • Use of positive reinforcement sufficient for strengthening desired behavior. • Description of data collection procedures. • Baseline or comparison data. • Signature of individual responsible for developing the PBSP. On the other hand, few of the PBSPs or functional assessments reviewed contained the following necessary components of a PBSP: • Rationale for selection of the proposed intervention • Clear, simple, precise interventions for responding to the behavior when it occurs. • Plan, or considerations, to reduce intensity of the intervention, if applicable. All of the above components should be included in functional assessments/PBSPs.	

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		It is important to note that the quality of many of the components that were included in the PBSPs, however, was often inadequate. For example, although all the PBSPs included interventions for responding to undesired behavior when it occurred, many of those interventions were complicated, and would likely make it difficult for DCPs to implement the interventions with consistency or integrity. For example: • Individual #17's PBSP specified that when she was physically aggressive, "…staff should use PMAB (prevention and management of aggressive behavior) techniques, using the least to most forceful interventions. This chain of techniques begins by prompting her to stop, redirecting her attention to something else, and then redirecting her to another area that is quiet and away from her peers. Withdraw from the immediate area, unless Individual #17 continues to show signs of wanting to hurt someone else. In this case, withdraw only a little ways apart and discreetly observe her behavior…" • Following physical aggression, Individual #304's PBSP directed staff to move immediately to intervene in order to prevent harm or injury to Individual #304 or to others and use any of the following that fits the situation: 1. Use verbal intervention 2. Alter the situation that started the aggressive behavior 3. Remove her from the immediate environment where the episode occurred by redirecting her to some other area to calm down. It is very important that PBSPs contain clear, simple, precise interventions that can be implemented by DCPs with integrity (see K11 for a discussion of treatment integrity). There appeared to be poor correspondence between functional assessment conclusions and PBSP interventions in many of the plans reviewed. In some plans, the interventions in the PBSPs appeared to be contraindicated by the functional assessment results. The following examples were typical: • Individual #153's functional assessment identified negative reinforcement (escape or avoidance of undesirable events/settings) as one function of his challenging behavior. One component of the intervention following his verbal or physical aggression was removing him from the environment until he calmed down. If his physical aggression was maintained by negative reinforcement, this intervention would likely result in an increase in the undesired behavior. • Individual #202's functional assessment concluded that her self-injurious behavior (SIB) served the function of gaining food, or escaping unwanted prompts/task demands. Her PBSP, however, specified that following SIB, staff should attempt to determine if she needs or wants anything, and either give her food or move her away from the unwanted event.	

#	Provision	Assessment of Status	Compliance
		Other plans appeared to be general and generic. For example: • Individual #283 and Individual #200 had interventions following undesired behavior that were identical (i.e., verbal intervention, remove from the immediate environment, alter the situation), despite the fact that their functional assessments identified different functions of their target behaviors. A critical aspect of applied behavior analysis is ensuring that interventions are based on functional assessment results. Although the majority of PBSPs at SGSSLC included the necessary components of an effective plan, the majority of PBSPs reviewed did not appear to be based on the results of the functional assessment. There was, however, at least one example of a PBSP that was clearly based on the results of the functional assessment. Individual #162's functional assessment concluded that her undesired behaviors were maintained by staff attention. Her replacement behavior consisted of teaching appropriate ways of gaining staff attention. The PBSP included clear, simple, and precise interventions for providing abundant staff attention to Individual #162 when she was NOT engaged in target behaviors, and minimizing staff attention when she was engaged in undesired behaviors. It is important to note that a review of Individual #162's progress (see K4) demonstrated clear decreases in her aggressive behavior. A positive characteristic of the 23 PBSPs reviewed at SGSSLC was the prescribed use of positive reinforcement. Every PBSP had a section that included encouraging and reinforcing appropriate behavior. The use of positive reinforcement is a generally accepted professional standard of care in the treatment of individuals with developmental disabilities. There is a tremendous amount of published research in the literature demonstrating its effectiveness for changing behaviors in this population and, further, its use is in line with the intent of this provision of the Settlement Agreement. Two PBSPs reviewed, however, indicated that the use of potentially effective consequences was not consistently applied at SGSSLC. • Individual #48's functional assessment reported that an effective response cost and a home restriction program were discontinued due to facility's "philosophical changes." • Individual #200's functional assessment reported that he did not experience consequences for displaying challenging behaviors, and therefore these undesired behaviors continued to occur. It was not clear from the functional assessment why there were not consequences for Individual #200 undesired behaviors. Changing and improving individual behavior across every unit at SGSSLC will be difficult, if not impossible, without the planned, thoughtful use of positive reinforcement. The use	

#	Provision	Assessment of Status	Compliance
		of positive reinforcement, such as the earning of special privileges or items (and thereby the potential failure of an individual to earn these privileges or items), should not be viewed as competing with the facility's (and the state's) goal of having positive behavior support plans. The monitoring team hopes that the facility will embrace the many well-researched applications of positive reinforcement contingencies. The psychologists who develop and manage the PBSPs should have the opportunity to program the most potent reinforcers available to encourage desirable behaviors and to discourage dangerous and undesirable behaviors in the individuals they serve. Access to more potent reinforcers is not a substitute for incomplete functional assessments or PBSPs, however, the inclusion of the most potent reinforcers for desired behaviors is not only a best practice in ABA, it would likely enhance the effectiveness of a well written, function-based plan. Psychology staff will need the support of senior administration at SGSSLC in order to successfully incorporate the use of positive reinforcement contingencies into their PBSPs. Finally, it was not apparent to the monitoring team that PBSPs had been completely integrated into vocational programming. Although vocational staff indicated they knew each individual's PBSP, no psychologist was responsible for the training of vocational staff in the implementation of the plans. Further, there was no psychologist available to write modifications in the PBSP specifically for behavioral issues that might occur in the vocational setting. The psychology department indicated that they were not involved in vocational programming because they were supervised by residential services. It is recommended that the facility consider a reorganization of the psychology department so that their role in the management of individual's behavior extends to all services of SGSSLC.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Inter-observer agreement measures were not collected for PBSP data at the time of the on-site tour. A system to regularly assess the accuracy of PBSP data is a necessary requirement for determining the efficacy of treatment. PBSP data were consistently graphed monthly at SGSSLC. As discussed in K4, however, these data 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.	

#	Provision	Assessment of Status	Compliance
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	All direct care professionals (DCPs) interviewed indicated that they understood each individual's PBSP. During a tour of one of the residences (516 East), the monitoring team asked the DCP working with Individual #40 how he responded when Individual #40 engaged in SIB. The DCP responded that they used "extinction." The PBSP indicated that staff should respond in a matter-of-fact manner (not providing attention, but block the behavior). Subsequent to further questioning, the DCP indicated that he would block the behavior if Individual #40 was hurting himself. The DCP's response was consistent with the written plan, but it was difficult for the monitoring team to further evaluate the accuracy of the DCP's description since the plan did not clearly specify the steps that staff should engage in following Individual #40's SIB (see K9 discussion on the general nature of many PBSPs at SGSSLC). The only way to ensure that DCPs can, and do, consistently implement PBSPs as written, is to establish and implement a systematic treatment integrity assessment tool. The psychologists at SGSSLC used a reliability probe to assess treatment integrity. The reliability probe was reportedly administered twice a week (across to different staff) in each home. The tool involved observing staff, and indicating if they correctly implemented specific components of the PBSP, such as prevention strategies, or responses to target behaviors. The psychologists collected and maintained these integrity data. In order to ensure that all staff have been trained, and integrity trends identified, it is recommended that these data be maintained centrally, and the data reviewed regularly.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	SGSSLC did not maintain training logs that reflected whether or not DCPs had received training on individual PBSPs. Each psychologist, however, maintained inservice sheets documenting the training of each staff on each individual's PBSP. It was not possible, however, to determine whether all staff who were supposed to have received training, had indeed received training. Each psychologist conducted monthly training, but no standard training methodology had been adopted by the department. Specifics of the monthly trainings varied from psychologist to psychologist, but generally involved reviewing plans and data systems, and answering staff questions. To ensure that staff training is consistently effective, it is recommended that staff training procedures be standardized across the department. Additionally, it is recommended that the department develop a more coordinated system to ensure that all staff (including floated staff) are trained in the implementation of each individual's PBSP. It is also recommended that the facility identify a standard methodology for staff training that includes a combination of didactic, modeled, role-play, and in vivo strategies.	

#	Provision	Assessment of Status	Compliance
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 10 psychologists and six psychology assistants/technicians serving 253 individuals. While the total number of psychology staff and assistants met the ratios required by this provision, none of the psychology staff had attained certification as a behavior analyst.	

Recommendations:

1. Ensure that all psychologists writing and monitoring PBSPs at SGSSLC are competent in applied behavior analysis and obtain board certification for behavior analysis (BCBA).
2. Appoint an interim director of psychological services to be responsible for the coordination of psychological services separate from the dual diagnosis program.
3. Establish an internal and external peer review system for PBSPs.
4. Ensure that the data system is flexible enough to reliably reflect each individual's needs.
5. Include replacement behaviors in the data collection system.
6. Regularly collect inter-observer agreement (IOA) data, establish IOA goals, and ensure goals are achieved.
7. PBSP target and replacement behaviors should be graphed at a frequency sufficient to promote effective decision-making.
8. Monthly progress notes should include the status of replacement behaviors as well as behaviors targeted to decrease.
9. Modifications to the PBSP should reflect data-based decisions, rather than annual timelines.
10. Each individual should have a current, accurate and complete, psychological assessment.
11. Each individual's psychological evaluation should contain, at minimum:
    - standardized assessment or review of intellectual and cognitive ability
    - standardized assessment of adaptive ability
    - screening for psychopathology, emotional, and behavioral issues
    - assessment or review of biological, physical, and medical status

- review of personal history

12. All functional assessments should use the same format.

13. Functional assessments should include a process that includes both direct and indirect measures. Direct assessment techniques should include, at minimum, the collection and analysis of descriptive data (e.g., ABC data).

14. Ensure that all functional assessments employ the correct use of "motivating operations."

15. Ensure that all replacement behaviors are functional.

16. Specific skill acquisition plans should be implemented for teaching individual replacement behaviors.

17. Functional assessments need to be revised when an individual's behavior does not meet treatment expectations.

18. Psychological re-assessments should be conducted as often as needed, but at least every five years.

19. Psychological assessments should be conducted within 30 days for newly admitted individuals.

20. All psychological services should:
    - be identified as a need in each individual's psychological assessment
    - include measurable objectives
    - reflect evidence-based practices
    - include documentation and review of progress
    - include a criterion for review and revision of the intervention
    - include a plan to generalize skills learned to living and work settings
    - be identified in each individual's PSP.

21. All PBSPs or functional assessments should contain:
    - a rationale for selection of the proposed intervention
    - clear, simple, precise interventions for responding to the behavior when it occurs
    - a plan, or considerations, to reduce intensity of intervention, if applicable.

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

23. PBSPs should include potent consequences for the absence of target behaviors, including contingent positive reinforcement.

24. Treatment integrity data should be maintained centrally, and the data reviewed regularly.

25. Develop a standard staff training methodology that includes a combination of didactic, modeled, and in vivo strategies.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: Documents Reviewed: o Record reviews of the following individuals: • Individual #164, Individual #203, Individual #249, Individual #383, Individual #385, Individual #390. o Relevant Health Care Guidelines o Schedule for all lab testing o Quarterly medical review dated 5/6/10 for Individual #116 o Medical care audit dated 1/25/10 for Individual #387 o Document submitted by Dr. Burnside, undated, regarding observations about hypothyroidism o Document with the header "Professional Staff," listing medical consultants to SGSSLC o Copy of e-mail correspondence chain regarding HPV vaccine, first e-mail by Dr. McKown dated 8/28/09 Interviews and Meetings Held: o Dr. Rebecca McKown, Medical Director, o Drs. McKown, John Burnside, Ernesto Bondarevsky, and David Bessman o Lisa Own, QE nurse Observations Conducted: o Medical rounds with Dr. McKown
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility had five primary care physicians at the time of the visit, though that was artifact, given the planned departure that week of one of the locum tenens physicians. The remaining four added up to 2.5 FTEs. The physicians were competent and committed, and struck a warm, collegial tone among themselves and with their psychiatric colleagues. One of the physicians, Dr. Bessman, was a hematologist, which was of great benefit to the facility. Another, Dr. Goodman, was a pathologist, and had no clinical duties. Rather, he was responsible for record reviews and medical quarterly reports as required by the Settlement Agreement. Dr. McKown, the medical director, lived on campus during the week, and took call at all times when on campus. The monitoring team was

	impressed with her availability. At the current staffing level, however, the PCPs were not able to conduct all of their clinical and administrative duties. As a result, they were unable to fully attend to administrative obligations. Additionally, they were not able to participate in the annual PSP meetings. The PCPs (and the psychiatrists) expressed significant concern about their obligation to sign orders for physical restraints where they had not been present at the time of the restraint. In one circumstance, one of the physicians indicated that he had not received a call about a 2 am restraint until 8 am. Dr. McKown would clearly value the opportunity to engage more fully in her administrative duties if staffing allowed. She presented as quite fluent in the process of quality improvement, and made a convincing argument that giving those duties short shrift is to the detriment of the care of the individuals served. The PCPs estimated that they would be adequately staffed if there were 3.5 FTEs. There was no facility-wide medical review system, nor a medical quality improvement program. The medical director indicated that they were waiting for this to be established by the DADS central office. 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 Health Care Guidelines), medical services appeared to be meeting, in general, the needs of the individuals. As this was a baseline on-site tour, more assessment will be required during subsequent on-site tours.

#	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	The PCPs utilized a prevention checklist, and the record review conducted by the monitoring team indicated good compliance with its use. The primary care physicians saw the individuals in their residences for routine care. The medical director indicated that the facility had good working relationships with Shannon Hospital Emergency Room in the community, and that emergency care went smoothly and efficiently. The parties had identified applicable standards and those were called Health Care Guidelines. These had not yet been incorporated into the medical systems at SGSSLC.	

#	Provision	Assessment of Status	Compliance
	separate monitoring plan.		
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.	Dr. Goodman's duties were to conduct case reviews under the direction of the medical director. The medical director was aware of the expectation that these would be done quarterly, but they were being done semiannually due to staffing constraints. The annual review included a physical exam. Non-facility assistance was adequate. The facility used Brazos Radiology Group, which provided mobile on-site services, Dr. Chris Vanderzant for neurology, and multiple specialty clinicians from Shannon Hospital.	
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.	SGSSLC did not have a medical quality improvement process. The facility's QE department, however, regularly reviewed the records, but, with the exception of tracking all infectious cultures and sensitivities, there were no trend analyses conducted. They also tracked how many of the individuals were hospitalized at a given time and their liaison nurse visited these individuals in the hospital. They also kept a tally each 24 hours of injuries, allegations against staff, and aggression of any individual served against another served. The medical staff cited other quality improvement initiatives: • The restriction of individuals visiting, unit to unit, at the time there was a case of hospital-acquired pneumonia; • Efforts to check Vitamin D levels on all individuals, with treatment as needed based on screen; • A determination that 10% of the residents had hypothyroidism, which was very substantially above the national average. This issued from Dr. Burnside's anecdotal observations of his patients seeming to have a high prevalence, and he subsequently undertook a record review of all individuals. Regarding such laudable efforts as the three described above, in the absence of a comprehensive medical improvement program, and an electronic medical record so as to be able to track findings, the facility will be limited in the capacity to turn such efforts ultimately to the benefit of the individuals served. Lisa Owen from the QE department indicated that she will be getting training in the near future at Rivercrest Hospital, regarding how to structure a quality improvement process.	

#	Provision	Assessment of Status	Compliance
		In the case of Individual #387, a record audit conducted by QE on 1/25/10 utilized a comprehensive template, and had findings such as: • "3 months of MARs, but blanks noted. Allergies noted on MARs—Abilify, Augmentin, Sulfa, and Tegretol. **Allergies noted on Physical exam—Sulfa, fish, and pinto beans." • "Not all labs are initialed by nursing" In the monitoring team's view, this audit demonstrated the auditor's commitment to performing the function despite inadequate training and inadequate information technology to process the data. While the individual performing the audit made the most of the available resource, the utility of the process was substantially limited by these inadequacies.	
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.	At the time of the baseline review, the standards for provision of medical care were in development. This provision item refers to the Health Care Guidelines, a detailed set of guidelines for medical care. Even though these applicable standards had been chosen by the parties, a policy had not yet been developed regarding implementation of these guidelines. It is expected that a new policy along with specific procedures will be required by the facility if it is to meet these standards and this provision item. As indicated above, at SGSSLC the Health Care Guidelines were being incorporated into the medical practices and policies. In addition, the medical staff indicated that they use CDC standards of care, and if the CDC does not have an established standard, they go to the available professional literature to establish community standard.	

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. Staffing of medical services should be augmented to allow for attention to administrative issues and quarterly case reviews.

4. An EMR should be considered because it may improve the quality of clinical care and facilitate vital quality enhancement initiatives.

5. DADS Central Office should develop a strategy statewide to address the PCPs' concerns about authorizing restraints. Restraints are an intervention that is not in their area of expertise. Beyond this, they are not in a position to clinically assess the decision staff has made to restrain an individual, much less engage the staff in improving their capacity for de-escalating individuals. This leaves open the real possibility that individuals will get inappropriately restrained, the PCP will be in jeopardy for having authorized (post-event) an unwarranted restraint, and there will be no mechanism for learning from experience for the staff having engaged in the restraint.

<table>
<tr><th>SECTION M: Nursing Care</th><th></th></tr>
<tr><td>Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o SGSSLC Map
o SGSSLC Organizational Chart
o SGSSLC List of Staff
o Records for:
• Individual #214, Individual #215, Individual #69, Individual #59, Individual #127, Individual #301, Individual #346, Individual #102, Individual #25, Individual #78, Individual #385, Individual #281, Individual #247, Individual #94, Individual #146, Individual #222, Individual #122, Individual #124, Individual #203, Individual #112, Individual #137, Individual #40, Individual #60
o Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Protection from Harm – Abuse, Neglect, and Incident Management, Policy Number: 002.1, Date: 11/6/09
o Texas Department of Aging and Disability Services, State Supported Living Centers: State Nursing Policies and Procedures
o SGSSLC Policies and Procedures:
• 1.1.01 Clinical Death Review Committee, Date: 1/22/09, Last Reviewed/Revised: 5/8/09
• 1.1.02 Infection Control Committee, Date: 3/5/96, Last Reviewed/Revised 6/15/07
• 1.1.07 Pharmacy and Therapeutic Committee, Date 3/17/00, Last Reviewed/Revised: 3/10/06
• 1.1.08 Skin Integrity Team, 4/13/07, Last Reviewed/Revised: 12/12/08
• 1.1.13 Administrative Death Review Committee, Date: 5/8/09
• 2.1.21 HST Rating Procedure, Date: 2/25/10
• 5.2.03 Mock Medical Emergency Drill Procedure, Date: 6/6/07
• 5.2.05 Emergency Response Procedure, Date: 9/1/01, Last Reviewed/Revised: 9/17/09
• 5.2.06 Physician's Order for Restraint, Date: 12/8/09
• 5.2.17 Request to Transfer to McKnight West/East, Date: 9/1/01, Last Reviewed/Revised: 4/14/06
• 5.2.18 Credit medication back to the inventory when they are returned from the home unused (Pharmacy), Date: 5/14/99, Last Reviewed/Revised: 2/3/05
• 5.2.19 Floor Stock Items (Pharmacy), Date: 5/14/99, Last Reviewed/Revised: 2/3/05
• 5.2.20 Purchasing and Receiving Pharmaceutical Orders, Date: 11/14/00, Last Reviewed/Revised: 2/3/05
• 5.2.21 Relaying Physician Orders to Pharmacy, Date: 4/14/00, Last Reviewed/Revised: 2/3/05
• 5.2.22 Transporting of medication to and from the Pharmacy, Date: 5/14/99, Last Reviewed/Revised: 2/3/05</td></tr>
</table>

	• 5.2.34 Automatic External Defibrillator (AED), Date: 2/13/04, Last Reviewed/Revised: 6/15/07 • 5.2.35 Prescribing Psychoactive Medication, Date: 9/15/04, Last Reviewed/Revised: 2/25/10 • 5.2.37, Date: 5/11/01, Last Reviewed/Revised: 8/8/08 • SGSSLC Infection Control Policy and Procedure Manual, 7.1.01 through 7.2.05 • SGSSLC Nursing Policy and Procedure Manual, including policies and procedures developed and adapted from the State Nursing Office ▪ Policy Statement – P-1 through P-29 ▪ Administration of Medication – M-0 through M-23 ▪ Gastrointestinal – G-1 through G-11 ▪ Respiratory – R1 through R-11 ▪ Genitourinary – U-1 through U-9 ▪ Routine Nursing Management – N-1 through N-32 ▪ Standard Documentation Requirements – D-1 through D-5 ▪ Infirmary – I-1 through I-17 o SGSSLC Nursing Case Manager's Meeting Minutes, 9/23/09, 10/14/09, 11/4/09, 12/15/09, 12/28/09, 1/7/10, 1/21/10, 2/18/10, 2/22/10, 3/25/10, o SGSSLC Nursing Daily Staffing List, 10/1/09 through 3/31/10 o SGSSLC Nursing 24 Hour Shift Report, all Unit, 5/6/10 through 5/10/10 o SGSSLC Health Maintenance Plan, Acute Care Plan, Self-administration of Medication, Breast Exams, and Psychotropic Consents Tracking Report, September, 2009 through May, 2009 (to date) o SGSSLC Clinic Appointment Schedule, October, 2009 through May, 2009 (to date) o SGSSLC Guide to Psychiatric Services, no date o SGSSLC Nurse Case Manager's Report to Psychiatrist – 90 Day Combined Review Form, 2/25/10 o Initial Comprehensive Psychiatric Evaluation for Individual #381 o SGSSLC Medical Chart Audit 2010 Schedule with Sample Chart Audit for January, 2010 o SGSSLC Infection Control Training Curricula and Training Material, Adopted from Texas Department of Mental Health and Mental Retardation, Date: September, 2003 o SGSSLC Infection Control Committee Minutes, 9/22/09, 1/26/10, and 4/27/10 o SGSSLC Infection Control Data Reports: Infections by Homes, July 2009 through January, 2010; Antibiograms, July, 20109 through January, 2010; and Seasonal Influenza and H1N1 Vaccine Report, no date o SGSSLC Environmental and Safety Committee Meeting Minutes, 9/29/09, 10/28/09, 2/24/10 o SGSSLC List of Individuals admitted to the Infirmary, July, 2009 through March, 2010 o SGSSL CRP Health Care Provider Teaching Outline, no date o SGSSLC Course Due/Delinquent Report for CPR Training, printed 3/30/10 o SGSSLC Daily Emergency Bag Checklist, Sample, February, 2010 and March, 2010 o SGSSLC All Code Blue, or Medical Emergency Reports and analysis, and Code Blue Drill Reports and Analysis, including Tracking Logs or Recommendations or Corrective Actions Based on these Reports, 7/1/09 through 3/31/10 o SGSSLC 5.2.05 Emergency Response Procedure, Date: 9/1/01, Last Reviewed/Revised: 9/17/09

	○ SGSSLC N-4 Crash Kit Policy, Date: 2/13/09 ○ SGSSLC 5.2.08 Life Sustaining Treatment and Resuscitation Status, Date: 8/17/07 ○ SGSSLC I-13 Infusaport, Access and Care, Date: 9/1/01 Late Reviewed/Revised Date: 8/19/05 ○ SGSSLC Orientation and Pre-Service Training and Refresher Training Schedule ○ SGSSLC Orientation for Agency Nurses ○ SGSSLC New (fulltime) Nursing Staff Orientation and Annual Certification of Nursing Skill Competencies Training Curricula, Schedule, Competency Checklist, and Signed Training Rosters ○ SGSSLC Nursing Preceptor Training Curricula and Evaluation Tool ○ SGSSLC Serious Medical Incidents Reports (Sample) for Past Six Months ○ SGSSLC At Risk Individual (All Categories), April, 2010 ○ SGSSLC Hospital Liaison Nurse Job Description ○ SGSSLC Hospital Liaison Nurse's Hospital Reports, March 2, 2010, through May 11, 2010 for: • Individual #60, Individual #315, Individual #203, Individual #116, Individual #38, Individual #76, Individual #131, Individual #193, Individual #373, Individual #206, Individual #90, Individual #301, Individual #109, Individual #161 ○ SGSSLC 2.1.01 Continuity of Care Policy, Date:5/1104, Last Reviewed/Revised: 7/10/09 ○ SGSSLC Transfer Committee minutes, 2/2/10 through 4/27/10 ○ SGSSLC Hospital and Emergency Room Visit Lists, 3/1/09 through 3/31/10 ○ SGSSLC Pneumonia Tracking Sheet, 3/29/09 through 3/29/10 ○ SGSSLC N-25 Weight Measurement and Monitoring, Date: 8/25/08 ○ SGSSLC Weight Tracking Log 2010, January, 2010 through April, 2010 ○ SGSSLC Nutritional Management Committee Meeting Minutes, 9/28/09 through 3/24/10 ○ SGSSLC Monthly Medication Error Reports with Corrective Action Validation for each Error, February, 2010, March, 2010, and April, 2010 ○ SGSSLC Medication Error Forms Completed (ten most recent errors) ○ SGSSLC Medication Error Committee Meeting Minutes, 8/28/09 ○ SGSSLC Pharmacy and Therapeutic Committee (Infection Control Sub-Committee and Medication Error Sub-Committee) Meeting Minutes, 9/15/09, 10/28/09, 12/15/09, 3/16/10 Interviews and Meetings Held: ○ Angela Garner, RN, Chief Nurse Executive ○ Lisa Busbee, RN, Nurse Operation Officer ○ Lisa Owens, RN, Quality Enhancement Nurse ○ Maria DeLuna, RN, Nurse Educator ○ Tatina Mahany, RN, Infection Control Nurse ○ Lori Diaz, RN, Hospital Liaison Nurse ○ Brandy Alderman, RN, Unit I Nurse ○ Julia Gilstrap, RN, Unit II Nurse Manager ○ Rachel Wittich, RN, Unit III Nurse Manager ○ Valerie Kipfer, MSN, RN, State Office Nursing Services Coordinator ○ Informal interviews with numerous Nurse Case Managers, Staff Registered Nurses and Licensed Vocational Nurses

	<u>Observations Conducted</u>: o Building Tour: Infirmary, East and West McKnight, Clinic, 509A, 511 A and B, 505, 502, 508, 501, and 504, on 5/10/10 o Personal Support Meeting for Individual #146, 10:00 a.m., 5/11/10 o Medication Observation Pass, 7:00 a.m., 516 McKnight West, 5/12/10 o Nursing Shift Report, 8:00 a.m., 5/12/10 o Nurse Managers' Morning Meeting, 8:45 a.m., 5/12/10 o Skin Integrity Committee, 1:15 p.m., 5/12/10 o Health Support Team Meeting, 3:00 p.m., 5/12/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: SGSSLC's Nursing Department's administrative and management structure is detailed below in section M1. Since 4/16/10, the facility no longer used agency nurses. The Nurse Managers and Nurse Case Managers provided direct nursing coverage to make up for the loss of agency nurses. The Nurse Managers demonstrated a team spirit and willingness to augment the nursing shortages. While it is commendable that they were willing and able to meet the need for direct nursing care, it was of concern that it may be done at the expense of their own responsibilities as Nurse Managers that included assessing and planning health care, attending required meetings, and so forth. Quality Enhancement monitoring tools were in the process of being developed and refined to meet required compliance with the Settlement Agreement and Health Care Guidelines. The Nursing Department did not have formalized nursing policies and procedures for monitoring nursing practices. According to the Chief Nurse Executive, the Nursing Department was in the process of developing and implementing numerous monitoring tools to improve the quality of nursing services. She related that medication pass observations were moving from conducting annual observations on each nurse who administered medication to quarterly. Review of the Emergency Medical Mock Drill Reports revealed that drills were conducted once per shift, per home, and per programming area quarterly, according to facility policy. The nursing and direct care staff consistently participated in the drill; however, physicians did not participate. Most Annual and Quarterly Nursing Assessments were completed as scheduled according to the PSP calendar. The Annual and Quarterly Nursing Assessments and Nursing Summaries failed to consistently contain substantive information documented in their respective comment sections for items checked in boxes. Information documented in the comment sections usually related to diagnoses and treatments

	failed to consistently summarize health status outcomes. Chronic health conditions contained on the Medical Active Problem List did not consistently have Health Management Plans, even if those conditions were stable, to ensure they remained stable or to prevent exacerbation of the conditions. The Nursing Department needs to ensure that Nursing Case Managers continue to strengthen comment sections and summaries of Annual and Quarterly Nursing Assessments to include whether the individual's health status was progressing, maintaining, or regressing; strategies that are working or not working; and to recommend changes, if indicated, in strategies, support and/or services.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	SGSSLC's Nursing Department's administrative and management structure consisted of a Chief Nurse Executive, Nursing Operation Officer, Infection Control Nurse, Nurse Educator, Hospital Liaison Nurse, three Nurse Managers, 18 Nurse Case Managers, eight Shift Supervisors (four for the 4 pm to 12 am shift and four for the 12 am to 8 am Shift, Clinic Nurse, and Staff Nurses (RNs and LVNs). SGSSLC's Nursing Department at the time of the review had 40 full time Registered Nurses with nine vacancies, and 38 full time Licensed Vocational Nurses, with one vacancy. Five RN positions were in the process of being downgraded to LVN positions to increase nursing coverage on the 10 pm to 6 am shift. The facility did not use agency nurses due to budgetary constraints. Nursing Department only provided 24/7 nursing care in the Infirmary – 516 McKnight West. All other residential units had nursing coverage on the 6 am to 2 pm and 2 pm to 10 pm shifts. The Shift Supervisors on the 4 pm to 12 am and the 12 am to 8 am shifts covered the residential units that did not have 24/7 coverage. According to the Chief Nurse Executive, plans were for the five downgraded RN positions to be used to increase nursing coverage in 508, 510, and 516 East where individuals resided who had increasing health care needs. She further related there was also a need for at least two or three more RN positions and five more LVN positions. The monitoring team met with the Nurse Managers and one of the topics was regarding nursing coverage. Since 4/16/10, the facility no longer used agency nurses. The Nurse Managers and Nurse Case Managers provided direct nursing coverage to make up for the loss of agency nurses. The Nurse Case Managers demonstrated a team spirit and willingness to augment the nursing shortages. While it was commendable that they were willing and able to meet the need for direct nursing care, it was of concern that it may be done at the expense of their own responsibilities as Nurse Case Managers, that included, for example, assessing and planning health care, and attending required meetings. This may be the only short term solution available to them, however, it does not solve the long term nursing shortage problem. The RN staff could only accumulate a limited number of	

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		overtime hours. Plus, there was the risk of "burnout" and loss of good dedicated nurses. Failure to provide adequate nursing care puts individuals' health and safety at risk for neglect. Further, it will be difficult for the Nursing Department to meet the Settlement Agreement and Heath Care Guidelines requirements without adequate nursing staffing. The Chief Executive Nurse, in collaboration with the Assistant Director of Programs, needs to evaluate the number of additional nurses necessary to ensure adequate staffing 24/7 in order to meet individuals health and safety needs. The Chief Nurse Executive needs to continue to recruit nurses for the unfilled positions. According to an interview with the Quality Enhancement Nurse, the Quality Enhancement Department did not have any formalized policies or procedures. Quality Enhancement monitoring tools were in the process of being developed and refined to meet required compliance with the Settlement Agreement and Health Care Guidelines. The Quality Enhancement Nurse developed a Medical Chart Audit Tool by incorporating audit items from the facility's Plan of Improvement (POI). The Medical Chart Audit Tool included the following categories: • Physical and Nutritional Management Plans (PNMPs); Nursing Services: Quarterly Nursing Reviews/Nursing Care, Nursing Care for Acute Illnesses/Injuries and Continuity of Care, Post Hospitalization/Acute Care Bed Setting, Fall/Injury Database/Acute Care Bed Setting, Skin Integrity, Medication Administration/Self Administration of Medication Training/Medication Prescription/Drug Regimen Reviews, Medical Care/Physical Exam/Physical Orders, Health Maintenance Plan, Labs, Preventative Care, Osteoporosis Prevention, Seizure Management, Adult Diabetes, Osteoarthritis, Psychiatric Services, and MOSES/DISCUS. The Medical Chart Audit Tool did not include items related to Infection Control. The tool included two questions regarding Dental Services in the Preventative Care section. The Quality Enhancement tool needs to include items relating to Infection Control and expand Dental related issues on the Medical Chart Audit Tool. The Quality Enhancement Nurse audited four randomly selected records each month. Details of the audit findings were summarized in an Excel database, given a percentage score of compliance for each category, and then an overall percentage was calculated for the overall category. Recommendations for identified deficiencies were placed in a separate Excel database. This information was sent to the facility's Settlement Agreement Coordinator, Chief Nurse Executive, Nurse Managers, Nurse Case Managers, Medical Director, and other relevant disciplines for corrective action. When the Quality Enhancement Nurse was asked how she ensured that recommendations for corrective action were carried out and/or effective, she stated they were confirmed through e-mail feedback, records were checked, or she received hard copies of verification. When corrective actions were recommended it is important that they are followed through to	

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		resolution. The Quality Enhancement Department needs to have a procedure in place to ensure that deficiencies identified through Medical Chart Audits and their accompanying recommendations for corrective action are tracked and followed through to resolution. Copies of the recently developed Quality Enhancement Medical Chart Audit Tool and report for January 2010 were reviewed. The tool covered the medical categories related to the Settlement Agreement and Health Care Guidelines, but failed to contain the necessary specificity. The auditing process needs to refine and develop the monitoring system into a process that identifies problematic systemic nursing practices and health related issues that can be tracked, trended, and analyzed to improve the quality of health care for the individuals who reside at SGSSLC. As the monitoring system evolves, it needs to be in alignment with the Settlement Agreement and Health Care Guidelines. In addition to conducting Medical Chart Audits, the Quality Enhancement Nurse performed a variety of other duties, such as monitoring weights, conducting ICF/MR regulatory requirements, completing clinical death reviews, attending Health Status Team Reviews (HST), attending Personal Support Plan (PSP) meetings, attending PNMP meetings, attending Pharmacy and Therapeutic (Infection Control and Medication Error Sub-Committee) meetings, attending Incident Management Meetings, and working on other special projects when requested. It was questionable as to how one nurse could have the time to adequately perform all of these duties. The facility and Quality Enhancement Director should evaluate the need for an additional Quality Enhancement Nurse. The Nursing Department did not have formalized nursing policies and procedures for monitoring nursing practices. According to the Chief Nurse Executive, the Nursing Department was in the process of developing and implementing numerous monitoring tools to improve the quality of nursing services. She related that medication pass observations of each nurse were moving from annual observations to quarterly observations. Medication pass observations were completed by the Nurse Managers, Nurse Case Managers, and Nurse Educator. Medication Administration Records and Control Drug Counts were audited weekly by a Nurse Manager from another unit to ensure the integrity of the audit. Review of the Medication Observation audit tool indicated that it met acceptable standards of practice for auditing all aspects of medication administration. Copies of the nursing monitoring tools were requested but not received. The Nursing Department's own monitoring process also needs to be refined and developed into a process that identifies problematic systemic nursing practice issues that can be analyzed and trended. The Nursing Department had a Hospital Liaison Nurse whose job responsibilities	

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		included: • Communication with the tertiary care facility to promote continuity of care for individuals served at SGSSLC, • Conducting daily hospital rounds and participating in the communication and coordination of care related to the medical and nursing needs of hospitalized individuals, • Developing health education strategies and locating resources for individuals and/or staff to assist in hospital stays and transitions back to SGSSLC, • Conducting or attending meetings as needed related to assessment findings, • Completing integrated progress notes and verbally communicating findings related to liaison activities with primary physicians at SGSSLC, • Assessing hospitalized individuals while making rounds and communicating findings and recommendations to hospital nurses and SGSSLC primary physicians as necessary, • Completing physical assessments and preparing or assisting in the preparation of care plans as needed. Developing discharge plan strategies for individuals returning back to SGSSLC in coordination with the interdisciplinary team, and • Participation as a professional member of the leadership team when making hospital rounds as a representative of SGSSLC. The Hospital Liaison Nurse who also served as the facility's Admission Coordinator explained her job duties during an interview. She stated that she was successful in establishing good working relationships with the local hospital's nursing staff. The Hospital Liaison Nurse called the hospital every morning to get a report on individuals who were hospitalized. Then, a report was sent to the staff that needed the information. At the time of the on-site tour, the Hospital Liaison Nurse's hospital rounds were on hold. Review of the job description for the Admission Coordinator indicated that if all of the required duties and responsibilities were carried out as described, it would be equivalent to a full-time position. The responsibility required for both positions did not appear to be reasonable for one nurse. This further demonstrated the facility's lack of adequate nursing staffing. The Nursing Department should evaluate the need for an additional nurse to provide either the Hospital Liaison Nurse position or the Admission Coordinator. The Hospital Liaison Nurse did not document hospital findings or communicate with relevant staff in the integrated progress notes. Rather, she communicated with relevant staff by telephone or through e-mail. Her e-mail communications for the current or recently admitted individuals to the hospital were reviewed. E-mail communications for the 14 individuals listed above revealed that the communications were generally brief, informal, and lacking specificity regarding the individual's diagnoses, treatments, and	

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		therapeutic response to treatments. In order for the Hospital Liaison Nurse to achieve optimum effectiveness it is important that she make routine hospital rounds to actually assess individuals and speak directly with hospital staff in order to derive a thorough understanding as to how individuals are responding and/or progressing with their course of treatments. It is also important that the Hospital Liaison Nurse ensure hospital staff are trained and carryout individuals' unique plans of care, particularly as related to Physical and Nutritional Management Plans. The Nursing Department needs to remove the hold on hospital rounds by the Hospital Liaison Nurse. Further, the Hospital Nurse Liaison needs to document all forms of communications regarding individuals' hospital course in the integrated progress notes to ensure continuity of care. Review of 21 individuals' records, listed above, revealed that those with identified episodes of acute illnesses or injuries consistently had Acute Care Plans (ACPs) developed and implemented. In reviewing the 24 Hour Shift Reports for all units, it was positive to find that it contained a list of individuals who had an active ACP. This was a system of flagging in order to help the nurses ensure that the ACPs were carried out. Further review of the reports indicated the interventions to be carried out on each shift. The ACPs, however, did not consistently contain Direct Care Professionals (DCPs) Supervisors' signature and date validating that the DCPs had received training on the interventions they were responsible for carrying out. When ACP issues were resolved, the nurses failed to consistently sign and date the ACPs indicating that the issues were resolved. Failure to document that health issues were resolved has the potential for confusion and continuation of an ACP that was no longer necessary. ACPs are typically for short term use. If the health issues continue for more that 14 days, they need to be renewed or, if the health issue resulted in a chronic condition, a Health Maintenance Plan (HMP) needs to be established. The Nursing Department needs to ensure nurses have the DCPs Supervisors sign and date ACPs when they contain DCP responsibilities for implementation in order to validate that DCPs have been trained. Additionally, the Nursing Department needs to ensure that nurses sign and date ACPs when health issues are resolved. While touring the Infirmary, East and West McKnight, Clinic, 509A, 511 A and B, 505, 502, 508, 501, and 504, the Emergency equipment was checked in each home. All had a red Emergency Crash Bag with an Automatic External Defibrillator (AED) and other emergency equipment. The Emergency Equipment Checklists were randomly reviewed and found to be checked on each shift. Nurses were able to successfully operate the emergency equipment. Review of the Emergency Medical Mock Drill Reports revealed that drills were conducted once per shift per home, and once in each programming area quarterly, according to facility policy. The nursing and direct care staff consistently participated in the drill,	

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		however, physicians did not participate. According to the Emergency Medical Mock Drill Policy, physicians were not specifically identified as required to participate. The Risk Management Department maintained a computerized database and tracked, trended, and analyzed drill data. The Health Risk Management Director was responsible for oversight of the Emergency Mock Drill Response system. When drills were reported failed, recommendations were sent from the CTD staff to the employee's supervisor with recommendation for corrective action/re-training. Re-training of employees was tracked through the CTD's training and tracking system. All employees were reported to be up to date on their CPR training. The facility did not have a committee to review Emergency Medical Mock Drills or Code Blue Responses. When indicated, Emergency Mock Drills and/or Code Blue Responses were discussed in the Incident Management Meeting. The facility and state need to consider evaluating the Emergency Medical Drill Mock Policy regarding physicians' participation in drills.	
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.	Review of 21 records for the individuals listed above revealed the following trends: • Most Annual and Quarterly Nursing Assessments were completed as scheduled according to their PSP calendar.. • Section I Consults and Section II Diagnostic Testing/Screenings were completed with raw data, but rarely contained information in the comment sections summarizing outcomes as related to the individual's health status. • Section III Medication Changes and use of PRN/Emergency Medications Given rarely summarized the individual's therapeutic effects, such as effectiveness, side effect, and/or adverse drug reactions, to the medications in the comment section. • Section IV Nutrition and Weight Management rarely contained information in the comment sections regarding health status related to nutritional risk issues. This was most relevant for those individuals who were under or over their Desired Weight Range and/or who had a Weight Management Programs or who had Nutritional Risks marked in the check box (e.g., unable to chew, GERD, choking, history of aspiration pneumonia). • Section V Tertiary Care Review consistently listed the dates of Inpatient or Outpatient visits and reason. • Section VI History, Functional, and Psychosocial only contained information regarding surgical history because that was what the comment section asked for. This was misleading because it eliminated the need to summarize past history information checked in the boxes above (e.g., history of GERD, hypertension, hypothermia, heart disease) that could be critical to developing future health care plans. The Functional Status portion of these sections rarely contained summarized comments for the individual's functional status items checked in the box (e.g., ambulation, positioning schedules, adaptive aids, toileting, awareness, behaviors). Again, important information was not documented that might be	

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		useful in future assessments and care planning. • Section VII Infection and Immunization types and dates were relatively consistently documented, but were not summarized in the comment sections. • Section VIII Physical Assessments of systems reviewed failed to consistently contain substantive information documented in their respective comment sections for items checked in boxes. Information documented in the comment sections usually related to diagnoses and treatments failed to summarize health status outcomes. This was particularly relevant for blood pressure summaries for individuals diagnosed with hypertension, Saturation of Peripheral Oxygen (SPO2), or for individuals with diagnosed respiratory compromise. • Section X Nursing Diagnoses were documented using the North American Nursing Diagnoses Association (NANDA) nursing diagnoses for health issues identified as requiring nursing interventions. Nursing diagnoses did not consistently include all chronic health conditions listed on the individual's Medical Active Problem Lists. Individuals with active problems for chronic conditions receiving medical interventions (e.g., medication, treatments, laboratory and diagnostic testing) required monitoring by nurses and needed Health Management Plans (HMPs). Often HMPs were found for which there were no nursing diagnoses. This indicated that the Annual or Quarterly Nursing Assessments were not reviewed/revised at the time the HMPs were established. For every nursing diagnosis there must be an HMP, and conversely, for every HMP there must be a nursing diagnosis. • Section X Nursing Summary - Review of this section revealed the following trends: o Nursing summaries failed to consistently describe the effectiveness of interventions described in individuals' HMPs, particularly as related to the effectiveness of anticonvulsant and psychoactive medication. Nursing Summaries for individuals with alteration in mental status typically stated, "will continue to assess for changes in through processes and behavior," but failed to actually describe their cognitive functioning. o Often, only responses to a few of the HMPs were summarized. Details of the summaries primarily consisted of listed treatments, diagnostic test, consults, and medications received, but not the therapeutic response or the effectiveness of the HMP. o Many of the Nursing Summaries simply stated, "will continue to monitor the respective HMP." It was difficult to discern whether the individual's health status was progressing, maintaining, or regressing, or whether intervention strategies were working or not working. Seldom found was documentation indicating recommendations for changes in	

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		strategies, supports, and/or services. o Self Administration of Medication (SAM) Program assessments and plans were consistently missing in the Nursing Summaries. According to facility policy, nursing staff were responsible for implementing SAM programs and collecting data. Nursing Summaries also failed to document information regarding MOSES and DISCUS screening, and sexual assessments. Review of the Annual and Quarterly Nursing Assessment Form indicated these items were not printed on the form. Note, however, that Annual and Quarterly Nursing Assessments, comments, and summaries completed within the past two or three months showed steady improvements. Annual and Quarterly Nursing Assessments enable the Nurse Case Managers to make comparisons of individuals' health status from quarter to quarter, culminating in a comprehensive annual assessment containing relevant information that contributes to development and/or revisions to HMPs, and provides the Personal Support Team (PST) information from which to develop Personal Support Plans (PSPs). The Nursing Department needs to ensure that Nursing Case Managers continue to strengthen comment sections and summaries of Annual and Quarterly Nursing Assessments to include whether the individual's health status was progressing, maintaining, or regressing; strategies that are working or not working; and to recommend changes, if indicated, in strategies, support and/or services. The Nursing Department needs to revise the Annual and Quarterly Assessment Policy and Procedure and reporting forms so that they include printed information regarding SAM, MOSES and DISCUS, and sexual assessments. The Nursing Department needs to ensure that Nurse Case Managers consistently have nursing diagnoses for each HMP, and that each nursing diagnosis has an HMP.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated	HMPs did not consistently include all relevant chronic heath conditions that the monitoring team identified through review of individuals' records and cross-walking them with their respective Nursing Diagnoses and HMPs. This review revealed the following trends: • Individuals with chronic health conditions listed on their Medical Active Problem who were receiving medical interventions (e.g., medication, treatments, laboratory and diagnostic testing) did not consistently have HMPs. Individuals with chronic health conditions, although stable when receiving medical interventions, require monitoring by nurses and need an HMP to ensure that those conditions remain stable and if they become unstable, are quickly identified and receive prompt medical attention to stabilized or prevent exacerbation of their chronic illness. For example:	

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	by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	○ Individual #222's Medical Active Problem List included diagnoses of seizure, osteoporosis, and chronic obstructive pulmonary disease (COPD), hypertension, and constipation for which there were no HMPs. According to individual #222's Quarterly Nursing Assessment, Nursing Summary, 7/9/09, the HMP for osteoporosis was discontinued because he had no injuries or falls in the past year; seizure HMP was discontinued because of no seizure activity since 2000; COPD HMP was discontinued because of no respiratory difficulty in the past year; HMP was discontinued for constipation because no PRN medication was required for constipation; and hypertension HMP was discontinued because the blood pressure had been with in normal limits for the past six months. Even though the chronic conditions were stable for a period of time, they were not eliminated and there remained the potential for the conditions to become unstable. ○ Individual #59's Medical Active Problem List included ventriculoperitoneal shunt implant, glaucoma, chronic anemia, weight loss, and degenerative joint disease for which there were no HMPs. According to the Annual Nursing Assessment, Nursing Summary, 2/2/10, the glaucoma HMP was discontinued because there had not been any change in vision, she ambulated without difficulty, had not had any falls or injuries, and used Travatan and Cosopt drops for glaucoma. • HMPs for individuals with mobility problems referred to following OT/PT recommendation per PNMP for mobility, positioning, and use of wheelchair. While there needs to be collaboration with those disciplines to ensure interventions are consistent, the nursing HMP should also include interventions for mobility issues because the interventions may vary as well as instructions for the DCPs (e.g., individual #122). • The HMPs were generic in nature. They were not individualized; many of the interventions read the same for all nursing diagnoses. There was no indication as to where or how the interventions were to be documented, by whom, or the frequency. • The HMPs contained goals and objectives however, most were classic textbook varieties and were not necessarily realistic. • The HMPs were not consistently specific as to the frequency in which interventions were to be carried out nor did they designate the person responsible for carrying out the interventions. • Often HMPs were found for which there were no nursing diagnoses. This indicated that the Annual or Quarterly Nursing Assessments were not reviewed/revised at the time the HMPs were established. For every nursing diagnosis there must be an HMP, and conversely, for every HMP there must be a	

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		nursing diagnosis. • The HMP instructions for the DCP staff were not consistently dated and signed by the DCP Supervisor on the designated line verifying that DCP staff had been trained. • The HMPs were not signed at the time of the Quarterly Nursing Assessment verifying that they had been review/revised. Inconsistently, the Nursing Summary stated to continue or discontinue the HMP. The Nursing Department's Nursing Case Managers need to ensure that all chronic health conditions contained on the Medical Active Problem List have an HMP, even if those conditions were stable, to ensure they remained stable or to prevent exacerbation of the conditions. HMPs need to be individualized with realistic goals and objectives. HMPs need to be applicable for long-term health maintenance issues specifically related to individuals with intellectual and developmental disabilities. The HMP procedure and form did not require a signature validating that the nurse reviewed/revised the HMP quarterly. The Nursing Department needs to include signature and date lines on the HMPs in order to ensure that they are reviewed and/or revised at the time the Quarterly Nursing Assessment are completed.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Review of the Nursing Policy and Procedure Manual indicated that the Nursing Department had adopted and implemented Nursing policies and procedures recently developed by the State Nurse Work Group. Review of the training records indicated that the nursing staff had received training on these policies. Training records also validated that the nursing staff had received annual competency-based training. Review of the N-21 Seizure Policy had not been updated since 6/8/08 and was not in alignment with the Health Care Guidelines. The Nursing Department needs to review all policies and procedures to ensure that are in alignment with the Settlement Agreement and Health Care Guidelines, particularly the Seizure Management Policy and Procedure. Any policies and procedures no longer in use need should be removed from the Nursing Policy. The Nursing Department had a Nurse Educator who developed the Nursing Orientation Curriculum. The Nurse Educator was responsible for overseeing the orientation of newly employed nurses, refresher training, and other identified training needs. Review of the orientation, refresher training, and competency-based testing materials indicated that they were comprehensive and included all relevant aspects of nursing practices as well as other facility-required training. According to the Nursing Orientation Schedule new nurses received six days of classroom training. All nurses received refresher training every six months and were competency-based tested annually. Due to the high risk for aspiration/aspiration pneumonia in the intellectual and developmentally disabled population, the Nursing Educator needs to continue to develop and present educational	

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		topics relevant to high risks and topics unique to individuals with intellectual and developmental disabilities. These topics need to be routinely covered in nursing orientations and in refresher courses. The Nurse Educator needs to ensure that nurses receive comprehensive Physical and Nutritional Management training from qualified professionals such a Speech and Language Therapist.	
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.	SGSSLC was using the Health Risk Assessment Tool-Nursing Section as the tool for the identification of clinical risk indicators for individuals. The Health Risk Assessment Policy and Procedure was of concern due to the fact there were no specific and/or clear criteria for determining risk levels. The tools asked "yes" or "no" questions for items relating to Cardiac, Constipation, Dehydration, Diabetes, GI Concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. This Health Risk Assessment Tool was not adequate to provide a comprehensive health risk assessment for any of the areas listed above, nor did it result in an appropriate identification of clinical risk indicators. This inconsistency was evident when cross-walking the 21 individuals' records reviewed with their Medical Active Problem Lists, Annual and Quarterly Nursing Assessments' Nursing Summaries, HMPs, and Health Risk Scores. Chronic health conditions identified on their Medical Active Problem Lists indicated they were receiving medical interventions, although their Health Risk Scores might have scored their risk levels as low or medium. Numerous individuals with low to medium risk levels assigned to their chronic health conditions failed to have HMPs. The facility's Health Risk Rating procedures for Nursing provided the following instructions: • Low Risk – If the individual has a diagnosis that is being controlled and maintained (with or without Medications) and has had no exacerbations or breakthrough episodes and has not had any for one year. • Medium/Moderate – If the individual has a diagnosis that is being controlled and maintained (with or without Medications) and has an occasional or infrequent exacerbation or breakthrough episodes and/or medication adjustment within the past one year. • High - if the individual has a diagnosis that requires frequent medication adjustment or change of medication, requires close monitoring of condition (labs, frequent vital signs, etc.), is medically fragile and still having exacerbation or breakthrough episodes within the past one year. The concern was that such guidelines had the potential for misleading nurses when identifying individual's need for HMPs. Individuals with chronic health conditions, although stable when receiving medical interventions, require monitoring by nurses and need an HMP to ensure that those conditions remain stable, and if they become unstable,	

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		are quickly identified, and receive prompt medical attention to stabilize or prevent exacerbation of their chronic illness. The facility used the standardized BRADEN Scale and the Pressure Ulcer Scale for Healing (PUSH) for assessing and managing skin integrity issues. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria in order to determine risk, to eliminate subjectivity, and to ensure that the Tool meets accepted professional standards of care. The monitoring team attended the Health Status Team (HST) Meeting held during the week of the on-site tour. David Ann Knight, RN, MSN, HST Coordinator, Chaired the meeting. Membership was comprised of all clinical disciplines. The meeting was well attended, coordinated, and ran efficiently. Each discipline presented Health Risk Assessment Ratings for 12 individuals. The HST reviewed and discussed recommendations for each risk category. There was active discussion and leadership from the medical director. Review of 21 current Personal Support Plans (PSPs) revealed that the Nurse Case Managers failed to include documentation for Nursing Assessments, Services, Recommendations, and comments in 14 (67%) of these PSPs. Moreover, two (10%) of stated, “refer to” the individual’s Nursing Assessment or HMPs. Failure for the Nurse Case Managers to include Nursing Assessments, Services, Recommendations, and Comments in the PSPs was not acceptable practice because the purpose of PSPs was to provide integrated services to individuals. Therefore, all disciplines were required to contribute to the PSPs in order to ensure that individuals’ total needs for supports and services were identified, reviewed, discussed, and compiled into comprehensive plans of care. The Nursing Department needs to ensure that Nurse Case Managers consistently include Nursing Assessments, Services, Recommendations, and Comments in individuals’ PSPs. The monitoring team attended the Annual PSP Meeting for Individual #146. The Nurse Case Manager participated in the meeting, discussing the individual’s heath status and health care needs. Individual #146 had declining health for the past year and required nursing care 24 hours a day, seven days a week, however, her present home did not provide nursing care 24 hours a day, seven days a week. She was scheduled to move to McKnight West, the only residential living unit that provided this level of nursing care. According to the PSP’s Nursing Assessment for the past year, this was the second time in less than a year that Individual #146 had to be moved to a residential living unit that provided a higher level of health care and support. It was of concern that this individual had to move from her familiar staff, relationships, and surroundings because the facility could not provide the health care services and supports required due to facility	

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		constraints for hiring adequate nursing staff. McKnight West was observed to be a more restrictive and hospital-like environment. This had the potential to cause additional emotional stress to her existing health issues. In addition, elderly individuals, such as Individual #146, typically do not have the emotional fortitude to cope and adjust to changes in their living arrangements. These moves appeared to be for the convenience of the facility due to the nursing shortage and demonstrated the dire need for the facility to adequately provide nursing coverage 24 hours a day, seven days a week, particularly in residential living units where individuals lived with increasing health care needs, such as in residential living units 508, 510, and 516 East.
		
		Review of the facility's Pneumonia Tracking Sheet, 3/29/09 through 3/29/10, revealed the following information:
		• There were 24 diagnosed cases of various types of pneumonia reported, involving 15 different individuals. Numbers of diagnosed cases by type were:
		  o 13 Bacterial
		  o 8 Aspiration
		  o 2 Viral
		  o 1 Other
		• Of the 15 individuals diagnosed with some type of pneumonia their methods of receiving nourishment were:
		  o 9 received nourishment by mouth
		  o 6 received nourishment by enteral feedings
		• Of the 5 individuals diagnosed with aspiration pneumonia their methods of receiving nourishment were:
		  o 3 were nourished by mouth
		  o 2 were nourished by enteral feedings
		• 5 of the 15 individuals had repeated incidences of some type of pneumonia:
		  o Individual #78: 2 aspiration pneumonia, 2 bacterial pneumonia
		  o Individual #89: 4 aspiration pneumonia (deceased)
		  o Individual #54: 3 bacterial pneumonia (deceased)
		  o Individual #282: 2 bacterial pneumonia (deceased)
		  o Individual #38: 1 bacterial pneumonia, 1 viral pneumonia
		
		Fifty four percent of the individuals with cases of pneumonia were diagnosed with bacterial pneumonia. The Infection Control Nurse and Hospital Liaison Nurse need to collaborate with the hospital physicians to ensure that the types of pneumonia are accurately diagnosed. Often, aspiration pneumonias are misdiagnosed. Having the correct diagnosis for pneumonia is crucial for developing preventative plans of care. Sixty percent of all individuals diagnosed with any type pneumonia, as well as 60% of those who were diagnosed with aspiration pneumonia, received nourishment by mouth.	

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		The PNMT needs to trend data to determine if individuals who are nourished by mouth are more at risk for developing aspiration pneumonia as oppose to those who were enterally nourished. According to the Nursing Department's N-2 Weight Management Guidelines – Team Roles, Nursing, #14, "RNs participate in mealtime monitoring." The Nursing Department did not have specific policies and procedures in place describing the role of nursing in the management of issues related to positioning and eating. Nurses did not routinely participate in mealtime observations. The Nurse Case Managers participated in NMT, PSP, and HST Committees. Nurses were responsible for assessing individuals who experienced difficulty swallowing during mealtimes. These assessments were typically made after the DCP staff reported such concerns to the nurses. It is of concern that the DCP staff appeared to be responsible for determining whether or not the severity of an individual's swallowing difficulty rose to the level necessary for assessment by nurses. The DCP staff may not readily recognize subtle signs and symptoms of aspiration. Therefore, it is critical that nurses are competent in assessing and managing swallowing difficulties for individuals at high risk for choking and aspiration. The Nursing Department needs to develop procedures that specifically define the RN's role and responsibilities for meal time monitoring. The Nursing Department needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by nurses. The facility had a Skin Integrity Committee that met monthly to review and address skin integrity issues. The committee was chaired by Rachel Wittich, RN, Unit Nurse Manager. Membership included the Quality Enhancement Nurse, Infection Control Nurse, Unit Nurse Managers, Unit Nurse Case Managers, Nutritionist, Habilitation Staff, Rehabilitation Staff, and Direct Care Professionals. The monitoring team attended the committee meeting during the week of the on-site tour. The Committee thoroughly reviewed and discussed individuals' #122 and Individual #222 skin integrity issues and made suggestions for managing their care. Individual #122 had a high risk score for skin integrity, secondary to chronic skin breakdown caused by yeasty dermatitis of abdominal folds. Individual #122 had BRADEN Skin Assessment score of 16, for which an HMP and ACP were in place. Individual #222 had a medium risk score for skin integrity, secondary to increased moisture between toes in addition to chronic redness and hardened areas of the medical gluteal fold. Individual #222 had a BRADEN Skin Assessment score of 17 for which an HMP and ACP were in place. Many of the facility's Infection Control Policies and Procedures, adapted from the DADS SSLC Infection Control Policies and Procedures, had not been reviewed and/or revised since 2007 or 2008. A review of the Infection Control Training curriculum and competency-based testing for nursing orientation and refresher training found that they	

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		met professional standards of practice, particularly as related to Hand Washing and Standard Precautions. The Infection Control Nurse provided relevant staff with training on specific topics related to the individuals' unique needs when infectious processes were diagnosed and/or identified (e.g., urinary tract infections, MRSA, pneumonia, other infectious diseases). The state and facility need to review and/or revise Infection Control Policies and Procedures to ensure they are current with Centers for Disease Control and Prevention Guidelines and professional standards of practice. The Infection Control Committee was also chaired by the Infection Control Nurse. Membership was comprised of the Chief Nurse Executive, Quality Enhancement Nurse, Nurse Managers, Risk Management Director, Assistant Director of Programs, Physical Therapist, facility Pharmacist, Physician, Plant manager, and facility and Environmental Supervisors. Review of Infection Control Committee Minutes, 9/22/09, 12/26/09, and 4/27/10, indicated that the Infection Control Nurse consistently reviewed and discussed the following issues: • Total number of infections by type • Antibiotic Susceptibility • Urinary Tract Infections (UTIs) • MRSA • C. difficile • Pneumonia • Influenza The Infection Control Committee Minutes revealed discussions regarding the number and type of infections reported each quarter and whether there was clustering of infection in the homes. • For example, the minutes reported an increase in UTIs in 508A during the combined 3rd and 4th quarter reports. Committee minutes from 4/27/10 stated that a single root cause could not be identified for the spike in UTIs on 508A. In this same document, it was noted that the same individuals continued having contaminated UAs. "Committee discussion" point two addressed this with the recommendation to collect all UAs via catheter if possible. • In the 1st quarter of this year, there was a spike of pneumonia in 516W. Measures such as limiting the flow of traffic, increasing education on handwashing, and purchasing individual sue slings for lifts were put in place to contain the spread without success. • The Medical director expressed the concern that the blue staff vests could have contributed to the spread. The state office was asked to consider this possibility and did so. New policies and procedures were implemented regarding discontinuation of the wearing of these vests.	

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		The Infection Control Committee needs to consistently examine causative factors for all infections regardless of whether they are clustered in order to take every means necessary to prevent infections. A review of Infection Control reporting and tracking document (Infections, Antibiogram Reports, and Avatar Pneumonia Tracking Report) demonstrated that the facility actively collected data with regard to infections and communicable disease. Data were maintained for tracking infections, identifying outbreaks, and other problematic trends. This information was reported to the Infection Control Committee, Physicians, Nurse Case Managers, and other relevant staff for follow up. There was no formalized written procedure in place describing how data were collected, communicated, and reported. The Infection Control Nurse stated that Nurse Case Managers filled out a form for individual-specific infection information and sent it to the Infection Control Office for entry into the respective Infection Control spreadsheet. The Infection Control Nurse reviewed the spreadsheet weekly for undesirable trends. When undesirable trends were noted in particular homes, she talked with the respective Physicians, Case Managers, and PSTs, as well as with other relevant facility program staff (e.g., Housekeeping, Food Services, Building Maintenance). When undesirable trends were identified, Nurse Case Managers were responsible for completing risk assessment tools, initiating care plans, and following through until issues were resolved. When issues were resolved, reports were completed and sent to the Infection Control Office. The Infection Control Nurse related that much of the information, described above, was communicated verbally by telephone calls and through e-mails. Such information was not routinely documented in the integrated progress notes. The facility's Infection Control Nurse needs to develop and implement written procedures for how communication flows to and from the Physicians, Case Managers, PST and other relevant facility program staff. The Infection Control Nurse needs to ensure that relevant individual specific information relating to Infection Control communication is documented in the integrated progress notes. The Infection Control Nurse did not maintain a centralized database for tracking individuals' immunization status. It was the Nurse Case Manager's responsibility to track individuals' immunization status and report to the physician when an individual's immunizations needed to be updated. The Infection Control Nurse needs to develop and implement a centralized database to track immunization status with flags to queue when immunization needs updating. The Infection Control Nurse maintained a formalized system in place to track, trend, and analyze infection control data. It is important to trend and analyze these data over time for data to be meaningful, and to identify systemic trends. The Infection Control Nurse needs to track, trend, and analyze data over time to identify risk indicators and systemic trends, and use such data for making systemic improvements when indicated.	

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		The Infection Control Nurse reported to the Chief Executive Nurse. The Infection Control Nurse related during the interview that she had other job responsibilities in addition to Infection Control. She assisted in the Dental Clinic and ordered medical supplies. When asked about environmental surveillance monitoring, she expressed the need for some help with completing, conducting, and obtaining the surveillance activities (which were completed by other staff at the facility). The Infection Control Nurse did not document in the Integrated Progress Notes. Communication to the physician, Nurse Case Managers, and other relevant staff were handled through telephone calls or email. The Infection Control Nurse needs to document infection control communication in the individual Integrated Progress Notes to ensure continuity of care. In order for the Infection Control Nurse to meet the entire requirements inherent in managing an effective Infection Control Program, the Nursing Department should evaluate the need for an additional nurse or relieve the Infection Control Nurse of extra duties.	
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.	Medication Administration Pass Observations were completed in McKnight West on 5/12/10. The staff nurse administering medications failed to follow correct medication administration practices. For the first individual observed, the staff nurse had set up and documented the medication on the Medication Administration Record (MAR) prior to the monitoring team's observation. The staff nurse related that there was a Physician's Order allowing the medication to be set up in advance because the medication was administered via G-tube and needed time to dissolve in liquid prior to administration, even though the medication had been crushed. The prepared medication was placed on a rolling cart without the MAR and transported to the individual's bedroom. The MAR must be present at the time medication is administered to identify the medication up to the point of administration, and identify the individual by picture and name. The individual resided in a room with another individual. The nurse failed to draw the privacy curtain. The G-tube was checked for placement by aspirating stomach contents, but the nurse failed to inject air into the tube while listening with a stethoscope for placement. Upon completion of the medication pass, the nurse failed to instruct the DCP to keep the individual's head elevated at 30 degrees for at least 30 minutes after receiving medication. The nurse prepared the medication for the second individual by properly checking the medications against the MAR, however, a pill was dropped on the medication cart, picked up with her fingers, and placed in the pill cup for administration. This was a violation. Medication accidently dropped must be discarded. After the medication was prepared, it was placed on the rolling cart without the MAR and transported into the individual's	

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		room. The nurse checked for placement by aspirating the stomach contents, but had to be prompted to check for placement by injecting air into the G-tube and listening for the air to pass with a stethoscope. The nurse instilled eye drops, and then used a wash cloth to wipe the individual's tearing. The dirty wash cloth was placed back on the clean cart, therefore, contaminating the cart. Upon completion of the medication pass, the nurse failed to instruct the DCP to keep the individual's head elevated at 30 degrees for at least 30 minutes after receiving medication. After administration of the medication, the nurse did not immediately chart the medications administered because the MAR was not on the cart. Another nurse was observed passing medication during the noon meal in 516 East, on 5/10/10. The nurse was observed placing medications in a drinking glass of liquid at an individual's table and walking away. This is a violation of correct medication administration practice. The nurse must stay with the individual when medication is administered to ensure that the medication was taken. According to facility's Medication Administration Policy and Procedure, medications are to be administered at the designated medication area or at the individual's bedside, only with Physician's Orders. The Chief Nurse Executive and Quality Enhancement Nurse were made aware of the improper medication administration practices observed. Both nurses were immediately re-trained in proper medication administration practices and validation of their training was provided to the monitoring team. The Chief Nurse Executive related that medication pass observations were moving from annual observations on each nurse who administers medication to quarterly observations. Medication pass observations were completed by the Nurse Managers, Nurse Case Managers, and Nurse Educator. Medication Administration Records and Control Drug Counts were audited weekly by a Nurse Manager from another unit to ensure the integrity of the audit. Review of the Medication Pass Observation audit tool indicated that it met acceptable standards of practice for auditing all aspects of medication Administration. The Chief Executive Nurse stated that the Nursing Department was in the process of formalizing procedures for auditing, tracking, and trending medication administration practices. Review of 21 individuals' Medication Administration Records (MAR) and Treatment Records for the month of April 2010, revealed that 11 (52%) of the 21 records contained omissions or discrepancies in documentation. • Individual #241 o Blood pressure and pulse assessments were ordered to be checked each Sunday–pm; the blood pressure and pulse assessments were not	

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		documented on 4/25/10.
		• Individual #59
		  o Acetaminophen 650 mg tablet, orally, as needed (PRN), administered at 1500 on 4/16/10 for headache, failed to document the effectiveness of the medication,
		  o Weekly weights were not documented on 4/9/10 and 4/30/10, and
		  o Diet Record for lunch was not initialed on 4/5/10.
		• Individual #127
		  o Multivitamin/Minera+ Tablet, one tablet, orally, daily at 0800 for nutrition, was not initialed on 4/30/10,
		  o Omega-3 Fatty Acids, one capsule, orally, three times a day with meals for high triglyceride and low high density lipoprotein (HDL), was not initialed at 0700 and 1130 on 4/30/10,
		  o Seroquel 300 mg, orally, each morning for 90 days, (purpose not listed), was not initialed at 0800 on 4/30/10,
		  o Rivastigmine 1.5 mg, one capsule, twice daily, orally, for Alzheimer's, was not initialed at 0800 on 4/30/10,
		  o Sennosides 8.6 mg, one tablet, twice a day, orally, for constipation, was not initialed at 0800 on 4/30/10,
		  o Reglan 10 mg solution (route or purpose not listed), ordered to be given for three days at 0800, according to the MAR instruction block, was put in the 1200 time block. The medication was initialed at 1200 on 4/28/10 as opposed to 0800 as ordered. The medication was not initialed at 1200 on 4/29/10 and 4/30/10. This medication was not given at the time ordered and the dose on 4/29/10 and 4/30/10. These two situations amounted to two different medication errors: wrong time and omission.
		  o Albuterol Ipratro+ Ampul-Neb, 3 ml, inhalation, four times a day, PRN, (purpose not listed), administered at 0300 on 4/8/10 and at 0230 on 4/9/10, failed to document the effectiveness of the medication,
		  o Robitussin (plain) 10 cc every six hours, (route not listed) for cough, administered at 0150 on 4/16/10 and at 0100 on 4/18/10, failed to document the effectiveness of the medication, and
		  o Intravenous fluids administered at 0700, on 4/28/10, failed to record the amount of fluid infused; at 0600 on 4/30/10, failed to enter the type solution infused.
		• Individual #301
		  o Tylenol 650 mg, orally, every six hours PRN for pain, administered at 0050 on 4/13/10, failed to describe the nature of the pain or the effectiveness,	

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		• Individual #346 o Chlorpromazine 100 mg tablet, orally, twice a day, at 0800 and 1200, for self-injurious behavior, was not initialed at 1200 on 4/18/10. • Individual #78 o Acetaminophen 650, orally, every four to six hour PRN, at 1500 on 4/18/10, failed to document effectiveness, o Weights every Wednesday were not documented on 4/7/10, 4/14/10, and 4/28/10, and o Check Oxygen Saturation (O_2Sats) one time per shift, 6-2 and 2-10, failed to initial on 2-10 shift on 4/6/10, 4/8/10, and 4/19/10. • Individual #385 o Propranolol 40 mg, one tablet, orally, four times a day, for aggression, was not initialed at 0800 on 4/3/10 and 4/4/10 or at 1200 on 4/3/10 and 4/4/10, o Potassium Citrate Tablet SA 10 mEq, one tablet, orally, three time a day, for seizure disorder, was not initialed at 0800 on 4/3/10 and 4/4/10 or at 1130 on 4/3/10 and 4/4/10, o Valproic Acid 250mg/5+ Syrup, 125 mg = 2.5 ml, orally, twice a day for seizures, was not initialed at 0800 on 4/3/10 and 4/4/10 or at 0800 on 4/13/10, o Quetiapine 50 mg, orally, daily at 2000 (bedtime), for aggression, was not initialed at 2000 on 4/27/10, o Sertraline 100 mg tablet, one tablet, orally, daily at 0800, for mood, was not initialed at 0800 on 4/3/10 and 4/4/10, o Polyethylene Glycol + Powder, 17 gm, orally, daily at 0800, mix with 8 ounces of water or 7UP, was not initialed at 0800 on 4/3/10 and 4/4/10, and o Terbinafine 1% cream (mg), topical, as directed for athlete's foot, was not initialed at 0800 on 4/4/10 and 4/4/10 (foot soak 10 to 15 minutes in H_2O_2 and H_2O prior to applying Terbinafine cream, was not initialed). • Individual #222 o Cholecalciferol 1200 units, three tablets = 1200 units, orally every day at 0800 for immunity, was not initialed at 0800 on 4/2/10 and 4/9/10. • Individual #122 o Carbodopa/Levopopa 25/50 tablet, orally, one tablet four times a day, (purpose not listed), was not initialed at 0800 on 4/6/10; at 0800 on 4/6/10, o Cholecalciferol 1200 units, three tablets, orally daily at 0800, for nutrition, was not initialed at 0800 on 4/6/10, o Cyproheptadine 4 mg tablet, orally three times a day, for appetite	

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		stimulant, was not initialed at 0800 on 4/6/10 or at 1200 on 4/6/10, o Fluvastatin sodium capsule, 40 mg = two capsules, daily at 0800 (purpose not listed), was not initialed at 0800 on 4/6/10, o Multivitamins/Minera+ tablets, one tablet, orally, daily at 0800, for nutrition, was not initialed at 0800 on 4/6/10, o Sucralfate Tablet, 1 gm, one tablet, orally, four times a day, (purpose not listed), was not initialed at 0800 and 1200 on 4/4/6/10, and o Nystatin 100,000 U/G+ Powder, 1 powder topical after bath and every Attends change, was not initialed on 6-2 shift on 4/6/10. • Individual #124 o Ibuprofen 400 mg, one tablet, orally, every eight hours PRN for headache, was also documented as given for ankle pain. The order should have included for ankle pain. The pain relief effectiveness was not consistently documented. • Individual #112 o Weekly weight was not initialed on 4/27/10. • Individual 137 o Metoprolop Tartrate 25 mg tablet, orally, twice a day for hypertension, was not initialed at 2000 on 4/5/10, 4/6/10, 4/9/10, 4/10/10, 4/11/10, 4/12/10, 4/14/10, 4/15/10, 4/16/10, 4/19/10, 4/20/10, 4/21/10, 4/22/10, 4/24/10, 4/25/10, 4/26/10, 4/27/10, 4/28/10, and 4/30/10. Orders were to withhold medication if the blood pressure readings were less than 100/60 or pulse rates were less than 60 beats per minute. For the dates listed above where initials for the medication were missing, blood pressure readings and pulse rates were above the established parameter to withhold medication; the medication should have been given, o Timolol/Dorzolamide 0+ Drops, one drop twice a day in both eyes, for glaucoma, was not initialed at 2000 on 4/2/10, and o Pepto Bismol, two tablets, orally, PRN, (purpose not listed) given at 2330 on 4/24/10, for stomachache, failed to document effectiveness. Another dose of Pepto Bismol, two tablets, was given at 0730 on 4/25/10, but the response was not documented. The omissions in initialing the medications identified above were medication errors. Whether they were due to omission in charting or actual omission in administering the medications could not be determined in this retrospective record review. Regardless of the reason for the omissions, these omissions resulted in medication errors. The MAR failed to include the purpose and route of administration for numerous medications. Medications that were hand written on to the MAR were difficult to read, disorganized,	

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		and did not contain pertinent information, such as route and purpose. When medications were discontinued, the dates and times for discontinuation were not consistently documented on the MAR, nor were lines drawn through the remaining blocks. These findings demonstrated the need for increased monitoring of the MARs and treatment records as well as increased medication administration pass observations. The Nursing Department needs to ensure that Nurse Managers and Nurse Case Managers increase monitoring for MAR audits and medication administration pass observations. The facility's Pharmacy Department needs to ensure that the purpose and routes of medications are included on the MARs. The facility's Nursing Department needs to ensure that the dates medications are discontinued are included on the MAR and that a line is drawn through the remaining block. Review of 21 Program records for the month of April 2010, revealed that 21 of 21 of the individuals had a Self Administration of Medication (SAM) program in place. All SAM Programs contained: Training purposes, instructions, objectives, program times, how often programs were to be done and scored, and the staff responsible. Seventeen of the SAM Programs were completed as designed. Four programs contained discrepancies as follows: • Individual #69's SAM Program instructions were for the program to be implemented one time a day, at the p.m. medication pass, Monday through Friday. The initialed data were not marked and initialed daily by the nurses. While this may not have caused harm, it indicated that the nurses may not be reviewing and following the program as designed. • Individual #59's SAM Program instructions were for the program to be implemented twice a day, on the 6-2 and 2-10 shifts medication passes. Data were not entered on the 2-10 shifts on 4/3/10 and 4/9/10. • Individual #301's SAM Program instructions were listed for the morning medication passes, however, the frequency of the program instructions stated twice a day. These two instructions were in conflict and should be corrected to ensure that the program can be implemented correctly. • Individual #281's SAM Program instructions were for the program to be implemented during the a.m. and p.m. medication passes, twice a day. Data were not entered on the p.m. shift on 4/18/10. The facility's Nursing staff and Qualified Mental Retardation Professional (QMRP) staff needs to ensure that instructions for program times are consistent with the instruction for how often the program should be implemented. Review of the Medication Error Reports, 2/1/10 through 5/8/10, indicated that medication errors were maintained in a computerized tracking database. All Medication	

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		Errors were entered in the database with monthly reports produced. The reports provided a detailed description of the errors in tabular and graphic forms. • In February 2010 a total of 10 medication errors were reported, of which nine were due to omissions, and one the wrong time. • In March 2010, a total of 14 errors were reported of which five were due to documentation, four due to omissions, two due to wrong dosage, two due to unauthorized medication, and one due to improper dose/quantity. • In April 2010, a total of eight errors were reported, of which six were due to omissions, one due to an extra dose, and one wrong medication. The report contained corrective action taken for each error. Review of the Medication Error Committee Minutes, (later a sub-committee of the Pharmacy and Therapeutic Committee) and the Pharmacy and Therapeutic Committee Quarterly Meeting Minutes, indicated that medication errors were reviewed and analyzed at each meeting. Medication errors were reported in graphic form. It was difficult to interpret without instructions. The facility's Nursing and Pharmacy departments needs to develop and implement a system that includes all disciplines responsible for medication administration to analyze, track, and trend clinical data for medication errors. These data need to be used to develop interventions to prevent or reduce medication errors. Data findings need to be included in the Nursing Management Meetings, Medication Error Committee, and Pharmacy and Therapeutic Committee meetings.	

Recommendations:

1. The facility's Chief Executive Nurse in collaboration with the Assistant Director of Programs should evaluate the number of additional nurses necessary to ensure adequate staffing 24/7 to meet individuals health and safety needs. The Chief Nurse Executive should continue to recruit nurses for the unfilled positions. The Nursing Department should evaluate the need for an additional nurse regarding the responsibilities of the Hospital Liaison Nurse position or the Admission Coordinator.

2. The Quality Enhancement Department and Quality Enhancement Nurse need to:
   - include items relating to Infection Control and expand Dental related issues on the Medical Chart Audit Tool,
   - have a procedure in place to ensure that deficiencies identified through Medical Chart Audits and their accompanying recommendations for corrective action are tracked and followed through to resolution,
   - refine and develop their monitoring system into a process that identifies problematic systemic nursing practices and health related issues that can be tracked, trended, and analyzed to improve the quality of health care for the individual who reside at SGSSLC. As the monitoring system evolves it needs to be in alignment with the Settlement Agreement and Health Care Guidelines, and
   - evaluate the need for an additional Quality Enhancement Nurse.

3. The facility's Nursing Department's monitoring process needs to be refined and developed into a process that identifies problematic systemic

nursing practice issues that can be analyzed and trended. In addition, these data need to be integrated into the facility's Quality Enhancement and Risk Management Systems.

4. The Nursing Department needs to remove the hold on hospital rounds by the Hospital Liaison Nurse. Further, the Hospital Nurse Liaison needs to document all forms of communications regarding individuals' hospital course in the integrated progress notes to ensure continuity of care.

5. The Nursing Department needs to ensure nurses have the DCPs Supervisors sign and date ACPs when they contain DCPs responsibilities for implementation in order to validate that DCPs have been trained. Additionally, the Nursing Department needs to ensure that nurses sign and date ACPs when health issues are resolved.

6. The facility and state should consider evaluating the Emergency Medical Drill Mock Policy regarding physicians' participation in drills.

7. The Nursing Department needs to ensure that Nursing Case Managers continue to strengthen comment sections and summaries of Annual and Quarterly Nursing Assessments to include whether the individual's health status was progressing, maintaining, or regressing; strategies that are working or not working; and to recommend changes, if indicated, in strategies, support and/or services.

8. The Nursing Department needs to revise the Annual and Quarterly Assessment Policy and Procedure and reporting forms so that they include printed information regarding SAM, MOSES and DISCUS, and sexual assessments.

9. Regarding HMPs:
    - The Nursing Department needs to ensure that Nurse Case Managers consistently have nursing diagnosis for each HMP, and that each nursing diagnosis has an HMP.
    - The Nursing Department's Nursing Case Managers need to ensure that all chronic health conditions contained on the Medical Active Problem List have an HMP, even if those conditions were stable.
    - HMPs need to be individualized with realistic goals and objectives. HMPs need to be applicable for long-term health maintenance issues specifically related to individuals with intellectual and developmental disabilities.
    - The Nursing Department needs to include signature and date lines on the HMPs in order to ensure that they are reviewed and/or revised at the time the Quarterly Nursing Assessment are completed.

10. The Nursing Department needs to review all policies and procedures to ensure that are in alignment with the Settlement Agreement and Health Care Guidelines, particularly the Seizure Management Policy and Procedure. All policies and procedures need to be reviewed and/or revised annually. Any policies and procedures that are no longer in use need to be removed from the Nursing Policy Manual and training materials.

11. The facility's Nursing Educator needs to:
    - continue to develop and present educational topics relevant to high risks, and topics unique to individuals with intellectual and developmental disabilities. These topics need to be routinely covered in nursing orientations and in refresher courses.
    - ensure that nurses receive comprehensive Physical and Nutritional Management training from qualified professionals such a Speech and Language Therapist.

12. The Health Risk Assessment Tool needs to be evaluated by the appropriate state and/or facility staff for clear criteria in order to determine risk, to eliminate subjectivity, and to ensure that the tool meets accepted professional standards of care.

13. The facility's Nursing Department needs to ensure that Nurse Case Managers consistently include Nursing Assessments, Services, Recommendations, and Comments in individuals' PSPs.

14. The facility in collaboration with the Chief Nurse Executive needs to critically evaluate the need for providing nursing coverage 24 hour, seven days a week in residential living units 508, 510, and 516 East.

15. The Nurse Case Manager and the Chief Executive Nurse need to re-evaluate individual #146's HMPs and include assessments and interventions for her two major risk indicators.

16. Regarding pneumonias:
    - The facility's Infection Control Nurse and Hospital Liaison Nurse need to collaborate with the hospital physicians to ensure that the types of pneumonia are accurately diagnosed. Often, aspiration pneumonias were misdiagnosed.
    - The facility's PNMT needs to trend data to determine if individuals who are nourished by mouth are more at risk for developing aspiration pneumonia as oppose to those who were enterally nourished.

17. The facility's Nursing Department needs to develop procedures that specifically define the RNs role and responsibilities for meal time monitoring. The Nursing Department needs to collaborate with the Physical and Nutritional Management team to evaluate the need for more nursing participation in the dining room by nurses.

18. Regarding infection control:
    - The state and facility need to review and/or revise Infection Control Policies and Procedures to ensure they are current with Centers for Disease Control and Prevention Guidelines and professional standards of practice.
    - The Infection Control Committee needs to consistently examine causative factors for all infections regardless of whether they are clustered in order to take every means necessary to prevent infections.
    - The facility's Infection Control Nurse needs to develop and implement written procedures for how communication flows to and from the Physicians, Case Managers, PST and other relevant facility program staff. The Infection Control Nurse needs to ensure that relevant individual specific information relating to Infection Control communication is documented in the integrated progress notes.
    - The Infection Control Nurse needs to develop and implement a centralized database to track immunization status with flags to queue when immunization needs update.
    - The facility's Infection Control Nurse needs to trend and analyze the data that were being collected over time to identify risk indicators and systemic trends, and use such data for making systemic improvements when indicated.
    - In order for the Infection Control Nurse to meet the entire requirements inherent in managing an effective Infection Control Program the Nursing Department should evaluate the need for an additional nurse to relieve the Infection Control Nurse of extra duties.

19. Regarding MARs:
    - The facility's Nursing Department needs to ensure that Nurse Managers and Nurse Case Managers increase monitoring for MAR audits and medication administration pass observations to track and trend data to improved medication administration practices, documentation, and prevent medication errors. The trend data needs to be included in Nursing Management Meetings, Medication Error, and Pharmacy and Therapeutic Committees.
    - The facility's Pharmacy Department needs to ensure that the purpose and routes of medications are included on the MARs.
    - The facility's Nursing Department needs to ensure that the dates medications are discontinued are included on the MAR and that a line is drawn through the remaining block.

- The facility's Nursing staff and Qualified Mental Retardation Professional (QMRP) staff needs to ensure that instructions for SAM program times are consistent with the instruction for how often the program should be implemented

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 Reviewed Records for: • Individual #214, Individual #215, Individual #69, Individual #59, Individual #127, Individual #301, Individual #346, Individual #102, Individual #25, Individual #78, Individual #385, Individual #281, Individual #247, Individual #94, Individual #146, Individual #222, Individual #122, Individual #124, Individual #203, Individual #112, Individual #137, Individual #40, and Individual #60 o Review of Individual #307 Nurse Case Manager's Report to Psychiatrist, 90 Day Combined Review Report o SGSSLC Pharmacy and Therapeutic Committee (Infection Control Sub-Committee and Medication Error Sub-Committee) Meeting Minutes, 9/15/09, 10/28/09, 12/15/09, and 3/16/10 o SGSSLC Drug Utilization Review – Metoclopramide, Pharmacy and Therapeutic 1st Quarter, 3/16/10 o SGSSLC Facility Support Services, HHSC, Facility Performance Indicators, Pharmacy Controls, 1st Quarter, FY2010 SGSSLC Monthly Medication Error Reports with Corrective Action Validation for each Error, February 2010, March 2010, and April, 2010 o SGSSLC Medication Error Forms Completed (ten most recent errors) o Medication Error Review Committee minutes and data for 8/28/09, 10/29/09, 12/15/09 o Nursing Policy and Procedure: Administration of Medication – M-0 through M-23 o Pharmacy Policies and Procedures: • 1.1.07 Pharmacy and Therapeutic Committee, Date 3/17/00, Last Reviewed/Revised: 3/10/06 • 5.2.18 Credit medication back to the inventory when they are returned from the home unused (Pharmacy), Date: 5/14/99, Last Reviewed/Revised: 2/3/05 • 5.2.19 Floor Stock Items (Pharmacy), Date: 5/14/99, Last Reviewed/Revised: 2/3/05 • 5.2.20 Purchasing and Receiving Pharmaceutical Orders, Date: 11/14/00, Last Reviewed/Revised: 2/3/05 • 5.2.21 Relaying Physician Orders to Pharmacy, Date: 4/14/00, Last Reviewed/Revised: 2/3/05 • 5.2.22 Transporting of medication to and from the Pharmacy, Date: 5/14/99, Last Reviewed/Revised: 2/3/05 • 5.2.35 Prescribing Psychoactive Medication, Date: 9/15/04, Last Reviewed/Revised: 2/25/10 o SGSSLC Guide to Psychiatric Services o SGSSLC Nurse Case Manager's Report to Psychiatrist, 90 Day Combined Review o Medication administration competency checklists

	- Pharmacy Controls report 1st quarter, fiscal year 2010 - DUR report 1st quarter 2010 - The 10 most recent Medication Error Reports <u>Interviews and Meetings Held</u>: - Don Conoly, Registered Pharmacist - Angela Garner, RN, Chief Executive Nurse - Lisa Owen, RN, Quality Enhancement Nurse <u>Observations Conducted</u>: - Pharmacy Facility - Medication Observation Pass, 7:00 a.m., 516 McKnight West, 5/12/10
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The facility had two FTEs of pharmacists, and three FTEs of pharmacy technicians. A doctoral level pharmacist was due to start full time employment in June 2010. This will likely help the facility attend to some areas where the pharmacy was lacking. Specifically, there was neither policy in place nor organized practice regarding the identification, reporting, and follow up remedial action for adverse drug reactions. The pharmacy controls report was only one minor element shy of a 100% score. The facility's Nurse Case Managers routinely participated in the Psychiatrist 90 Day Combined Reviews. They prepared and presented relevant information related to individuals' response to psychoactive medication. Annual and Quarterly Nursing Assessment and Nursing Summaries did not consistently summarize individuals' therapeutic response as described in the HCG.

#	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	The pharmacist reported compliance with all elements listed here, however, there was no documentation to indicate that this occurred. Nursing staff conducted five audits/week, by random sample that addressed all elements listed here. These audits, however, were not included in the records of the individuals.	

#	Provision	Assessment of Status	Compliance
	medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.		
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 pharmacist reported compliance with this standard, but again documentation was not provided to indicate its occurrence.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic	There was not collaboration to attend to this standard; medication orders were documented as "stat" in the facility's system, but there was not collaborative monitoring of the use of "stat" medications, nor of benzodiazepines or anticholinergics. While there was not collaborative monitoring of polypharmacy, as described in Section J, the psychiatry department was largely complying with active monitoring, reduction, and, where appropriate, documenting the ongoing rationale for polypharmacy. In the 90 day medication reviews, however, there was demonstrated adequate monitoring of metabolic and endocrine risks associated with second generation antipsychotics.	

#	Provision	Assessment of Status	Compliance
	medications.		
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.	There was no documentary evidence of medical practitioners' responses to the pharmacist's recommendations on the 90 day combined review forms.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The Nurse Case Managers participated in the Psychiatrist's 90 Day Combined Reviews. Review of the Nurse Case Manager's Report to Psychiatrist, 90 Day Combined Review, revealed that the following information was provided during the reviews: • Medical Changes: (including any new treatments, studies, or medication changes), • Metabolic and Lab Data: (use four months including current month), • Current Psychoactive Medications: (if on seizure medications also, state medication and "for seizures"), • Emergency and PRN use of Psychoactive Medication: (describe outcome: benefits/adverse effects, name, route, and date), • Medication Refusal Data: (for psychoactive medications only; last 90 days), • Present DISCUS (only for appropriate medications) and MOSES (all psychoactive medications), • Other Comments from Nurse Case Manager, and • Reconciliation of Diagnosis: Do diagnoses in psychiatrist's report correspond with current diagnosis list? If no, discuss. Review of the Nurse Case Manager's Report to Psychiatrist, 90 Day Combined Review for individual #307 demonstrate that the above information was completed and presented at the 4/8/10 review. Review of the Nursing Department Training Curricula and training records revealed that Nurse Case Managers received competency-based training on completing MOSES and DISCUS Screenings. The Nurse Case Managers were responsible for completing MOSES and DISCUS Screenings on individuals who received psychoactive medications. Review of Annual and Quarterly Nursing Assessments' Nursing Summaries and HMPs on individuals who were receiving psychoactive medications revealed trends that the assessments and summaries, did not consistently describe the therapeutic response to	

#	Provision	Assessment of Status	Compliance
		psychoactive medications, e.g., effectiveness, side effects or adverse drug reactions. Often the Annual and Quarterly Nursing Assessments and Nursing Summaries contained only Physician's Orders for the psychoactive medications, listed by name, dosage and frequency of administration with a statement "will continue to monitor." For example: • Individual #78 had a Physician's Order on 2/7/10 to start tapering-off Geodon. The Quarterly Nursing Assessment, Nursing Summary, 2/18/10, stated, "start Geodon 40 mg BID x 7 days (tapering-off)." The Nurse Case Manager failed to describe in the summary the individual's response to the tapering-off of Geodon. The individual also routinely received Cymbalta and Abilify, neither of were mentioned in the Nursing Summary. • Review revealed there were no HMPs or ACPs related to monitoring Individual #78's psychoactive medications. The HCG states, "The nurse will include review of the effectiveness of individual's treatment regiment and any medication side-effects in their quarterly assessment. Nursing care plan interventions will list the major side effects that staff needs to monitor for long-term medications prescribe." The Nursing Department needs to ensure that Nurse Case Managers follow the HCG for summarizing therapeutic responses to psychoactive medications (e.g., effectiveness, side effects, and adverse drug reactions) in Annual and Quarterly Nursing Assessments and Nursing Summaries. The Nursing Department needs to ensure that Nurse Case Managers develop and implement HMPs for psychoactive medications that are prescribed long-term, and when necessary develop and implement ACPs when new psychoactive medications are prescribed or when tapering plans are ordered.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	As mentioned in the summary of Monitor's assessment for Section N, the facility was not compliant with this standard. The pharmacist indicated that a policy was being devised; the monitoring team will follow up on this during the next on-site tour.	
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	The pharmacist affirmed compliance with this standard. The DUR report dated 3/16/10, for example, demonstrated the required components. The P & T committee reviewed the use of metoclopramide, and Individual #60, Individual #137, Individual #260, and Individual #278 were prescribed it. The findings were as follows: "All met the criteria for use of metoclopramide. The only discussion was that DISCUS-	

#	Provision	Assessment of Status	Compliance
	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.	MOSES were done quarterly on all residents above except for #278, and his were done every 6 months. The MOSES-DISCUS was changed to quarterly on him after discussion at P & T meeting." During a meeting with the monitoring team, the pharmacist indicated that he would raise the idea of taking metoclopramide off of the formulary at the next P & T meeting. He was inclined to do so due to potential long-term side effects of tardive dyskinesia.	
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 Medication Error Review Committee met regularly. The minutes provided evidence of a vital and well-functioning process. Excerpts demonstrating this are below: • "Reduction in amount of controlled drugs in the home. Do we still need to look at individualizing versus floor stock? Are certain controlled drugs unit dose versus floor stock bottles and visible to count the amount in liquid bottles. Would it be better for those meds that are floor stock be prepackaged by pharmacy into individualized unit doses versus floor stock?" • "Stop dates not being placed on labels and on MARs when specified by the physician." Graphs used to process the data regarding medication variances included: • Type of medication error • Facility versus agency • Level of staff making error • Classification of error • Cause of error • Location of error • Medication with high occurrences of error • Time of error • Time error was discovered • Contributing factors • Top 10 errors by individual • Name of staff making initial error The minutes from the Medication Error Review Committee were submitted to the P & T Committee.	

Recommendations:

1. The facility should complete the hiring of a doctoral level pharmacist.

2. The pharmacist should document discussions they have with the prescribers regarding any concerns they have about an order; the documentation should indicate that the medication was not dispensed until the issue was resolved.

3. The facility should develop and utilize policies for monitoring the use of "stat" medications, benzodiazepines, and anticholinergics.

4. The facility should develop and utilizes policies for timely identification, reporting, and follow up remedial action regarding ADRs.

5. The facility's Nursing Department needs to ensure that Nurse Case Managers follow the HCG for summarizing therapeutic responses to psychoactive medications, e.g., effectiveness, side effects, and adverse drug reactions, in Annual and Quarterly Nursing Assessments and Nursing Summaries.

6. The facility's Nursing Department needs to ensure that Nurse Case Managers develop and implement HMPs for psychoactive medications that are prescribed long-term, and when necessary develop and implement ACPs when new psychoactive medications are prescribed or when tapering plans are ordered. The facility's Nursing Department needs to ensure that Nurse Managers and Nurse Case Managers increase monitoring for MAR audits and medication administration pass observations.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: Documents Reviewed: o Current Census Alpha o CVs for PNMT members o DADS policy, At Risk Individuals #006, dated 10/5/09 o DADS policy, Nutritional Management Team #013, dated, 1/31/10 o DADS policy, Physical Nutritional Management #012, dated 1/31/10 o DADS policy, Occupational/Physical Therapy Services #014, dated 10/7/09 o Health Management Consult Log policy, dated 2/8/08 o Clinical Staff list, dated 3/23/10 o Continuing Education for PNMT members o Nutritional Management Committee meeting minutes o List individuals with modified diets and/or thickened liquids o Individuals who received a downgraded texture o Individuals with BMI Greater than 30 as of 3/30/10 o Individuals with BMI Equal to or Less than 20 as of 3/30/10 o Email from Leslie Morrison to Leslie King on 4/2/10 regarding individuals with unplanned weight changes of more than 10% o Weight Report samples o Nutritional Management Committee evaluation/progress note template o Modified Barium Swallow Study July 2009 to March 2010 o At Risk- Non-Ambulatory/Assisted Ambulation as of 4/5/10 o Individuals who used Orthotics and/or Braces o Slip/Trip Fall Data January to March 2010 o Individuals who used ambulation assistive devices o Individuals who used wheelchair as primary mobility o Individuals who used transport wheelchairs o Rehabilitation Therapy Evaluation template o Sample positioning plan o OT/PT spreadsheet o Use of wheel locks and tilt/recline mechanisms of wheelchairs and Geri chairs policy 3/9/07 o Wheelchair Van- Use of Lift and Positioning of Wheelchairs policy 2/9/01 o Diet Order policy 11/6/08 o Snacks policy 10/11/02 o Falls Prevention policy 1/5/01 o Fall Prevention Risk Assessment o Bedrails policy 12/13/02

	○ Lifting/Transfer of Individuals 10/8/04 ○ Lifting/Transfer handouts for New Employee Orientation ○ Stand/Pivot transfer-Assessment Checklist form ○ Two-Person Manual Lift- Assessment Checklist form ○ Mechanical Lift- Assessment Checklist form ○ Maintenance Log ○ PNMP Coordinator Duties ○ PNMP Coordinator Position Description ○ PNM Spreadsheet ○ Individual Overview documents for Home 508A McKnight Blvd ○ Dining Plans submitted ○ PNM Spreadsheet ○ PSPs for the following: • Individual #7, Individual #66, Individual #179, Individual #211, Individual #287, Individual #331, Individual #126, Individual #90, Individual #150, Individual #264, Individual #189, Individual #390, Individual #352, Individual #237, Individual #241, Individual #202, Individual #26, Individual #109, Individual #273, Individual #31, Individual #334, Individual #44, Individual #127, and Individual #318 ○ PNMP format ○ Dining Plan format ○ PNMP Monitoring Sheets ○ Training Rosters ○ PNMP Monitoring form templates ○ PNMP Monitoring forms (completed) ○ PNMP Monitoring Follow up Tracking ○ PNMPs submitted for SGSSLC individuals ○ PNM Clinic Assessment templates ○ PNMP Clinic schedule from 12/1/09 to 3/30/10 ○ PNM Clinic Meeting Summary spreadsheets ○ PNM Clinic Initial Reviews, Annual Reviews, Annual Mat Assessment, PNM Equipment Reviews, Quarterlies and Annual Updates including: • Individual #26, Individual #334, Individual #2, Individual #127, Individual #273, Individual #128, Individual #130, Individual #380, Individual #118, Individual #107, Individual #44, Individual #89, Individual #202, Individual #109, Individual #31, Individual #352, Individual #189, Individual #143, Individual #7, Individual #241, and Individual #390 ○ Rehabilitation Therapy Evaluations and Updates for the following: • Individual #66, Individual #203, Individual #109, Individual #203, Individual #318, Individual #44, Individual #390, Individual #127, Individual #334, Individual #2, Individual #26, Individual #40, Individual #271, Individual #193, Individual #34, Individual #382, Individual #226, Individual #236, Individual #233, Individual #229, Individual #237, Individual #181, Individual #281, Individual #271, Individual #310,

	Individual #7, and Individual #273 o Criteria for PNM Risk Levels o Health Risk Assessment Tool- Aspiration/Choking template o NMC Screening Tool template o Health Status Team Meeting Schedule and minutes June 2009 through October 2010 o Pressure Ulcers March 2009 through March 2010 o At Risk Lists as of April 2010 (Skin Integrity, Aspiration/Pneumonia, Weight, Cardiac, Polypharmacy, Hypothermia, Diabetes, medical concerns, UTIs, Respiratory, Chronic Respiratory Infections, Contractures, Dysphagia, Aspiration, Choking, Osteoporosis/Osteopenia, Metabolic Syndrome, Seizures, Falls, GERD, Oral Status, Medical Concerns, GI Concerns, Impaction/Bowel Obstruction/Constipation, Dehydration,) o Fractures 7/1/09 to 3/29/10 o Falls 5/7/10 o Individuals seen in Emergency Room 3/1/09 to 3/25/10 o Individuals Admitted to the Hospital 3/1/09 to 3/31/10 o Individuals who require mealtime assistance o Pneumonia Tracking 3/29/09 to 3/29/2010 o Individuals with G-tubes 3/30/10 o Daily Level of Supervision documentation for 508A McKnight Blvd. o Direct Care Sign in Sheets for 508A McKnight Blvd. o Choking Events from 5/1/09 to 5/16/10 o Documentation of Choking events for the following: • Individual #249, Individual #91, Individual #249, Individual #68, Individual #287, Individual #334, Individual #143, and Individual #138, o Individual Record documents including: • Annual Medical Summaries • Annual Nursing Evaluations and quarterlies • PSPs and addendums • Training Guides • GI consults • Chest x-rays • NMC Meeting minutes, progress note, evaluations • PNMPs • Dining Plans • OT, PT, SLP evaluations/updates • Rehabilitation documents, Clinic notes, updates, annual reviews, etc. • Nutrition assessment • Fall risk assessments o For the following individuals: • Individual #7, Individual #281, Individual #78, Individual #384, Individual #143, Individual #146, Individual #203, Individual #2, Individual #181, Individual #66, and

	Individual #310 <u>Interviews and Meetings Held</u>: o Dena Johnston, OTR, Rehabilitation Therapies Director o Cindy Bolen, PT o Judy Perkins, PT o Charis Worden, OTR o Sally Smith, LD, MBA o PNMP Coordinators o Discussions with various supervisors and direct care staff o Discussions with various day program staff <u>Observations Conducted</u>: o NMC Meeting 5/13/10 o PNMP Clinic 5/11/10 o PNMP Review Team meeting 5/10/10 o Webinar o Mealtimes o 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 PNM Clinics appeared to be a well-organized process, but was largely Rehabilitation Therapies rather than an interdisciplinary process. There was good representation of home and staff at the NMC meetings, but professional staff representation was limited to the director, an OTR, the dietitian, SLP, and nursing. The SLP participation was inconsistent in the past, but there were plans for more consistent involvement of the single SLP working at SGSSLC as of 5/26/10 (also see section R below). In addition, this clinician had limited experience in the area of PNM supports and will require significant continuing education opportunities. There did not appear to be a plan for training all NMC members and/or PNM clinic team members beyond the DADS sponsored instruction. The NMC met weekly which enabled them to see a significant number of individuals and spend greater time reviewing the status of each case and developing a plan for PNM supports. The meeting minutes were brief, but each individual reviewed received a review note that was more detailed and person-specific. There was some inconsistency of follow up review by the NMC as well as follow up related to issues identified via the PNMP monitoring system. Recently, PNMP coordinators had been hired/assigned to conduct PNMP monitoring and will require extensive training, supervision and re-validation of competency to monitor and train others to be successful. The existing monitoring and training was inadequate as the

	monitoring team noted numerous examples of noncompliance with the PNMPs and Dining Plans with regard to position, alignment, and support, as well as food texture, liquids consistency, adaptive equipment, and assistance strategies across a number of homes. As a result SGSSLC failed to ensure the safety of many who had been identified at greatest risk, particularly for choking and aspiration. It was of concern that these issues had not been identified and addressed appropriately via the extensive assessment and review process in place.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs.	PNM team consists of qualified SLP, OT, PT, RD and as needed, consultation with MD, PA, RNP. The current state-approved policy, dated 12/9/09, 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 received 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. Conduct other activities as appropriate to ensure safe eating and adequate physical and nutritional health. A team that addressed PNM concerns was in place at SGSSLC, including the PNM team that conducted the PNM clinic evaluations and the Nutritional Management Committee. Both of these were observed by the monitoring team during the week of this on-site baseline review. The PNM clinic will be discussed in more detail in section P below. An NMC meeting was conducted the week of the on-site review. Core team membership at the time included Dena Johnston, OTR, Rehabilitation Therapies Director, Sally S. Smith, LD, MBA, Susan Holler, MS, CCC/SLP. Additional team members attended depending upon the individual reviewed. Representation, as of this report, generally included the QMRP, home manager, RN, RTC, and/or PNMP Coordinators for each of the individuals reviewed during the meeting. SLP attendance during this period was approximately 50%, while OTR participation was by the director only for approximately 80% of the meetings (though these absences were typically prior to 2010). The RD representation was consistent, as was RNs, QMRPs, and other home staff. Additional participants were present for some meetings for specific individuals, including psychology and pharmacy, for example. Other than a psychiatrist on 3/17/10 and a MD on 3/10/10, attendance by physicians was minimal. There was no evidence of PT participation.	

#	Provision	Assessment of Status	Compliance
	The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	<u>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</u>. Resumes/CVs for team members were submitted as requested, including the Rehabilitation Therapies Director, Dena Johnston, OTR, and the RD. Additional resumes were submitted for the two SLPs as core team members. The OT and RD professionals appeared to have extensive experience. The contract SLP who was to continue on the Committee after 5/26/10. Resumes for other committee members were not submitted. 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." Continuing education was not delineated per staff and there was no indication that SGSSLC had a plan for this training, though dates of a variety of DADS sponsored continuing education were generally listed and presumed to have been attended by at least some of the professional staff. <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 NMT met 52 times from 4/16/09 through 3/11/10. The NMT met three to seven times per month during that time and reviewed over 400 individuals, with a number of individuals being reviewed multiple times, including 62 who were seen three or more times, including: o Individual #384 (9), Individual #264 (8), Individual #60 (8), Individual #54 (7), Individual #2 (7), Individual #301 (7), Individual #33 (6), Individual #185 (5), Individual #78 (5), Individual #260 (5), Individual #203 (5), Individual #127 (5), Individual #178 (5), Individual #154 (5), Individual #282 (5), Individual #339 (5), Individual #212 (5), Individual #392 (5), Individual #146 (5), Individual #257 (5) and Individual #387 (5). Eighteen others were seen on four occasions, and twenty three were seen three times.	

#	Provision	Assessment of Status	Compliance

Number of Times Reviewed in NMC	Number of Individuals Reviewed in NMC
3	23
4	18
5	14
6	1
7	3
8	2
9	1
Total	62

A sample of 40 individuals was tracked to determine if the committee consistently reviewed individuals within the timeframes documented in the meeting minutes. Approximately 38% of the reviews were not reviewed within the month designated in the minutes including: Individual #301, Individual #14, Individual #250, Individual #130 (2), Individual #162, Individual #368, Individual #45, Individual #68, Individual #279, Individual #373, Individual #256, Individual #153, Individual #77, Individual #217, and Individual #16.

Meeting minutes were in a spreadsheet format that included the individual's weight, ideal body weight range, and disposition that briefly addressed comments and recommendations by the committee with the reason for review, the individual's designated risk level, and the date of the next review. The meeting minutes consistently identified the reason for review, such as:

- Aspiration/Choking Risk (Individual #334, Individual #373, Individual #271)
- GERD (Individual #150, Individual #277, Individual #114)
- PEG management (Individual #2, Individual #364, Individual #260)
- Weight loss (Individual #257, Individual #146, Individual #278)

NMT risk level was clearly stated for each individual and the date of the last review was generally identified. It was not, however, always clear that the individual had been seen multiple times previously. The summary provided limited analysis or synopsis of group discussion, but did include recommendations and actions to be taken to address the issues for which the individual was being reviewed, including the date of the next review.

The findings of PNMP monitoring had been generally unknown to the NMT. As a result,

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		they were not used previously in the review of individuals with PNM risks, however recently, the PNM coordinators began to participate in these meetings with information gleaned from the monitoring conducted. Further formal analysis of monitoring findings will also yield additional information useful to the Committee. PNM plans are incorporated into individuals' Personal Support Plans (PSPs). PNMPs were only marginally addressed in the PSPs reviewed. The PSPs reviewed reflected integration of the PNMP in the following ways: • PNM-related information was included in the assessment section of the PSP under OT/PT and Speech. • PNM-related assessments, such as the OT/PT Evaluation Update, were summarized under the Assessment/Services section of the PSP. • The Assessment/Services section of the PSP also listed the recommendations previously identified in the assessments. • The General Discussion section of the PSP occasionally included a heading for the PNMP and stated that the PNMP was reviewed. In some cases, there was only a statement that the PNMP had been reviewed, was accurate, and did not have any changes that needed to be made. In the case that changes were indicated, these were usually outlined in this section. While there was some limited evidence of PST review and discussion of the PNMPs, they continued to appear as a habilitation therapies responsibility rather than that of the entire team. Identification, assessment, interventions, monitoring, and training as outlined in sections O-2 through O-8 as described below. See below.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional	A process is in place that identifies individuals with PNM concerns. Per the current state policy implemented on 1/31/10, 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 1), Medium (Level 2), and Low (Level 3). Individuals at high risk had experienced a recent aspiration, aspiration pneumonia, or unexplained weight loss. Those at medium risk were reviewed in two to three months. Those at lowest risk were dismissed if health and intake were adequate. These risk levels were consistently reviewed and modified as indicated based on the individual's health status. There was reference to the aspiration/choking risk level applied under the HST system but in general, reference to other risk indicators were not utilized by the NMC or during PNMP reviews. Other risk levels were used by the PNMT that were not included under the HST system.	

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	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.	There was also a disconnect between the NMT and the system of assigning risk via the Health Risk Screening completed on individuals living at SGSSLC, though the Rehabilitation Therapies clinicians completed that HST screening for aspiration pneumonia and choking. 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 also observed numerous instances of inadequate alignment and support during meals and other times during the day. Inadequate trunk alignment and support, foot support, and/or head alignment were noted for many of these individuals. Some examples were: • Individual #264 was observed in a posterior tilt, his feet were unsupported and his knees and thighs extended well forward of the seat bottom. • Individual #15 was observed seated in a wheelchair with a sling seat bottom that did not provide sufficient support and stability to her pelvis and trunk. • Individual #138 was observed in a dining chair with a cushion and attached foot box for support. She was positioned in a posterior tilt, her lower extremities were windswept to the right and her feet were unsupported. • Individual #325 was observed being assisted to eat with her head in hyperextension. • Individual #128 was not repositioned before his meal and his pelvis was posteriorly tilted and off to the right side of the seat bottom. His pelvic positioning device/seatbelt was too loose to maintain his pelvis in proper alignment. 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. The Rehabilitation Director accompanied the monitoring team to the homes observed during mealtimes. Some of these examples included: • Individual #137's Dining Plan indicated that someone should sit with her at meals. No staff was seated beside, or even near, her while she ate. • Individual #45 had two Dining Plans on the table, one of which was not the most	

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		current version, yet her current diet card was attached to it. She was to use a red divided plate, but she was eating food out of small bowls. Staff were to be seated with her, but were not. • Individual #171 was to use a weighted mug to drink, but was using a paper cup and plastic glass. The weight prescribed for her wrist had not been applied until the monitor pointed this out to staff. By report, she seldom coughed, but had been coughing throughout the meal observed. • Individual #334 was to receive reminders to keep her right elbow on the table, but had not received any prompts by staff. She was to receive a soft pureed food that was not runny. The food served to her was runny and too thin. • Individual #198 was observed gulping full paper cups full of liquid. She was to have staff seated with her “to remind me to eat safely.” No one was seated with her. Her bread was to be chopped or diced in larger than ½” pieces though she was to receive bread crumbs. • Individual #321 was supposed to get a sandwich, but did not. • Individual #177 was to receive all ground foods and nectar thick liquids. She was served diced bread and thin liquids in her soup as well as were several others in the dining room. The above observations were the first meal (Home 510) observed by the monitoring team during the on-site tour. It was a great surprise to discover so many errors in one dining room. When these errors were brought to the attention of the staff member who was in charge of the dining area on that date, she made each correction. She did not, however, attempt to review all the plans on her own to ensure that others were being implemented correctly, but instead waited for errors to be brought to her attention. Moreover, at one point, she began to giggle which seemed to be an inappropriate response to the situation. There were at least 10 individuals seated during a meal in the extremely small dining areas in home 516 East. Many were seated in wheelchairs and it would have been difficult to reach an individual who was choking in this environment and, further, it made it difficult for staff to provide appropriate assistance, prompts, cues, and supervision throughout the meal. A poster in the area described the various liquid consistencies used at SGSSLC as follows: • Nectar: Coats and drips off the spoon like unset gelatin or nectar,. • Honey: Flows off the spoon in a ribbon just like honey. • Soft pudding: Stays on the spoon in mass and plops off the spoon like pudding. Staff were instructed to wait one to five minutes to allow the thickened liquid to reach the	

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		desired consistency. These guidelines were consistent with generally accepted professional standards of care. Even so, there were a number of individuals who were drinking fluids at mealtime that were inconsistent with these instructions: • Individual #78 was to receive honey thick liquids, but his beverage was thinner than that described above. • Individual #15 was to receive honey thick liquids, but her beverage was thinner than that described above. • Individual #25 was to receive honey thick liquids, but her beverage was thinner than that described above. • Individual #325 was to receive nectar thick liquids, but it was thinner than that described above. • Individual #18 was to receive honey thick liquids but those offered to him were pudding thick. • Individual #138 was to receive honey thick liquids that were thinner than that described above. • Individual #87 was to receive nectar thick liquids, but her beverage was noted to be thicker that that described above. • Individual #288 was to receive soft pudding thick liquids. He was offered a bowl of thickened V-8 juice at the end of his meal. It was too thin to remain on the spoon as described above. Additional concerns noted included: • Individual #25 was to be seated in a dining chair, but was seated in her wheelchair during her meal. She was served very stiff mashed potatoes. Her prescribed diet texture was pureed. • Individual #281 was to receive two teaspoons of lemon ice before his meal and then again half way through. The lemon ice was melted. • Individual #18 was to be transferred to a dining chair for his meals, yet he remained in his wheelchair. He was seated in a posterior tilt with no foot support. His diet order specified that he should receive soft pureed food and honey thickened liquids. His food was a very thick puree, and his beverage was pudding thick and it was offered to him by spoon. When asked about these errors, the staff made no attempt to make the appropriate corrections. Individual #18 was also given medications in his glass which was not an accepted method for administration of medications. This observation was reported to the nursing member of the monitoring team who followed up with nursing staff to address this concern. • There were three individuals seated at the dining table for over 45 minutes without food. • Individual #40 received two-inch pieces of bread, noodles that were half- to one-	

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		inch and potatoes that were one inch to one and one-half inches in size. His meal had been prepared by a PNMP Coordinator who indicated that she was also a nurse. • Individual #264 was inadequately aligned and supported in his wheelchair. • Individual #78's plan prescribed all ground foods, but he was eating pieces of bread that were dry and larger than one inch in size. No one was attending to him and the other individuals at his table because all were involved in food preparation at the counter with their backs to the individuals seated at the tables and eating or drinking. • Staff was standing to assisting Individual #146 during her meal until the Rehabilitation Director provided her a stool. Again, the area was very small and congested with many individuals seated in wheelchairs, so it was difficult for staff to comply with these instructions. Later in the meal, this staff was noted to not alternate food and fluids as instructed on the Dining Plan. In addition, the staff was using a regular spoon to assist her rather than a coated youth spoon. While being observed, she referred to the plan and changed to the correct spoon. • Individual #345 received long pieces of lettuce even though he was on a chopped diet. He did not have regular plates and bowls, but rather was eating out of the re-therm dishes and bowls. • Individual #325 was assisted to eat at too fast a pace with her head in hyperextension. When staff were asked about this, she replied that she was familiar with Individual #325 and knew that this was not too fast. This was the same PNMP Coordinator who was also a nurse. It was of great concern that the staff who were responsible for recognizing errors in the implementation of PNMPs and Dining Plans, and to provide training, coaching and modeling to other staff, was observed to make two serious implementation errors at the same meal in this home placing individuals at risk of harm from aspiration and choking. • There was no supervisor present in the Dining Room on this date. Additional meals were observed with the following concerns noted: • Individual #216 was to have his chair scooted up to the table and it was not. His plate guard was not positioned correctly. • Individual #128 was positioned in a posterior tilt with his hips shifted to the right and his seat belt was too loose. He was not repositioned before his meal. • Individual #144 was to use an Aladdin mug for drinking, but he was using a regular glass. • Individual #154 was to receive chopped foods, but he was served whole okra instead. When this was pointed out, the home manager made the correction. • Individual #307 did not have picture on his Dining Plan because he refused. The picture was "pending." The monitoring team did not understand whether there	

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		was a plan to address this. • Individual #164 was wearing a gait belt and helmet during her meal. • Individual #7 was administered medications during her meal. • Individual #310 was wearing a helmet and gait belt, but staff told the monitoring team that they were not required to hold onto the gait belt while she was walking. • Individual #130 was observed repeatedly scooping empty spoonfuls from her dish without intervention from staff. Her Dining Plan instructed that staff were to "direct me to other food," but this was not done. She also was not served a beverage with her meal. Her feet did not contact the floor and there was no foot support provided. • When staff was asked about the oversight in supervision and the provision of beverages, the supervisor reported that the staff were so busy they did not get it done. • The gentlemen in home 502A were served their meals on a tray rather than on plates and in bowls. • Individual #389 was eating at a very fast pace without staff intervention. • Individual #173 was observed to take huge bites of food. He was on a ground texture and his Dining Plan instructed that staff were to prompt him to eat slowly and to take small bites. Clearly, these supports were not provided by staff. • Individual #287's Dining Plan stated that he needed reminders to put his spoon down in between bites. He was prompted to do so and this was effective in slowing his pace. Staff, however, were standing over him rather than seated down next to him at the table. • Individual #344 did not have any beverage prepared for him during his meal. Staff had to be prompted by the monitoring team to provide this. • Individual #389 was served potatoes with added broth rather than gravy as instructed on his Dining Plan and staff stated, "We did not have gravy." • Individual #288 was to receive soft pudding thick liquids. He was offered a bowl of thickened V-8 juice at the end of his meal. It was too thin to remain on the spoon. There were no instructions in the Dining Plan to offer fluids throughout his meal. 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. There were extensive criteria outlined for the establishment of risk levels across a variety of areas including nutritional, skin integrity, mobility, falls, fractures, hearing loss, speech and others such as reflux, pain and edema. The system used was more comprehensive than merely nutritional and aspiration/choking risk levels. The Health Risk Assessment Tool for aspiration and choking was completed by Rehabilitation Therapies. The NMC Screening Tool was used to assign PNM risk levels to individuals during the NMC	

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		meetings. Each of these was documented in assessments and used to guide the development of supports and services to address them via the PNMP.	

- There were 13 individuals listed at high risk per the NMC screening, yet they were not reviewed in NMC with increased frequency. Some examples included Individual #170, Individual #368, Individual #301, Individual #344, Individual #7, Individual #181, Individual #232, Individual #164, Individual #78, Individual #356, Individual #282, Individual #203, and Individual #274.
- Only Individual #368 (4), Individual #301 (7), Individual #344 (5), Individual #78 (5), Individual #282 (4), and Individual #203 (5) were reviewed at least four times in a year per the NMC minutes submitted.
- There was no evidence that some who were listed at high risk were reviewed at all by the NMC including Individual #170 and Individual #356, with others were seen only twice (Individual #181, Individual #232, and Individual #164).

The Health Status Review Committee met weekly to review all individuals living at SGSSLC in two 18 to 19 week cycles annually. The HST 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. 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

Risk	High	Medium	Low
Aspiration	6	42	208
Choking	5	81	170
Weight	13	66	168
Medical Concerns	13	32	210
Skin Integrity	6	24	226
GI Concerns	5	19	234

The frequency of review was not consistent with the high risk levels for PNM-related

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		concerns for a number of these individuals. Some examples included the following. • Six individuals were considered to be at high risk of aspiration. The number of times they were reviewed by the NMC in the last year shown is shown in parentheses: Individual #7 (3), Individual #54 (7), Individual #18 (4), Individual #278 (4), Individual #281 (1), and Individual #2 (7). • Five individuals were considered to be at high risk of choking. The number of times they were reviewed by the NMC in the last year is shown in parentheses: Individual #7 (3), Individual #54 (7), Individual #278 (4), Individual #281 (1), Individual #2 (7). • Six individuals were considered to be at high risk for skin integrity concerns. The number of times they were reviewed by the NMC in the last year is shown in parentheses: Individual #346, Individual #122, Individual 116, Individual #146, Individual #15, and Individual #2. • Five individuals were considered to be at high risk for GI concerns. The number of times they were reviewed by the NMC in the last year is shown in parentheses: Individual #60 (8), Individual #116 (2), Individual #54 (7), Individual #325 (4), and Individual #271 (2). There were also other inconsistencies across these two systems. For example: • There were approximately 50 individuals listed with skin integrity risk per the PNM database versus only 30 with medium or high risk per the HST screening. • There were 64 individuals listed with risk of reflux per the PNM database versus only 24 at medium or high risk of GI Concerns per the HST screenings. • There were approximately 127 individuals listed with aspiration/choking risk per the PNM database versus 134 at high or medium risk per the HST screening. Individual #202 was diagnosed with aspiration pneumonia on 4/16/09 but was considered to be only at moderate risk. Individual #78 had aspiration pneumonia on 10/30/08, 12/19/08 and bacterial pneumonia on 3/20/09 and 2/10/10. He was considered to be only at moderate risk. Individual #146 was diagnosed with aspiration pneumonia on 3/16/09 and was at medium risk of aspiration, but was not considered to be at risk for aspiration pneumonia per the list submitted. Individual #2 was also diagnosed with aspiration pneumonia on 1/7/09 but was not even included on the list At Risk- Aspiration Pneumonia as of 4/5/2010. Additional inconsistencies were noted related to skin integrity as well. • Individual #202 had a documented Stage II pressure ulcer on her coccyx, though was listed as low risk for skin integrity. • Individual #387 also had a documented Stage II pressure ulcer at the left gluteal fold but was not on the risk list for skin integrity. • Individual #38 had a documented Stage II pressure ulcer on the bottom of his left	

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		foot, but was listed as medium risk for skin integrity. • Individual #181 had a documented Stage II pressure ulcer on her coccyx in 1/10 and her left inner buttock in 3/10, but was listed only at low risk for skin integrity. Documentation of choking events indicated additional concerns. Documentation within the last year was not submitted, but rather documentation for choking events in 2008 to 2009 was submitted, so it was not possible to track if those individuals were reviewed by the NMC for either year. • The only event identified as occurring in 2009/2010 was for Individual #249. This incident was related to her inhaling an object she put in her mouth while she was crying and upset after cutting herself on the head. The Heimlich was conducted several times and the object was expelled. She had several previous incidents where abdominal thrusts were required to dislodge objects or food items including 1/10/07 (pickle), 3/19/07 (after a meal), 5/31/07 (spring from pen), and 12/5/08 (chicken and ice). She was determined, during a mealtime assessment on 12/19/08, to be at risk of choking due to taking large bites. She required staff prompts to take smaller bites. She was considered to be at low risk per the HST screening tool findings as of 4/5/10. • Individual #91 had a choking incident in 12/08, though the incident report was not available. Diet modifications were made at that time. She was evaluated on 1/7/10 due to reported increased frequency of coughing during meals. Per her Aspiration/Choking Risk Assessment Tool dated 2/6/09, she was deemed to be at moderate risk though she had experienced two choking events since 2007. She was not listed on the current HST risk list for aspiration and her disposition was unknown to the monitoring team. • Individual #177 experienced a choking event on 2/4/09 requiring the Heimlich and food was expelled. She was listed at low risk of choking per the HST Screening Tool findings, At Risk – choking as of 4/5/10 submitted which was decreased from Moderate Risk on 9/17/09. Interestingly, the Aspiration/Choking screening tool dated 4/7/10 indicated that she was at moderate risk of aspiration and choking. Her risk concerns related to choking included taking food from others, poor chewing and swallowing, and unsafe eating habits. She required monitoring by staff for prompts to chew her food and staff supervision for food purchases. Individual #177 lived in the very same home cited above with numerous serving, supervision, intervention, and equipment errors during the first meal observed at SGSSLC. Each of the individuals living in that home was at significant risk of choking, especially Individual #177, given her previous history. She was observed being served diced breads and thin soup, though her dining plan indicated that she was to	

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		receive all ground foods and nectar thick liquids. • Individual #334 had a choking event on 8/17/08 requiring abdominal thrusts. She was listed at medium risk of choking per the list dated 4/5/10. She too lived in the same home noted above. • Individual #138 experienced a choking event on 9/22/08. She was listed at medium risk per the list dated 4/5/10. She lived in another of the homes observed by the monitoring team with numerous errors in implementation of Dining Plans. Each of these individuals was identified as having a safety plan in place to address this risk. It was of great concern to the monitoring team that SGSSLC did not recognize this high risk of harm in these cases by properly identifying risk levels and establishing effective systems to safeguard these individuals during meals. Clearly staff training and mealtime monitoring were severely lacking. The aspiration/choking screening tool considered whether and individual had experienced a choking event in the last year to assign the risk level in addition to other indicators. Generally choking history for three to five years should be considered to make a determination of choking risk. <u>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</u>. All PNM-related assessments were completed per the annual staffing schedule with additional PNMP reviews conducted for some based on PNM risk. Other interim assessments were also conducted for some individuals based on referral related to falls, choking incidents, fractures, and other concerns. There was no evidence, however, that the assessment was comprehensive, that is, that it involved other team members. It was reported that in some cases, the therapists were not notified in all cases of falls with injuries, choking events, and other incidents that pertained to PNM. <u>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</u>. Annual Evaluation Updates were generally comprehensive, but were limited to the provision of supports and services via the PNMP rather than functional outcomes or skills-based interventions. Mealtime assessments were conducted following most choking incidents though were completed by the OTR only. See section P of this report below.	
O3	Commencing within six months of	<u>All individuals identified as being at risk (requiring PNM supports) are provided with a</u>	

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	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.	comprehensive Physical and Nutritional Management Plan (PNMP). There was a plan for each individual living at SGSSLC to have a PNMP when indicated. An individual was not provided a PNMP if he or she ate a regular diet, had no adaptive or assistive equipment, required no staff supports necessitating written instructions, did not have GERD, and did not have Dining Plan. The format was generally consistent across all of the plans. The PNMP Review Team had initiated a process of reviewing each PNMP prior to the PSP annual meeting to review the language of the plans for clarity of instructions, to ensure that sentences were in first person language, and to eliminate or at least minimize, the use of professional jargon. The department was commended on these efforts and the plans were very user-friendly as a result. 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 a stated focus in physical, dining and/or communication domains, listed specialized equipment, and outlined supports and strategies related to communication, mobility, lifting/transfers, movement techniques, skin care, alternate positioning (bed), skin care, dining equipment, mealtime instructions and PNM risks. Bathing, toileting, oral hygiene, and medication administration were not addressed. The PNMPs submitted had a head shot of the individual for identification purposes, but did not have any pictures of equipment or of the individual using the equipment to highlight proper alignment and support. The Dining Plans had a picture of the individual in his or her optimal dining position and pictures of any adaptive mealtime equipment prescribed for use with eating and drinking. Each PNMP was dated, some with a date of revision. Changes to the plan were highlighted using a square bullet. The Dining Plans were not consistently dated. Staff would likely benefit from additional visual prompts and cues for improved implementation of the PNMPs. Individuals who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above. All individuals who received enteral nutrition 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. The PNMPs were developed during the PNMP clinic without significant input from team members other than the OT, PT, and SLP, though some home staff did participate. By report, participation by additional team members was inconsistent during these clinics. From observation of the clinic, it was largely a "therapy" process during which other team members for the most part observed.	

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		PNMPs are reviewed annually at the PSP meeting, and updated as needed. There was a section of the PSP to address "review Physical and Nutritional Management Plan for accuracy/changes." There was great variation in the manner in which this review was documented. Some merely stated that a review was conducted, while others identified specifics of the plan. 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. There was some evidence that PNMP monitoring triggered changes in the PNMPs or staff training, however, the prevalence of errors in implementation was significant and called into question the validity of the existing monitoring system and the competence of those monitoring. 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 updates and what was included in the PNMPs.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	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 plans. 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. Individuals are in proper alignment and position. As noted above and described in section P of this report, a number of individuals were observed 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, however, implementation errors were noted in dining rooms, living areas, and day program areas. Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP. There were many errors noted by the monitoring team related to mealtime, and staff were generally not able to provide the appropriate justification for the strategies outlined in the Dining Plans. There was concern noted above with a PNMP Coordinator responsible for a number of serious errors as well as for attempts to provide justification for her actions to the monitoring team that she knew the individuals so well. It was of serious concern that this staff member was to	

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		provide training, modeling, and review of others, when she did not demonstrate competency herself.	
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. This training addressed mealtime supports as well as lifting and transfers, however, this training had not been effective to address the many problems with PNMP and Dining Plan implementation observed by the monitoring team. There were no refresher courses offered other than in the area of lifting. 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, staff inservice training was "competency-based" with return demonstration required for skills-based elements. Clearly this training, as well as monitoring, had been ineffective as evidenced by the numerous implementation errors described throughout this report. All foundational trainings are updated annually. Per the documentation submitted, annual re-training for physical management was conducted every two years. Other PNM training was not updated annually at the time of this review. Staff are provided person-specific training of the PNMP by the appropriate trained personnel. Rehabilitation Therapies staff provided training for home managers, supervisors and direct support staff when there were new plans implemented or for changes in existing plans. A training roster was signed by all participants, with competencies as assigned by the trainer. Monitoring was intended to check for continued staff competency with retraining provided as indicated based on findings. A system of "cascade" training was utilized whereby charge staff originally trained by the clinician may in turn train others. This was indicated via pink copies of the training rosters. Training rosters were maintained by Rehabilitation Therapies. Again, due to significant errors in implementation, this training was clearly ineffective. 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. Individual #202 was diagnosed with aspiration pneumonia on 4/16/09. She was at moderate risk for further aspiration/aspiration pneumonia as well as for choking. She required one to one supervision to ensure her safety to prevent her from crossing her legs post hip surgery and to prevent pica behavior. Pulled staff assigned to Individual #202 had not signed the sign-in sheets to indicate that she had read the programs and training guides until 5/13/10, though she had been working with	

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		Individual #202 since 5/6/10 on three different days, per her report. It was routine for pulled staff to read information about the individual(s) they were responsible for rather than receive competency-based skills training. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP. Same as above.	
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. PNMP monitoring was conducted by therapy clinicians and by PNMP Coordinators. There was a plan to analyze and trend the monitoring results, but this had not yet been initiated. Many of the completed forms, however, failed to identify the staff providing supports to the individual monitored and, therefore, made the information much less useful than it otherwise might have been. Further, the current plan for monitoring did not systematically ensure that staff were monitored to validate continued competency. In the event that issues were identified from the monitoring, it was reported that the monitors conducted coaching and inservice training. Based on the monitoring team's observations, however, this was ineffective. It was of significant concern to observe a PNMP Coordinator providing assistance during a meal with unacceptable compliance with individual plans. A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted. SGSSLC did not submit a policy that specifically addressed the monitoring process. DADS policy #012 Physical Nutritional Management, approved on 12/17/09 with implementation on 1/31/10, 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 • Monitoring of equipment at least annually and as needed by therapy staff	

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		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 SGSSLC monitors to ensure consistency and accuracy, though this was discussed at length with the Rehabilitation Therapies Director. Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities). Monitoring forms were developed to address the provision of supports and services in the PNMP, including positioning, bathing, lifting and transfers, mealtimes and "off home" monitoring of ambulation, transfers, food texture and liquid consistency, positioning, reflux precautions and other aspects of the PNMP. These forms, however, were not the same as those completed and submitted to the monitoring team. All members of the PNM team conduct monitoring. At the time of this on-site review, the professional therapy staff conducted PNMP and mealtime monitoring. PNMP Coordinators had been hired to serve as monitors and trainers. There was a plan in development to aggregate monitoring data collected and use the data to guide further staff training, coaching, and support. Formalized monitoring of PNMPs also occurred in the PNMP Clinic, PNMP Review Team meetings, and the NM Committee meetings. 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 were in development and further review would occur in subsequent reviews by the monitoring team. Immediate intervention is provided if the person is determined to be at risk of harm. There was evidence of follow up on issues identified by the clinical staff during monitoring. By report, there was additional follow up in one month to ensure completion, but documentation was incomplete and it was not determined if in fact the issue was adequately resolved. Other deficiencies noted during monitoring are corrected within an appropriate period of time based on the level of risk that they pose. There was no system to track this or to follow concerns through to resolution. There was no mechanism to aggregate the data gathered through the monitoring process for use to focus training needs. System exists through which results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow up by the relevant supervisor. Staff training occurred on the spot when indicated based on findings of the SGSSLC monitor,	

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		and supervisors and QMRPs were notified. Process includes intermittent internal validation checks to ensure accuracy. No validation checks were conducted at SGSSLC 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 routinely to review individuals with regard to aspiration pneumonia, MBS studies, significant weight loss, and other concerns as well as follow ups from previous meetings. The approach utilized included a review of previous PNM history and discussion to identify potential recommendations. Follow up was generally consistent, but there were some oversights, as described above. 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 PNMP Monitoring Form and focused predominately on staff compliance with implementation of the PNMP, though specific staff were often not identified. Monitoring was completed routinely, though the frequency of monitoring did not appear to be driven in any way by need or risk level. PNMP Clinic and PNMP Review Team examined the effectiveness of the plan with revisions implemented as indicated. Additional person-specific monitoring by clinicians was generally in response to a request, referral, or identification of a problem rather than as a result of scheduled routine monitoring of health status and the effectiveness of supports to address identified PNM health risk indicators. There was also no mechanism in place to tabulate findings from follow up monitoring for trend analysis per individual or system wide. Issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted. A spreadsheet was generated to summarize completion of monitoring and to attempt to track problem resolution. The system was very limited and did not reflect a date of actual resolution, but merely a target date. There was also no clear method to ensure follow up to evaluate effectiveness of the resolution implemented. 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. A summary of findings from those reports was included in the PSP. There was general 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.	

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		<u>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</u>. There was no evidence in the records submitted of routine monthly review by the PST or members of the NMT. <u>Members of the PNM team complete monitoring system</u>. PNMP monitoring was conducted by the PNM Team members and PNMP Coordinators. <u>Immediate interventions are provided when the individual is determined to be at an increased risk of harm</u>. 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 are described above. By report and as evidenced by training forms submitted, staff were inserviced as indicated by the monitoring results. It was of concern, however, that this system was ineffective in ensuring staff compliance, competency, and individual safety, such as the issues identified above.	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status</u>. Discussion by the NMC did not specifically address whether enteral nutrition continued to be medically necessary for each person who received it (approximately 12). There did not appear to be a specific discussion of this issue during the PSP annual meeting with other PST members. A meeting was held during the week of this on-site review to discuss a plan for reviews of individuals who received enteral nutrition. Outcomes of this process will be examined during subsequent reviews. <u>The need for continued enteral nutrition is integrated into the PSP</u>. Issues related to enteral nutrition were evident throughout the PSP with regard to diet order, nutritional assessment, and other medically-related information. There was no evidence that the PST addressed the continued need for enteral nutrition. <u>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</u>. There were two individuals who also received oral pleasure feedings (Individual #98 and Individual #217). <u>There is evidence of discussion by the PST regarding continued need for enteral nutrition</u>. There was insufficient evidence that the PST discussed the individual's condition in order to determine whether enteral nutrition continued to be medically necessary.	

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		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. A multi-disciplinary meeting was held the week of the on-site baseline review. A timeout was taken from the NMC meeting to accommodate the many staff in attendance to discuss plans to review those with enteral nutrition. The implementation of these plans will be investigated in subsequent monitoring team reviews. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. Via PNMPs and 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 was ineffective in the identification and remediation of these errors and this put individuals at risk of harm for aspiration and/or choking and increased the potential for tube placement.	

Recommendations:

1. Promote improved consistency in the screening process and integration with the Health Risk Screening process.

2. Establish a broader, more consistent NMC membership to include a speech-language pathologist and physical therapist.

3. Ensure increased opportunities for annual continuing education opportunities to include all NMC team members.

4. Establish measurable outcomes and thresholds related to occurrences of risk indicators or identified PNM concerns.

5. 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 of this report.

6. 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 the findings of this monitoring should be utilized to better target staff training.

7. Conduct intensive focused staff training to address serious deficiencies in implementation of PNMPs, particularly Dining Plans.

8. 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.

9. 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.

10. Ensure that the PNMP Coordinators receive adequate and appropriate competency-based training, routine review and oversight of the monitoring process in action, and revalidation of competency on a routine basis to promote improved consistency and accuracy. At this time, the process was merely a paper exercise and provided little to ensure that individuals were protected from risk of harm.

11. Ensure that the monitoring system is based on individual-specific needs; those at higher risk should be monitored with greater frequency.

12. Consider revision of monitoring tools 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.

13. Conduct trend analysis of all monitoring data. Review findings and make system adjustments.

14. 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.

15. 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. The NMT 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:** <u>Documents Reviewed</u>: o Current Census Alpha o CVs for PNMT members o DADS policy, Occupational/Physical Therapy Services #014, 10/7/09 o Clinical Staff list, dated 3/23/10 o Continuing Education for PNMT members o At Risk- Non-Ambulatory/Assisted Ambulation as of 4/5/10 o Individuals who use Orthotics and/or Braces o Slip/Trip Fall Data January to March 2010 o Individuals who use ambulation assistive devices o Individuals who use wheelchair as primary mobility o Individuals who use transport wheelchairs o Rehabilitation Therapy Evaluation template o Sample positioning plan o OT/PT spreadsheet o Use of wheel locks and tilt/recline mechanisms of wheelchairs and Geri chairs policy 3/9/07 o Wheelchair Van- Use of Lift and Positioning of Wheelchairs policy 2/9/01 o Diet Order policy 11/6/08 o Snacks policy 10/11/02 o Falls Prevention policy 1/5/01 o Fall Prevention Risk Assessment o Bedrails policy 12/13/02 o Lifting/Transfer of Individuals 10/8/04 o Lifting/Transfer handouts for New Employee Orientation o Stand/Pivot transfer-Assessment Checklist form o Two-Person Manual Lift- Assessment Checklist form o Mechanical Lift- Assessment Checklist form o Maintenance Log o PNMP Coordinator Duties o PNMP Coordinator Position Description o PNM Spreadsheet o PSPs for the following: • Individual #7, Individual #66, Individual #179, Individual #211, Individual #287, Individual #331, Individual #126, Individual #90, Individual #150, Individual #264, Individual #189, Individual #390, Individual #352, Individual #237, Individual #241, Individual #202,

	Individual #26, Individual #109, Individual #273, Individual #31, Individual #334, Individual #44, Individual #127, and Individual #318 o PNMP format o Dining Plan format o PNMP Monitoring Sheets o Training Rosters o PNMP Monitoring form templates o PNMP Monitoring Follow up Tracking o PNMPs submitted for SGSSLC individuals o PNM Clinic Assessment templates o PNM Clinic Meeting Summary spreadsheets o PNM Clinic Initial Reviews, Annual Reviews, Annual Mat Assessment, PNM Equipment Reviews, Quarterlies and Annual Updates including: • Individual #26, Individual #334, Individual #2, Individual #127, Individual #273, Individual #128, Individual #130, Individual #380, Individual #118, Individual #107, Individual #44, Individual #89, Individual #202, Individual #109, Individual #31, Individual #352, Individual #189, Individual #143, Individual #7, Individual #241, and Individual #390 o Rehabilitation Therapy Evaluations and Updates for the following: • Individual #66, Individual #203, Individual #109, Individual #203, Individual #318, Individual #44, Individual #390, Individual #127, Individual #334, Individual #2, Individual #26, Individual #40, Individual #271, Individual #193, Individual #34, Individual #382, Individual #226, Individual #236, Individual #233, Individual #229, Individual #237, Individual #181, Individual #281, Individual #271, Individual #310, Individual #7, and Individual #273 o DADS policy, Communication Services #014P, 11/4/09 o DADS policy, At Risk Individuals #006 dated 10/5/09 o DADS policy, Nutritional Management Team #013 dated 1/31/10 o DADS policy, Physical Nutritional Management #012 dated 1/31/10 o Health Management Consult Log policy dated 2/8/08 o Criteria for PNM Risk Levels o Individual Record documents including: • Annual Medical Summaries • Annual Nursing Evaluations and quarterlies • PSPs and addendums • Training Guides • GI consults • Chest x-rays • NMC Meeting minutes, progress note, evaluations • PNMPs • Dining Plans

- OT, PT, SLP evaluations/updates
- Rehabilitation documents, Clinic notes, updates, annual reviews, etc.
- Nutrition assessment
- Fall risk assessments

- For the following individuals:
  - Individual #7, Individual #281, Individual #78, Individual #384, Individual #143, Individual #146, Individual #203, Individual #2, Individual #181, Individual #66, and Individual #310

Interviews and Meetings Held:

- Dena Johnston, OTR, Rehabilitation Therapies Director
- Cindy Bolen, PT
- Judy Perkins, PT
- Charis Worden
- PNMP Coordinators
- Discussions with various supervisors and direct care staff
- Discussions with various day program staff

Observations Conducted:

- NMC Meeting 5/13/10
- PNMP Clinic 5/11/10
- PNMP Review Team meeting 5/10/10
- Webinar
- 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 Director of Rehabilitation Therapies was a strong leader, was very knowledgeable, and very much up to the task of meeting the expectations of the Settlement Agreement. The therapists did an excellent job of linking risks to interventions, though the process of justification was somewhat rote rather than a true clinical analysis for selecting one intervention over another. It will be important to ensure that they examine the interrelatedness of the assessment findings and have considered all the viable options to address each individual uniquely based on his or her specific needs. The PNMP Clinic appeared to work well though interventions were largely foundational in nature rather than with a focus on skill acquisition. Implementation was very weak, however, as evidenced by the numerous errors cited throughout this section as well as in section O. This reflected poorly on the staff training and monitoring aspects of their

	system. The department seemed to focus more on assessment and less in these important areas and, as a result, placed individuals at risk of harm.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	<u>The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience</u>. The census at SGSSLC was approximately 209 at the time of this baseline review. The department director, Dena Johnston, OTR was an occupational therapist. PT services were provided by two physical therapists, Cindy Bolen, PT, and Judy Perkins, PT. There were no PT Assistants. OT services were primarily provided by one full-time occupational therapist, Charis Worden, OTR. The Director, Dena Johnston, OTR completed the Rehabilitation Therapy Annual Reviews for each individual living at SGSSLC and participated in the PNM Clinics and served as a leader for the Nutritional Management Committee in addition to numerous other responsibilities as the Director of Rehabilitation Therapies. There were no OT Assistants. Evidence of credentials was submitted for each of the OT/PT professional staff as requested. There were a total of five positions allotted for OTs and/or PTs, with two of those positions remaining vacant for the past two or three years by report. Given the census of 209, it was of concern to the monitoring team that there was only one OT to provide supports and services to all individuals who required them. Some manufactured components for seating systems were acquired from area vendors, though all custom seating systems were foam-in-place and fabricated on site. Fabricators were responsible for collaborating with therapy clinicians to design seating systems for individuals living at SGSSLC, fabricating custom components, and completing repairs and modifications as needed. <u>All individuals have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission</u>. OT/PT assessments were completed for each individual newly admitted to SGSSLC, by report. Subsequent assessments for those who received supports and services were in the form of updates. Annual Reviews completed by Dena Johnston, OTR, served as a screening of sorts for those who had not received services to determine if any new needs had emerged as a result of changes in health status or functional performance. Other screenings were not directly OT/PT related though certainly pertained to overall physical and nutritional risk indicators. The OT/PT assessments were integrated assessments completed by the physical therapist and an occupational therapist, and signed by both. Professional staff indicated that these were completed for individuals newly admitted within 30 days. The only initial evaluation for a new admission submitted for review as requested by the monitoring team was for Individual #271. This was a comprehensive assessment dated within the 30-day	

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		timeframe required. Further validation of this element was not accomplished during this baseline review by the monitoring team and will require investigation in a subsequent review. Five assessments completed by each clinician as well as the most current OT/PT assessments of 11 individuals for whom records were requested by the monitoring team. Five OT/PT assessments completed by each PT were submitted and 10 of the 11 additional OT/PT assessments were submitted with the exception of one for Individual #143. Six of these were completed by Judy Perkins, PT and four were completed by Cindy Bolen, PT. The OTR had participated in each of the 20 evaluations submitted for review. A Rehabilitation Therapy Evaluation was completed for individuals newly admitted, or for readmissions, to SGSSLC. The Annual Evaluation Update was completed for individuals on an annual basis if they had received supports and services in the last year, had experienced a health status change in the last year or were at risk for a health status change. An Annual Review was completed for those who received "minimal services (issues resolved)" or for those who were not considered to be at physical nutritional risk based on their annual screening. The system utilized was clearly outlined and appeared to be consistently implemented as intended with the exception of the Annual Reviews as discussed below. All assessments submitted were current within the 12 months prior to this review, with the exception of that submitted for one individual that was dated 2/12/09 for a PSP on 3/3/09. Each of these assessments was identified as an Evaluation Update and each was of a consistent format. The update addressed general information including active medical issues, medications, allergies, sensory impairments and a brief statement with regard to communication. The assessment portion of the document identified consults in the last year, a summary of mealtime management, upper extremity function, self-care, environmental controls, alternate positioning and a gait assessment. Additional areas reviewed included transfers, a review of fall history in the previous year, foot and shoe assessment as well as skin care. Further documentation addressed review of PNM Clinic review findings, adaptive/supportive equipment, the PNMP and Nutritional Management Committee review. The report concluded with a summary and recommendations. The updates were thorough and provided an excellent overview of the individual's current status and supports and services over the previous year. There was no reference to changes noted since a previous evaluation or update however. <u>All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification</u>. By report, new issues that required additional assessment by OT or PT were generally addressed well within the 30 day period. Rehabilitation Therapy Consults and Updates were submitted for those for whom personal records were requested by the monitoring team. The updates appeared	

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		to be documentation of an individual's participation in therapy or programming, while a consult appeared to be a response to a referral. While it was not possible to effectively evaluate this element during the baseline review, further investigation of this will be conducted in subsequent reviews. A fall assessment was conducted by PT for individuals who had experienced three falls in the previous quarter or per referral by the PST. In many cases, it was not documented when the referral had been made. It was noted that in the case of Individual #26 that there was an evaluation by PT in March 2009 subsequent to a fall in the bathroom. She was again referred to PT following a right patellar fracture as a result of a fall (date not documented by the clinician). It was of concern, however, that "the circumstances of the fall were not available." This would be an important element in her assessment. Supports were put in place to address immediate issues related to her injury with ongoing follow up to ensure that the appropriate supports were in place once she was released for weight bearing and walking. These updates were documented through to apparent resolution of the fracture injury. It was further noted in her Evaluation Update on 1/13/10, that she had not experienced any falls subsequent to the fall with fracture in October 2009. It appeared that the supports implemented were effective in protecting her from further injury secondary to falls. <u>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</u>. Per the PNM Handbook developed by Karen Hardwick, Ph.D., OTR, FAOTA, and updated in 2010, a comprehensive assessment was completed upon admission to the facility and updates were completed annually thereafter when supports and services were provided to the individual. There was not a clearly delineated comprehensive baseline assessment with interim updates, as described in the Settlement Agreement, but rather the evaluations submitted were each "updates." The Updates completed by clinicians at SGSSLC were strong, though there was no reference to a previous evaluation or update findings for analysis of progress or change since that time. PNM Clinic assessments were also completed for those presenting with new or existing PNM risk indicators. These clinics were generally conducted for several hours on each week and two to three individuals were reviewed during each clinic for those with more significant PNM needs and were reviewed quarterly. One time monthly, an additional clinic was conducted for those with low to moderate PNM needs. This was a day long clinic and, per the clinic notes, as many as 25-30 individuals were reviewed at that time. The initial PNM assessment included a review of PNM risks, the assignment of risk levels, and a plan to address each of these with recommendations and the establishment of the interval for ongoing review. The PNM clinic was conducted routinely with individuals	

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		scheduled for review according to need. PNM health status was reviewed and risk levels with associated plans were reviewed and modified as indicated. Each individual was to receive at least an annual review approximately two months prior to the PSP, while others were seen more frequently. When needed, the review also included a mat assessment for those who had customized seating. These assessments focused on equipment, but specific concerns that arose since the last review were also documented. 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. An Annual Review was conducted by the Director, Dena Johnston, OTR, for those who did not receive any or minimal supports and services from Rehabilitation Therapy or for those who were not considered to be at physical/nutritional risk. There were seven of these submitted for the following individuals: Individual #189, Individual #143, Individual #7, Individual #352, Individual #31, Individual #241, and Individual #237. The date of the "full" evaluation at the time of admission was listed in each review with the exception of Individual #27 who, per her review, had received a full evaluation on 2/12/09, though she had by report lived at SGSSLC for 30 years. In addition, she was noted to have significant physical and nutritional risk indicators. Only two were identified at low risk. Four others were noted at low to moderate physical nutritional risk. It was unclear to the monitoring team as to the purpose of the Annual Review and to whom it was to be submitted. Further, this was inconsistent with the general guidelines submitted. Findings of comprehensive assessment drive the need for further assessment such as a wheelchair/ seating assessment. Per the baseline assessments/updates reviewed and lists submitted, there were approximately 32 individuals who required the use of a wheelchair as their primary means of mobility. Another 17 individuals used a wheelchair for transport only, and approximately 20 individuals used some type of assistive device for ambulation. There were 20 individuals who required a gait belt or transfer belt for assistance, some in addition to an assistive device necessary for ambulation. In each of the Evaluation Updates, there was a section that provided an overview of activities related to the individual's assistive equipment. While there was no specific statement as to whether the existing equipment met their needs, it was clear what actions had been taken via PNM Clinic in that regard as in the case of Individual #203 and Individual #66. There was evidence of a more extensive mat evaluation noted from the PNM Clinics, as documented in the PNM Clinic reviews conducted quarterly, annual, or at some other interval as indicated by the individual's needs. Some inconsistencies across documentation were noted, however. For example: • Individual #66 had been reviewed in PNM clinic on 6/2/09 at which time	

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		modifications were recommended for his seating system. Though the rationale was not included in the Update, it was documented that Individual #66 required a complete new seating system as of 9/22/09 and that, at the time of the Update on 2/9/10, the system was still pending and was being fabricated at that time. The PNM clinic review report for 9/22/09 did not identify the need for a new system and the rationale for a new system could not be determined versus the modifications previously recommended. It was of great concern that issues related to Individual #66's seating had been identified as far back as June 2009, yet as of February 2010, he still had not yet received an acceptable device. A PNM Clinic Review dated 5/11/10 documented that Individual #66 had been fitted for a new Solara tilt in space wheelchair with custom foam in seat and back on 4/28/10. There was no delivery note included in the document request materials, though that entry may have been placed in the integrated progress notes and a copy had not been submitted. There was no statement in the Review in May 2010 with regard to whether it met his needs at that time. • Per the Maintenance Log, a work order request was documented for Individual #257 on 9/16/09. The completion date was listed as 1/25/10, over four months later. The projected timeframe was 90 days. <u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions</u>. This information was scattered throughout the Evaluation Update and was used to justify supports, particularly as they related to equipment, though it was done somewhat loosely at times. Modifications to the PNMP were generally described in most cases. There were, however, very limited references to direct therapeutic interventions. These were generally well documented with sufficient justification when they did occur (Individual #7). The summary was generally merely a summary with a linear approach to justifying supports and services with limited actual analysis of the interrelatedness of risk factors or medical/health events that may have occurred throughout the previous year. Even so, the assessments were thorough and well written. As health or safety issues arose, they appeared to be addressed via consults resulting from direct referrals or based on findings generated from the monitoring tools completed. It was not possible to determine the timeliness of the response within the documents reviewed because it was difficult to determine when the referral occurred because physician orders were not requested during this review. Follow up related to response time will be a focus of future reviews. <u>Evidence of communication and or collaboration is present in the OT/PT assessments</u>. OT and PT completed a combined assessment report. Also during the PNM Clinic, there were additional professional staff that participated included the SLP, audiologist,	

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		nursing, and DCPs, though this was reported to be inconsistent at times. A physician attended the clinic for review of Individual #122 as observed by the monitoring team. The physician attended in order to collaborate on strategies to address ongoing concerns for skin integrity and wanted to see the findings of the pressure mapping completed on that date. During this clinic each therapist participating appeared to have a specific role and the process was smooth, interactive, and productive.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	<u>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 generally limited to PNMPs and Dining Plans. Plan development was the responsibility of Rehabilitation Therapy staff and, in the case of PNMPs and dining plans, implementation was by DCPs. By report, all plans were in place and when a revision was necessary, each of the plans was modified. A date of revision was included on the PNMPs the changes made to the plan were identified by a symbol or bullet. <u>Within 30 days of development of the plan, it was implemented</u>. Though PNMPs were in place with staff training reported, more attention to position and alignment in wheelchairs was indicated, particularly during meals. Some individuals were observed with insufficient foot support and others were not positioned well back in the seat. Some examples included: • Individual #264 was observed in a posterior tilt, his feet were unsupported and his knees and thighs extended well forward of the seat bottom. • Individual #15 was observed seated in a wheelchair with a sling seat bottom that did not provide sufficient support and stability to her pelvis and trunk. • Individual #138 was observed in a dining chair with a cushion and attached foot box for support. She was positioned in a posterior tilt, her lower extremities were windswept to the right, and her feet were unsupported. • Individual #325 was observed being assisted to eat with her head in hyperextension. • Individual #128 was not repositioned before his meal and his pelvis was posteriorly tilted and off to the right side of the seat bottom. His pelvic positioning device/seatbelt was too loose to maintain his pelvis in proper alignment. It was reported that, in most cases, modifications required for the PNMP were implemented nearly immediately when related to safety concerns and well within the 30 day timeframe. A noted exception was related to seating equipment that often extended well beyond 30 days to gain approval, order commercial products, and complete custom fabrication which was not unusual to see in other similar settings. In some cases, however, the time frames for delivery of seating systems was well outside what was	

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		acceptable, as in the case of Individual #66. 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. Most of the interventions provided to individuals related to supports provided through the PNMPs, but were more limited as related to treatment by licensed clinicians or specialized programs offered, such as ambulation, mobility, fine motor skills, etc. There appeared, however, to be adequate support to justify the interventions within the evaluation updates and PNM clinic findings. Review of PSPs revealed that highlights of the OT/PT Evaluation Updates or Annual Reviews were included in the OT/PT section of the document. There was an additional review of the PNMP and some aspects were included for the supports outlined in the Living Options section of the PSP. There were no objective, measurable, or functional outcomes with established criteria associated with direct therapy interventions in the form of training objectives noted in the PSPs reviewed and, by report, this would not be typical. Interventions are present to enhance: a. movement; b. mobility; c. range of motion; d. independence; and e. as needed to minimize regression. Interventions provided were largely in the form of supports via the PNMPs. Though limited, the additional interventions provided included fitness class, gait training/ambulation, standing, transfer training, range of motion, and strengthening. The majority of the interventions documented were related to treatment of injuries, such as fractures or, in the case of Individual #146, post-suspected CVA. Specific measurable, functional goals were not documented even in these cases including Individual #146, Individual #2, Individual #181, and Individual #78, for example. The focus of interventions appeared to be functional and, in discussion with the clinicians, this had been their intent. It will be important to address this through documentation as well. 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 individual's needs. As described above, more attention and training related to implementation of this aspect of the PNMPs was indicated particularly during mealtimes. It was reported by the clinicians that they did not have alternate positions in place and there was limited specialized bed positioning addressed beyond the head of bed elevation for those with GERD precautions. Therapists provide verbal justification and functional rationale for recommended interventions. Evaluation Updates and Rehabilitation Updates reviewed generally	

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		provided a verbal description of the rationale for recommended interventions that were then integrated into the PNMP and listed in the PSP, particularly related to supports. This, however, was limited because it pertained to more direct interventions as described above. While specific activity or intervention plans were not reviewed, the Rehabilitation Updates written by the clinicians related to interventions clearly indicated the justification and were generally functional in nature. The PTs provided direct intervention to approximately five individuals and the OT provided intervention to one individual only. Given the staffing ratio and the extensive assessment process, the focus of intervention was on supports rather than direct treatment. Interventions were typically implemented by the PNMP Coordinators, including ambulation, range of motion and mobility. Training of these staff was by licensed professional staff. Documentation of competency was not clearly established, however. Many of the PNMP Coordinators also served as therapy technicians previously and had been with the department for some time. Though they were generally experienced, specific, well documented evidence of competency-based training will be critical to ensure appropriate implementation of these programs. <u>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</u>. Interventions were reviewed at least monthly with an update written to describe progress and justification for continuation or discharge. PNMPs were reviewed at a prescribed interval (annual, semi-annual, quarterly) during the PNMP Clinics. Assessment reports clearly documented findings, interventions, and rationale for changes made to the PNMPs. Additional PNMP monitoring was conducted by the PNMP Coordinators (recently implemented as of 4/1/10), as well as the clinicians. By report, concerns noted were addressed at the time of the monitoring, resulting in program changes as indicated. A simple database was submitted that identified who was monitored, when, and a description of any issues identified with recommendations for retraining, referral, and so forth. Follow up was assigned with an estimated date of resolution listed in the database, but there was no evidence that any of the concerns identified were actually resolved based on the documentation submitted. By report, there was a plan for a more extensive database to incorporate all PNM monitoring information (by clinicians and the PNMP Coordinators) and to allow for analysis and trending. This system was to be directed by the director and review of the findings was to occur in the PNMP Review Team meetings at which time all PNMPs were reviewed prior to the PSP meeting for consistency and wording. By report and observation of one of these meetings, this was an excellent process used by the department to catch errors in the plans, inconsistencies with instructions and photos, and to ensure that the plans were void of professional jargon for optimal understanding by DCPs. The element of review of findings from the monitoring appeared to be a good fit for this meeting and team members.	

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P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	<u>Staff implements recommendations identified by OT/PT</u>. As described above, there were numerous instances of incorrect implementation of Dining Plans. In addition, staff implementation of positioning plans and alignment guidelines needed more attention via staff training and focused monitoring activities, such as drills. The monitoring forms completed by professional staff (80 across nearly three months) appeared to more consistently identify issues (22) of varying types with follow up to address each issue. The monitoring sheets or spreadsheet submitted, however, did not document when and if the problem identified had been resolved. There was no specific system to complete a follow up monitor to determine the successful implementation post-retraining. These elements would be critical in the development of an effective system of monitoring. The PNMP Coordinator positions were newly created and these should become critical elements of their training. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations</u>. The only competency-based training aspect of new employee orientation provided in the area of OT and PT supports was related to lifting and there was a check-off list related to mealtimes. Training in other areas of new employee orientation relied on written test questions and classroom participation. A refresher related to lifting was required of staff every two years. Person-specific training was provided to home managers and DCPs and was in some cases, skills-based. Some of the inservices reviewed were a communication of information and the competency identified was that staff were able to verbalize the change in the individual's plan. Pulled staff were to read the plans for individuals assigned to them before they started to work with them, but in one case (Individual #202), there was no evidence that the pulled staff responsible for her care and supervision had ever read the information until she had worked with that individual for three days. The individual required one-to-one supervision at the time of this observation by the monitoring team. <u>Staff verbalizes rationale for interventions</u>. Staff did not consistently appear to understand the rationale for prescribed interventions. While this was primarily observed to affect the implementation of Dining Plans as described above, this would be an important aspect of training to emphasize through monitoring, review, retraining, and drills.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and	<u>System exists to routinely evaluate: a. fit; b. availability; function; and c. condition of all adaptive equipment/assistive technology</u>. Clinicians, DCPs, and PNMP monitors were responsible for identifying concerns related to adaptive equipment and assistive technology. The PNMP Clinic reviews were set up in a manner to note issues with	

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	implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	existing equipment outside of mealtime. Based on the maintenance log submitted, it appeared that the condition of adaptive equipment was largely based on work order requests, though some were generated as a result of the PNMP monitoring findings and corrective actions. There did not appear to be a specific system to routinely and systematically review the condition of adaptive equipment for proactive identification of issues requiring repair or preventative maintenance beyond that of the PNM Clinics. Most of the repairs were completed on the day the work was requested with the exception of Individual #257 for the quarter for which the log was submitted. 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, DADS 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 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. By report, there was a plan to track the frequency or findings through formal review of monitoring findings, but not to specifically target staff competence and performance. Though indicated on the form currently used, staff names were not consistently identified, so tracking and trending would be impossible. 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. All new employees attended training related to physical management as an aspect of the new employee orientation. By report, all SGSSLC staff with direct support responsibilities had received this training. Person-specific staff training was provided for staff with evidence submitted with regard to monitoring completed in the form of sign-in sheets. This did not generally impact the pulled staff	

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		used in many of the homes on a regular basis. In those cases, the programs were to be reviewed by assigned staff to ensure that they were familiar with all aspects of the individual's supports. Additional sign-in sheets were not requested related to person-specific training for 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, however, based on observations noted by the monitoring team, the current system of training and review of staff performance was inadequate. Responses to monitoring findings are clearly documented from identification to resolution of any issues identified. The monitoring log submitted listed the issues identified for each individual monitored and recommendations for resolution were also listed, however, the date of completion or resolution was not. It was documented that follow ups were conducted monthly to ensure that corrective plans were completed. Completion dates should be a critical aspect of this process. There was no tracking or trending of issues identified, though a plan was in development to begin this process. Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available. This did not appear to be a problem and concerns were generally addressed in a timely manner. Individuals with greater PNM risk were typically reviewed with greater frequency in the PNM clinics but at this time there was no specific schedule to ensure that individuals considered to be at higher risk were monitored with greater frequency. The PNMP Coordinators were assigned a caseload of individuals to be monitored, however, there was no established tracking system to determine how consistently this schedule was implemented. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs. Person-specific monitoring was conducted on a limited basis by professional staff and had been recently implemented by the PNM Coordinators as of 4/1/10. The monitoring form was not specifically designed to address plan effectiveness, but rather to address consistent implementation by DCPs. The licensed clinicians were qualified to make the determination that the plans were effective and make adjustments or referrals, but the PNMP Coordinators were not. The review of effectiveness was accomplished during the PNMP Clinics but the frequency of these reviews was likely not sufficiently frequent for those most at risk. There was some limited aggregation of data obtained from the monitoring forms, but this spreadsheet only identified concerns noted and did not specifically track findings by the 26 indicators listed on the monitoring form to also guide the identification of trends for greater focus of staff training. Data collection method is validated by the program's author(s). There were no	

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		interventions implemented that involved data collection. There was no evidence that the program authors reviewed the implementation of the program to ensure it was being done as designed.	

Recommendations:

1. OT staffing must be increased to ensure that all elements of the Settlement Agreement can be implemented and sustained. With only two PTs, there may also be some concerns for their ability to increase the intensity of more direct supports as well. Additional staffing such as licensed OT and/or PT assistants should be investigated.

2. Training of PNMP Coordinators must be competency-based to include didactic presentation of content information necessary to recognize issues related to PNM, as well as hands-on opportunities to practice necessary skills. This must include monitoring strategies, follow up steps, documentation, and interaction with staff and supervisors, as well as hands-on opportunities to complete the monitoring form and, in addition, 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. These staff must be able to properly demonstrate implementation of each of the elements of PNM in order to successfully model for and coach direct support staff.

3. The monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded, and 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, and so forth.

4. 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. The director already had plans in development to address this.

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

6. The PNMP Clinics appeared to work well at SGSSLC, though there was insufficient focus on skills training and integration of actions in the PSP process. The professional staff appeared to understand this need but were concerned with time and staffing limitations.

7. A review of the system of training, coaching and monitoring of pulled staff will be necessary to ensure that these staff are competent to implement all supports and services to the individuals to whom they are assigned.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Dental Restrain Checklist – Pre-treatment Sedation for: • Individual #138 and Individual #253 o DADS policy: Dental Services, Draft: no date o SGSSLC Philosophy of Dental Clinic o SGSSLC Dental Procedure: Dental Appointment Attendance, Date: 3/5/10 o SGSSLC Dental Appointment Monthly Tracking Sheet, January 2010 through April 2010 o SGSSLC Dental Appointment Attendance, Date: 3/5/10 o SGSSLC Dental Procedure: New Employee Oral Care Training Curricula, Date: 2/1/10 o SGSSLC Dental Assessment Questionnaire for Desensitization Form o SGSSLC Functional Assessments for: • Individual #274 and #9 o SGSSLC Dental: Preliminary List of Desensitization Participants – Pending Functional Assessment by Psychologist o SGSSLC Dental: Consent Explanation and Consent for Use of Sedating Medications for Dental Procedures o SGSSLC Health Management Policy: N-34 Guidelines and Recovery for Individuals Receiving Use of Sedation for Dental Procedures, 7/10/09 o SGSSLC Initial Examination Procedure for Initial Examination, Date: 2/1/10 o SGSSLC Initial Examination Procedure for New Admits and Dismissal, Tracking Log, January 2010 through February 2010 o SGSSLC Dental: Admission Activity (All Admissions), 9/1/09 through 4/1/10 o SGSSLC Dental Records for: • Individual #215, Individual #214, Individual #112, Individual #102, Individual #346, Individual #301, Individual #127, Individual #59, Individual #69, Individual #137, Individual #203, Individual #124, Individual #122, Individual #222, Individual #146, Individual #94, Individual #247, Individual #281, Individual #385, Individual #78, and Individual #25 o Oral Healthcare for People with Special Needs: Guidelines for Comprehensive Care, dated 2004. <u>Interviews and Meetings Held</u>: o Dr. Rebecca McKown, MD, Medical Director o Dr. Tom Anderson, DDS o Belinda Lendermon, Registered Dental Hygienist o John Church, Psychologist, Psychology POI Coordinator <u>Observations Conducted</u>:

	o Dental Clinic
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The Dental Department's staff were comprised of a Dentist, Dental Hygienist, part-time Dental Hygienist, Dental Assistant, and a contract Dentist/Anesthesiologist. The Dental Department reported to the Medical Director. The Dental Clinic was well equipped, organized, and clean. It projected a user-friendly atmosphere. The Dental Department staff stated they would begin using suction toothbrushes as soon as the nursing staff were trained. Individuals most at risk for aspiration had been indentified. The Dental Department's plan was to first use suction toothbrushes for individuals diagnosed with gastroesophageal reflux disease, then progress to individuals diagnosed with dysphagia and/or who had a history of aspiration pneumonia. The Nursing staff were to be responsible for using the suction toothbrushes. Annual dental examinations were completed on 19 of the 21 individuals reviewed within their anniversary month of admission and/or the last dental examination. New Admissions received their initial dental assessments within 30 days of admission. Although numerous refusals and/or cancellations for annual and routine dental services were noted in the individuals' records, there was evidence that appointments were tracked, rescheduled, and kept. The Dental Department maintained a comprehensive computerized database tracking appointments, pre-treatment sedation and/or restraint use, and desensitization programs. There was no trend analysis completed for dental services that tracked, trended, and analyzed the use of sedation/restraints and desensitization plans. The Dental Department was working collaboratively with the Personal Support Teams and Psychology Department to develop and implement Desensitization Plans for individuals who were resistive to receiving dental care. These individuals were identified and were in the process of having Functional Assessments completed by the Psychology Department. The Psychology Department was responsible for developing the Desensitization Plans. State policy needed to be developed and subsequent to that, facility policies need to be developed. The facility also needed to incorporate the guidelines as indicated in provision Q1 regarding published dental guidelines. The state had provided a copy of a document called, "Oral Healthcare for People with Special Needs." This was not yet being addressed at SGSSLC.

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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 standards.	The Dental Department's staff were comprised of a Dentist, Dental Hygienist, part time Dental Hygienist, Dental Assistant, and a contract Dentist/Anesthesiologist. The Dental Department reported to the Medical Director. The monitoring team toured the dental clinic and conducted interviews with Dr. Rebecca McKown, Medical Director, Dr. Tom Anderson, Dentist, and Belinda Lendermon, Registered Dental-Hygienist. The Dental Clinic was well equipped, organized, and clean. It projected a user friendly atmosphere. Two dental chairs were available, one for use by the Dentist for treatment, and the other used by the Dental Hygienist for cleaning, tooth brushing, and as part of the residences to see individuals and to work with the staff. The Medical Director also stated the increased dental staff visibility and interaction with the DCPs improved the overall oral hygiene care of individuals. The Medical Director and the Dental staff explained the use of intravenous sedation recovery procedures. The Infection Control Nurse, who was certified in Advance Cardiac Life Support (ACLS), was called and brought the Emergency Crash Bag before the individual woke up. If the individual had not received pre-treatment sedation he or she usually awoke within three to five minutes. Then, a physician completed a modified assessment. When the individual was fully awake and recovered he or she was transported back to the home. The Infection Control Nurse notified the Nurse Case Manager who continued to assess the individual. Typically, the DCP Supervisor placed the individual on increased supervision. If the individual was unusually drowsy, another diagnostic exam was completed, and the individual was monitored according to the outcome of the assessments. The Medical Director stated they would soon begin using suction toothbrushes. Individuals most at risk for aspiration had been indentified. The Dental Department's plan was to begin using suction toothbrushes for individuals diagnosed with gastroesophageal reflux disease, then progress to individuals diagnosed with dysphagia and/or who had a history of aspiration pneumonia. The facility has just received a supply of suction tooth brushes and was preparing to train the nursing staff in their use. The Nursing staff were to be responsible for using the suction toothbrushes. On future tours, the monitoring team will follow up on progress made toward the use of suction toothbrushes for individuals identified at risk for aspiration. Review of the past year's dental records for Individual #215, Individual #214, Individual #112, Individual #102, Individual #346, Individual #301, Individual #127, Individual #59, Individual #69, Individual #137, Individual #203, Individual #124, Individual #122, Individual #222, Individual #146, Individual #94, Individual #247, Individual #281, Individual #385, Individual #78, and Individual #25 revealed the following information:	

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		• Annual dental examinations were completed on 19 of the 21 individuals within their anniversary month of admission and/or the last dental examination. One individual's annual examination was documented as refused. There was no explanation documented for the other individual's missed annual examination, however, the exam was completed approximately five months later. • Although numerous refusals and/or cancellations for annual and routine dental services were noted in the individuals' records, there was evidence that appointments were tracked, rescheduled, and kept. When dental services were rescheduled there was evidence that they received dental services according to their recommended follow up care or when emergency care was indicated. • Documentation of routine dental services included but were not limited to: o Review of physical health impact on dental services. o Review of individual's medication. o Review of allergies. o General condition of current oral environment. o Findings of dental assessments. o Descriptions of any treatment provided. o When extractions were necessary and/or other restorative and preventative procedures were performed there was clinical justification documented describing the rationale for each. o Plans of care were consistent with examination findings. o Oral hygiene instructions were provided to either the individuals or the staff accompanying the individuals at the time of their dental visit. • According to the facility's Health Risk Screening Tracking Reports, April 2010, for the 21 individual records reviewed, six (29%), were scored with some degree of risk for aspiration and/or aspiration pneumonia: o Individual #281 had high risk scores for both aspiration and aspiration pneumonia with plans for both risk indicators. o Individual #127 had moderate risk scores for both aspiration and aspiration pneumonia with a plan for aspiration risk indicator. o Individual #203 had a moderate risk score for aspiration, but no plan for the risk indicator, and a low risk score for aspiration pneumonia with a plan for the risk indicator. o Individual #222 had a low risk score for aspiration, but no plan for the risk indicator, and a moderate risk score for aspiration pneumonia, but no plan for the risk indicator. o Individual #59 had a low risk score for aspiration, but no plan for the risk indicator, and a moderate risk score for aspiration pneumonia, but no plan for the risk indicator. o Individual #146 had a moderate risk score for aspiration with plans for	

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		aspiration and aspiration pneumonia risk indicators. In the review of the above individuals' Dental records that were identified as having plans for aspiration and/or aspiration pneumonia, no documentation was found relating to their plans when receiving dental services. The facility's Dental staff needs to ensure those individuals at risk for aspiration and/or aspiration pneumonia and who have plans, that the plans are implemented and documented in their Dental records. It is inconsistent for individuals to have a low risk score for aspiration but have a moderate risk score for aspiration pneumonia, because to have aspiration pneumonia, the individual must have first aspirated. Therefore, the risk scores for both aspiration and aspiration pneumonia should be the same. This demonstrates the inconsistency between the various Health Risk Screening Tools. The reasons for the inconsistency could not be determined from the review. The facility's Health Support Team needs to evaluate the Health Risk Screening Tools for inconsistencies between the aspiration and aspiration pneumonia risk screening tools to ensure that individuals' risks for aspiration are accurate. • Of the 21 individuals' records reviewed, 17 (81%) did not require any form of sedation for their dental treatments, three (14%) required intravenous sedation; two were for teeth extractions; one was for dental restoration (fillings). Review of three individuals' dental records who received intravenous sedation, when cross-walked the findings with the Health Management Policy: N-34 Guidelines and Recovery for Individuals Receiving Use of Sedation for Dental Procedures, 7/10/09, there was evidence that the policy was followed. Review of New Admission Tracking Report for two individuals who were admitted within the past six months validated that they were seen within 30 days of admission. One individual was admitted on 1/27/10 and received an initial dental assessment on 2/11/10. The other individual was admitted on 2/26/10 and received an initial dental assessment on 3/15/10.	
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:	The Dental Department maintained a comprehensive computerized database that tracked the following information: • Individual first and last name, • Individual residence address/home, • Appointment date and time, • Name of dental provider (e.g., Dentist, Dental Hygienist),	

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	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.	• Individual attended appointment (yes or no), • Individual received pre-treatment sedation/restrain (yes or no), • Whether the individual had a desensitization program (yes or no), • Return visit recommended (rescheduled) (yes or no), and • Date of return visit There was evidence in the Dental records reviewed on the above individuals that when appointments were refused/missed/cancelled, the Dental staff notified their home staff and appointments were rescheduled. There was no trend analysis completed for dental services that tracked, trended, and analyzed the use of sedation/restraints and desensitization plans. According to the draft DADS Policy for Dental Services, such a trend analysis was required. The Dental Clinic was collecting information from stand alone databases that could be utilized to produce a trend analysis. The Dental Clinic needs to develop and implement a system for tracking, trending, and analyzing the use of sedation/restraints, and effectiveness of desensitization plans. The Dental Clinic maintained its own dental records, with periodic notes written in the Integrated Progress Notes. Dental staff did not chart in the SOAP format as required by the Health Care Guidelines. The facility needs to ensure that dental staff document in the Integrated Progress Notes. The facility needs to ensure that the dental staff uses the SOAP format for charting clinical information in individuals' records. According to the Medical Director and the Dental Clinic staff, they were working with the Psychology department to develop desensitizing plans for individuals who were resistant to receiving dental care. Selection criteria were typically based on three refusals by an individual to cooperate with dental procedures and/or those who had previously required pre-treatment and/or intravenous sedation. Once individuals were identified, recommendations for desensitization plans were sent to the Human Rights Committee, and if approved, forwarded to the individual's Personal Support Team for approval. The Physicians and Dentist made the final decision for those who might benefit from a desensitization plan. The requests were then sent to the respective psychologists to conduct functional assessments, and to develop the desensitization plans. Functional assessments completed for Individual #274 and Individual #9 were reviewed. Individuals were prioritized into two lists. Priority #1 included 14 individuals; priority #2 included 21 individuals. On the next on-site tour, the monitoring team will review the status of the facility's efforts toward completing the above functional assessments and desensitization plans.	

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		The Dental Policy: New Employee Oral Care Training, Dated: 2/1/10 stated its purpose was, "to enhance quality personnel in the field or care for the individuals who reside at SGSSLC. To train direct care staff (through cooperative efforts with training and development) in life skill care of individuals and help to equip personnel to better care for individuals." Review of the Oral Care Training Curricula and competency based testing materials, along with signed training records validated that such training was occurring for new employees as well as refresher training. The Oral Care Training Curriculum was in keeping with accepted professional standards of practice. The Dental Department did not have an internal monitoring process in place to evaluate the quality of dental services provided. The Quality Enhancement Monitoring Tool did not monitor Dental Services. The facility's Dental Services needs to develop and implement monitoring procedures and monitoring tools in alignment with the Settlement Agreement and Health Care Guidelines. In addition, the facility's Quality Enhancement Department needs to develop monitoring tools for Dental Services in alignment with the Settlement Agreement and Health Care Guidelines. A state policy developed by DADS had not yet been completed. It is expected that this new policy will provide direction to the facility regarding this Settlement Agreement provision. It was the understanding of the monitoring team that a document titled, "Oral Healthcare for People with Special Needs: Guidelines for Comprehensive Care" that was published in 2004 would serve as a standard for dental services provided at all of the facilities. More work will need to be done between the facility and DADS to determine how to interpret and implement those published guidelines.	

Recommendations:

1. The facility's Dental Department needs to ensure that individuals who are at risk for aspiration and/or aspiration pneumonia, and who have plans, have their plans implemented and documented in their Dental records.

2. The facility's Dental Department needs to develop and implement a system for tracking, trending, and analyzing the use of sedation/restraints, and effectiveness of desensitization plans.

3. The facility needs to ensure that dental staff document in the Integrated Progress Notes.

4. The facility needs to ensure that the dental staff uses the SOAP format for charting clinical information in individuals' records.

5. The facility's Dental Department needs to develop and implement monitoring procedures and monitoring tools in alignment with the Settlement Agreement and Health Care Guidelines.

6. The facility's Quality Enhancement Department needs to develop monitoring tools for Dental Services in alignment with the Settlement Agreement and Health Care Guidelines.

7. Determine how to incorporate the contents of the document "Oral Healthcare for People with Special Needs" as noted in section Q1.

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 Current Census Alpha o CVs for PNMT members o DADS policy, Communication Services #016, 10/7/09 o AAC and Speech-Language Evaluation templates o Clinical Staff list, dated 3/23/10 o Continuing Education for PNMT members o AAC Spreadsheet o PNM Spreadsheet o AAC Monitoring forms 1/21/10 to 3/30/10 o Speech-Language Evaluations for the following: • Individual #211, Individual #7, Individual #331, Individual #90, Individual #287, Individual #66, Individual #384, Individual #281, Individual #203, Individual #271, Individual #179, Individual #126 o Speech-Language Therapy Plan of Care and Monthly Summaries for Individual #7 o Annual Reviews for Individual #181, Individual #384, Individual #78, and Individual #2310, o Speech-Language Updates for Individual #146 and Individual #203 o Speech-Language Summary and Recommendations for Individual #2 o Communication Dictionaries o PSPs for the following: • Individual #7, Individual #66, Individual #179, Individual #211, Individual #287, Individual #331, Individual #126, Individual #90, Individual #150, Individual #264, Individual #189, Individual #390, Individual #352, Individual #237, Individual #241, Individual #202, Individual #26, Individual #109, Individual #273, Individual #31, Individual #334, Individual #44, Individual #127, and Individual #318 o PNMP format o Dining Plan format o PNMP Monitoring Sheets o Training Rosters o PNMP Monitoring form templates o PNMP Monitoring Follow up Tracking o PNMPs submitted for SGSSLC individuals o PNMP Clinic Meeting Summary spreadsheets o PNMP Clinic Initial Reviews, Quarterlies and Annual Updates o Rehabilitation Therapy Evaluation Updates for the following: • Individual #66, Individual #203, Individual #109, Individual #203, Individual #318, Individual #44, Individual #390, Individual #127, Individual #334, Individual #2,

	Individual #26, and Individual #273 o DADS policy, Occupational/Physical Therapy Services #014P, 11/4/09 o Health Management Consult Log policy dated 2/8/08 o Criteria for PNM Risk Levels o Individual Record documents including: • Annual Medical Summaries • Annual Nursing Evaluations and quarterlies • PSPs and addendums • Training Guides • GI consults • Chest x-rays • NMC Meeting minutes, progress note, evaluations • PNMPs • Dining Plans • OT, PT, SLP evaluations/updates • Rehabilitation documents, Clinic notes, updates, annual reviews, etc. • Nutrition assessment • Fall risk assessments o For the following individuals: • Individual #7, Individual #281, Individual #78, Individual #384, Individual #143, Individual #146, Individual #203, Individual #2, Individual #181, Individual #66, and Individual #310 Interviews and Meetings Held: o Dena Johnston, OTR, Rehabilitation Therapies Director o Krista Roberts, MS, CCC-SLP o Susan Holler, MS, CCC/SLP o PNMP Coordinators o Discussions with various supervisors and direct care staff o Discussions with various day program staff Observations Conducted: o NMC Meeting 5/13/10 o PNMP Clinic 5/11/10 o PNMP Review Team meeting 5/10/10 o Webinar o Mealtimes o 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: SGSSLC was soon to have only one part time speech clinician attempting to meet the many communication needs of the individuals living there. Adequate and appropriate supports and services will then not be possible. There was inconsistency in the number of completed screenings and/or assessments reported by the clinicians as well in two of their databases with regard to assessment tracking. The current evaluations were weak in format and substance and will need to be redone. This will be a monumental task and serious thought must be given to the logistics of this to ensure that the re-evaluations are thorough and accurate, and that appropriate recommendations are brought forward with timely implementation. This must be considered to be of the highest priority. Of the 69 individuals listed with a communication evaluation or screening, only 12 were listed with devices, another nine individual's devices had been discontinued, and one individual's was pending. Four were listed with devices being investigated for use. There was a serious deficiency in the provision of communication supports at SGSSLC. Many individuals had communication dictionaries serving as one important aspect of support, but, for most, the clinicians had not moved beyond this to ensure that individuals who required them had systems that were functional and meaningful. A few great systems were in place, but the individuals only had access to them during therapy sessions rather than throughout their day.

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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. SGSSLC had no speech language pathology services prior to two years ago, by report. At the time of this on-site tour, there were two speech and language pathologists with clinical responsibilities. Susan Holler, MS, CCC/SLP, had worked as a consultant three to four days per week (approximately 20 hours) since November 2009, and Krista Roberts, MS, CCC/SLP worked full time (until 3:00 each day), but had recently resigned her position effective 5/26/10. There was one vacancy for speech with another pending upon the departure of Ms. Roberts. By report, the facility had been unsuccessful with recruitment of SLPs due to more competitive salaries at other locations, such as nursing homes in San Angelo. The part time clinician's background was pediatrics. Susan Bradley, MS, CCCA was an audiologist who participated in the team assessments. There was one Speech Assistant, Tanya Nyakunika. The number of speech clinicians was of very significant concern time because each individual living at SGSSLC (209 individuals) communicated in some manner and participated in mealtimes and, as a result, potentially required the direct and/or indirect supports from a speech-language pathologist. Approximate caseload responsibilities were 104.5 individuals each for communication and the same 104.5 individuals each for oral motor and mealtime. That would be the ratio if both clinicians were full time. At	

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		SGSSLC, one of the clinicians was available only as a part time consultant, and the other had resigned. Thus, As of 5/26/10, less than two weeks from the time of the on-site review, there would be only one part time clinician solely responsible for the communication and mealtime needs of all 209 individuals living at SGSSLC. Her primary experience was in pediatrics, though, by report, she had a strong background in AAC, which was important. The speech assistant would be able to assist with these responsibilities, but would require supervision and was not licensed to provide assessment or to develop intervention and support plans. As a result, these tasks would fall squarely on one speech clinician, who was relatively new to the facility. The lack of qualified professional staff available for communication and mealtime supports and services was of serious concern to the monitoring team. <u>Supports are provided to individuals based on need and not staff availability</u>. The clinicians indicated that they provided supports and services based on prioritized needs. As stated above, at the time of the on-site review, each of the two clinicians had a caseload of approximately 104.5 (soon to be 209:1) in two critical service areas: communication and mealtime supports. Given this ratio, it would be impossible to adequately meet the needs of the individuals at SGSSLC. Basic supports include 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 or more intensive supports necessary for using AAC systems, and/or attention to address increased risk for aspiration or choking during meals. There is no way that supports and services were provided based on the needs of the individuals, rather than staff availability, at this time at SGSSLC, and certainly not as of 5/26/10 upon clinician's resignation.	
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	<u>All individuals have received a communication screening. If newly admitted, this occurred within 30 days of admission</u>. All individuals were reported to have been provided a full assessment, with none older than two years. One database submitted listed only 69 individuals who had received either an evaluation (60) or screening (9). Though each was current within the last two years, this represented only 33% of the current census at SGSSLC. Another database submitted listed 276 individuals, showing that approximately 76% of the individuals had been provided a screening, while the	

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	benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	others had been provided an evaluation. Of approximately 20 new admissions in 2009 and 2010, 13 had not been evaluated or screened within 30 days related to communication per the database submitted by Rehabilitation Therapies. A request for five current communication assessments from each clinician was also made by the monitoring team. Only three annual evaluations, however, were submitted for Susan Holler, MS, CCC/SLP. She began completing assessments just recently, in January 2010, per the statement submitted in response to the monitoring team's document request. Five submitted for Krista Roberts, MS, CCC/SLP. By Krista Roberts, MS, CCC/SLP: • Individual #90 (3/9/10) • Individual #7 (3/9/10) • Individual #287 (3/16/10) • Individual #211 (3/15/10) • Individual #126 (3/16/10) • By Susan Holler, MS, CCC/SLP: • Individual #66 (3/22/09) • Individual #179 (1/25/10) • Individual #331 (3/15/10) Each of the documents submitted were identified as annual evaluations. Four individuals had been admitted over the previous few months. No assessments for these individuals were submitted in the sample requested, so it was not possible to determine if communication assessments for those individuals newly admitted were conducted within the required 30 days. This will be further evaluated in subsequent reviews by the monitoring team. 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. There were individuals who were identified with communication related needs per the database submitted, yet had not received a comprehensive assessment. Some of these individuals had been recommended for AAC without this critical step. Thirteen individuals who had been screened had been recommended for and, in some cases, had received AAC (Individual #98, Individual #331, Individual #44, Individual #236, Individual #384, and Individual #93). Interestingly, an annual evaluation had been submitted for Individual #331 dated 3/15/10, yet a communication screening was listed as completed on that day and she had been issued a communication book at least as far	

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		back as 3/20/09. In the sample of eight assessments reviewed, six were described as annual evaluations and two were described as Speech/Language Evaluations. Of these two, the evaluation for Individual #179 was described as serving as a comprehensive assessment of speech, language, and communication skills. Each of these was brief and certainly not comprehensive, and supports for those reviewed as listed above were grossly inadequate based on the communication limitations described by the clinicians. For example: • Per her annual evaluation dated 3/16/10, Individual #126 was assigned a high risk level with regard to her communication status on 2/23/09 based upon a "comprehensive speech-language evaluation with recommendations for exploration and development of augmentative communication strategies and devices. She was again assigned high risk on 5/7/09 and 8/6/09. A communication dictionary was developed, trained, and issued though "no new recommendations were noted" despite a "Communication Focus" associated with her PNMP. During the annual review on 1/7/10, she continued to be identified at high risk, though only a communication dictionary was available to her. The assessment submitted and dated 3/16/10 stated that Individual #126 had "NO EFFECTIVE means of communication." A recommendation stated that speech-language pathology consultation was indicated regarding "exploration, development and instruction of augmentative communication strategies." The only support provided to her in the last 12 months, however, was a communication dictionary, though two assessments had indicated the need for the development of augmentative communication strategies or devices. • Per his annual evaluation dated 3/16/10, Individual #287 was provided direct speech services initiated on 4/7/09 for development of AAC. He had been provided a communication dictionary, and was assigned a high risk designation with regard to communication abilities. Per a PNM Clinic notation, the SLP was in the "process of development of a system for Individual #287 to use for routine activities." He was discharged from direct speech therapy in July 2009 with a "roundhead object" for "facilitation of awareness and predictability of daily routine." PNMP Clinic review in August indicated that his communication dictionary continued to meet his needs, though the roundhead object was not mentioned at that time. Three months later, during the PNMP Clinic quarterly review, it was stated that his AAC device had been lost. It was recommended that the SLP acquire a replacement, though the device was no longer in production. Again two months later in January 2010, it was stated that the device was no longer in production and that the SLP would need to investigate other AAC options. This review of interventions included a statement that Individual #287 communicated his needs with facial expressions, behavior, body language and occasional vocalizations. His priority level continued to high as he	

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		had "NO EFFECTIVE means of communication." Recommendations included only that the SLP would continue to provide AAC consultation and that "devices, programs and/or plans will be reviewed during scheduled PNM Clinics." There was no plan outlined to provide a system of communication for Individual #287 over one year from when a need was identified. • Per her annual evaluation dated 3/15/10, Individual #331 was described as expressing herself verbally in short phrases. No examples were presented in the evaluation report submitted, but it was stated that her intelligibility continued to limit her ability to communicate and caused "visible frustration" when she was not understood. She had a communication book that was "rarely" used, though new pictures were added. Her priority level was a 2 because she had "LIMITED language skills in the modalities of: speech, language, gesture or sign." The evaluation further stated that negative behaviors may be exacerbated by decreased communicative function." Speech therapy consultation was recommended for AAC needs with review of supports in PNM clinic. There was no plan outlined to provide a system of communication for Individual #331. • Per her annual evaluation dated 3/9/10, it was reported that Individual #90 participated in direct speech therapy to explore and develop an AAC system on 12/22/09. This was discontinued less than two weeks later "due to inability to establish a consistent skill set for development of communication devices." Her Priority Level Code was listed as a "1" because she had no effective means of communication. Per her PSP, the nursing evaluation stated that she was alert and attentive when spoken to and was able to nod to "yes" questions. There was no plan outlined to address Individual #90's communication needs other than the communication dictionary issued very recently on 1/14/10 per her PSP. • Per her annual evaluation dated 3/9/10, Individual #7 had a communication dictionary at least since 5/14/09. She was assigned a high risk level with regard to communication abilities in 8/13/09 and 11/19/09 with no additional supports provided, though she had "NO EFFECTIVE means of communication." On 12/9/09 direct speech therapy was initiated to "focus on increased functional communication for socialization as well as communication of wants/needs." As of 1/7/10, direct intervention continued though there was no description of goals or progress per the evaluation submitted for review. The only recommendation was for speech therapy to continue "consultation for AAC needs" and review during PNM Clinic. The database indicated that a device was being investigated. There was no indication as to the expected outcome of direct service for Individual #7. • Per her annual evaluation dated 3/15/10, Individual #211 used facial expression, body language, occasional words, and a picture communication book. She initiated communication and sought socialization with others. She	

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		recognized familiar caregivers and followed simple directives with occasional verbal cues and/ or gestural prompts. The recommendation stated that speech therapy would continue to provide consultation for AAC needs. There was no plan outlined to further address her AAC needs beyond that of the communication dictionary. The format used for each of these evaluations was consistent, though the only difference between the "comprehensive" evaluation and the annual evaluations submitted was that the comprehensive evaluation stated that a communication profile had been administered while the annual evaluation listed only "speech-language therapy intervention," current communication status, and a Priority Level Code. Per his "comprehensive" speech-language evaluation dated 1/25/10, the Functional Communication Profile-Revised was administered to Individual #179, though the results were not documented in the written document. A very brief statement was provided to describe his vision, hearing, motor skills, behavior, attentiveness, pragmatic and social skills, speech, voice, and fluency, as well as expressive and receptive language, though the clinician indicated that the information reported was based on record review and caregiver interview rather than direct interaction with Individual #179. He was described as essentially nonverbal with a few "rote" phrases used regardless of meaningful context. His speech was largely intelligible and he had limited language skills. Further, negative behaviors were likely to be exacerbated by decreased communicative function. Direct speech-language therapy was recommended to address AAC. There was no description of speech supports and interventions and the section titled Augmentative Communication was blank. This evaluation did not meet the standard of comprehensive and offered very limited information beyond that of the other annual evaluations submitted. Assessments for Individual #271 were requested by the monitoring team and received. The Speech/Language Evaluation submitted was dated 9/22/08 and, although two years old, was significantly more comprehensive in format and substance than any of the evaluations completed within the last two years. This assessment was completed by Terry Tobias Mathis, MS, CCC/SLP, a clinician no longer employed at SGSSLC. There was no evidence submitted that he had been evaluated subsequently by any other speech clinician, though a screening was listed in the database as completed on 8/4/09. Clearly there was no well-established, accurately tracked system to provide communication evaluation. The annual evaluations were also poorly developed and many statements used were rote, with identical phrases used in many of the evaluations submitted. For example, the following recommendation was noted in four of the eight evaluations submitted for review: "Speech therapy to continue consultation for AAC needs as indicated by his/her PST. Devices, programs and/or plans will continue to be reviewed during scheduled PNM	

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		clinics." In the case of Individual #179, it was recommended that "upon PST approval, direct speech-language therapy is indicated to address exploration, development and instruction of augmentative communication strategies." "Speech-language consultation is indicated regarding exploration, development and instruction of communication strategies" was recommended for Individual #126. Only Individual #90 and Individual #66 had different recommendations. In the case of this individual, speech therapy consultation was recommended "as indicated" and "ongoing speech-language therapy targeting development of augmentative communication strategies" was recommended for Individual #66. Upon review of the personal records of 11 individuals, additional assessment formats or types were noted. Two other individuals had also received "comprehensive" evaluations (Individual #203 and Individual #281) on 1/21/10 and 9/1/09 respectively. Individual #281's comprehensive assessment was listed as a screening in the database. Five others had received a half page Annual Review with the same headings as the more current Annual Evaluations reviewed, but none had received any supports for communication. The recommendations for these individuals was the same or very similar to those who had received interventions or supports. Individual #310 on 11/10/09 (Priority Level Code 3) and Individual #78 on 5/27/09 (Priority Level code 5) were described with only mild or no communication concerns, while the other three individuals were described with severe communication disorders and Priority Level Code 1 (Individual #181 on 3/9/10) or Priority Level Code 2 (Individual #384 on 4/22/10 and Individual #2 on 3/9/10). Other documents submitted included a Summary and Recommendations report for Individual #2, dated 4/19/10, Speech-Language Updates for Individual #146 (5/1/09) and Individual #203 (5/11/09). While the reviews appeared to be intended for those who did not require services, and evaluations were intended for those who received some level of communication supports, it was not at all clear what purpose the updates served in the process. There was significant confusion within the department as the database was not an accurate representation of the work completed by the speech clinicians. • One individual was described as using verbal communication (Individual #78) with no recommendations for communication supports because he had no noticeable articulation problems and used complex sentences. • Two individuals were described with only mild deficits, with occasional articulation problems and use of simple sentences. The clinicians, however, made generic statements: "occasional articulation problems and/or uses only simple sentences" and did not specify which concerns pertained to each. • Two other individuals were described with a severe communication disorder, yet were considered a Priority Level Code 2 (Individual #2 and Individual #384). A generic recommendation was made for each: "Speech-language pathology	

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		consultation is indicated regarding exploration, development and instruction of augmentative communication strategies" as also used in the annual evaluations described above. There was no plan for communication supports. • Two other individuals were described with severe communication deficits and "no effective means of communication." The Priority Level Code assigned to them was "1," yet each annual review included the exact same recommendations for consultation as stated above for the Individual #2 and Individual #384 with no plan outlined for communication supports. 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. None of the evaluation formats submitted varied significantly in substance and none would be considered to be comprehensive, other than the one submitted for Individual #271. There was a section in the Annual Evaluations submitted for review of interventions provided during the previous 12 months, but this typically described that a PNM Clinic review had been completed. There was no report of progress as a result of supports and no reference to a previous comprehensive assessment and a comparison with the individual's past and current status. By report, there were approximately 150 individuals who were identified as requiring some level of direct and/or indirect communication supports and, thus, received an annual evaluation, though, per the database, only 68 had received evaluations versus a screening. Further assessment was reported to be conducted for those with a change in status, though there was no example of this noted in the small sample submitted. 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. Five of the eight individuals for whom assessments were submitted were reported to have positive behavior support plans to address challenging behaviors, though these were often not described specifically in the PSPs. There was no evidence that the SLPs collaborated with psychology regarding interventions to address these concerns, though the communication assessments indicated that, for some, communication limitations often impacted negative behaviors (e.g., Individual #331 and Individual #211). The same sentence was used to describe each of these women: "Negative behaviors may be exacerbated by decreased communicative function." Additional PSPs reviewed noted individuals identified with behavior concerns, but no description of the individual's communication abilities anywhere in the PSP (Individual #26, Individual #202, and Individual #241). In some cases, verbal skills could be deduced by a reference to a statement made by the individual, but no specific descriptions of the individual's communication abilities was noted in the PSPs for Individual #237, Individual #318 and Individual #127, each of whom had significant	

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		behavioral concerns. 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. Further review of this element will be necessary in the future as none of the documentation submitted yielded sufficient information to discern this during the baseline review. Policy exists that outlines assessment schedule and staff responsibilities. The DADS policy dated 10/7/09 required review and revision of the "communication provisions of the PSP as needed, but at least annually." The Master Plan and Database were described to dictate the schedule of assessment based on need. The database submitted by SGSSLC appeared to indicate that most of the individuals on the list (276) had received either a screening or evaluation with three exceptions as follows. Individual #151's screening was listed for 3/9/11. This was presumed to be an error because no others listed projected dates for completion of the evaluation/screening. There was also no evaluation or screening listed for Individual #324, for Individual #170, and for Individual #249, who had refused to participate. Assessments were generally completed per the PSP schedule, though there were several individuals who had not received an annual evaluation or screening per the PSP submitted including Individual #390, Individual #189 and Individual #352. Findings of comprehensive assessment drive the need for further assessment in augmentative communication. The intent of the current evaluation was to include assessment for augmentative communication, though this was grossly inadequate for each of the evaluations reviewed. In some cases, an individual was scheduled for direct therapy to further assess potential for use of an AAC device (Individual #287 and Individual #66), though, as described above, this was discontinued for another individual in less than two weeks. Of the 69 individuals listed with a communication evaluation or screening, only 12 were listed with devices, another nine individual's devices had been discontinued, and one individual's was pending. Four were listed with devices being investigated for use (Individual #7, Individual #325, Individual #111, and Individual #130). Individual #111's evaluation had been completed over 10 months earlier, yet a device was still being investigated for his use. Individual #130's and Individual #325's evaluations had been completed nearly five months earlier, but a device was still being investigated for their use. Approximately 53 individuals had been provided a communication dictionary; these were submitted and were listed as such in the database. There were seven individuals with communication dictionaries listed as pending, six of whom had received communication evaluations in March 2010. Individual #198 had been evaluated in June 2009 and a communication dictionary was still "in progress." Another 12 individuals were listed in the database with a device pending without	

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		specifying what the device was. Equipment listed included: eye gaze pictures or objects (1), pocket book (1), REC.2 GO (1), communication ring (1), Small Talk Sequencer (1), communication folder (1), pocket wallet (2), and visual schedule (1). Individual #126 was listed with a hand washing sequencer, though this would not necessarily be considered a communication-based system. It was reported that, based on the priority screening tool administered, there were 55 individuals with highest needs, another 50 with moderate needs, and 150 requiring some level of communication supports and services. A Plan of Care (12/9/09) was submitted for Individual #7 in which she was to activate a button AAC device to initiate interaction with a verbal cue and/or physical prompt from caregiver as necessary. Another objective for direct intervention was that she would respond to a "7-Space" device activated by caregiver upon transition to dayroom activities. She was to receive direct intervention at a frequency of three times a week. A monthly summary dated 1/7/10 indicated that she had only participated in three sessions during the month. The device identified to be appropriate (7-Step Take and Talk) had not yet been released for use in her home. Recommendations were to continue with speech therapy intervention and "reduce frequency" to one time weekly. It was of concern that Individual #7 had not received communication supports at the frequency recommended by the clinician during the first month of implementation of a three month program and already the intervention was being reduced. With the availability of speech clinicians greatly reduced, this individual did not receive the supports as recommended nor did numerous others who were merely relegated to a generalized "consultation."	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP</u>. As stated above there was no evidence of a communication assessment in the PSP (Individual #390, Individual #189 and Individual #352). In most cases, there was little to no information regarding an individual's expressive or receptive communication abilities. In some cases, the fact that a person was verbal had to be deduced from statements within the PSP, as for Individual #202 (page 9), Individual #26 (page 3), or were unknown as in the case of Individual #241. <u>The PSP contains information regarding how the individual communicates and strategies staff may utilize to enhance communication</u>. As stated above, there were a number of cases in which the PSP did not identify an individual's communication abilities, needs, or methods for staff to use to enhance communication. The clinicians reported that there	

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		was a need for more training of QMRPs as to what should be included in the PSP. It was clear to the monitoring team that the speech clinicians also needed additional training as to what should be included in their assessments. AAC devices are portable and functional in a variety of settings. There were 12 individuals listed with some type of AAC device with another nine devices identified as discontinued and one pending. Four individuals were listed with devices being investigated for use (Individual #7, Individual #325, Individual #111, and Individual #130). While these were intended to be portable and functional, the number of individuals who had access to devices was very sparse. While it was not known to the monitoring team how many individuals were non-verbal, it was clear that there were more than these few who would likely benefit from AAC. Approximately 53 individuals had been provided a communication dictionary; these were submitted and were listed as such in the database. There were seven individuals with communication dictionaries listed as pending. AAC devices are meaningful to the individual. There were nine individuals with an AAC system that had been discontinued per the database submitted with no replacement provided or pending. It was likely that the devices lacked meaning and function to the individual and, as a result, were not successful. Staff are trained in the use of the AAC. The speech clinicians indicated that implementation was not consistent due to significant staff turnover and pulled staff who were assigned, but were not familiar with the individuals or their programming. 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. A number of devices had been discontinued and, by report, inconsistency of implementation of other devices issued was significant. General AAC devices are available in common areas. By report, there were general systems available for use in 509 and 501A, though these were not observed in use during the on-site visit.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three	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. AAC monitoring forms were submitted (11) for eight individuals completed	

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	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.	between 1/21/10 and 3/30/10. All forms were completed by Susan Holler, MS, CCC/SLP. Of these, two were identified for updates, two required repair, and, in the case of Individual #266, monitored on four occasions. The device was missing 50% of the time and then on 3/25/10, the device was discontinued by the SLP because the individual no longer wanted to use it. A large number of individuals with other devices and/or a communication dictionary were not monitored for availability, appropriateness, use, cleanliness and need for repair, revision, or staff training. The Rehabilitation Therapies Director was not aware of specific QE monitoring in the area of communication. <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 SGSSLC to ensure ongoing consistency of findings between monitors and across time.	

Recommendations:

1. Aggressively recruit and hire experienced speech clinicians to ensure all communication needs are appropriately met. One part time clinician cannot possibly meet the needs of the individuals who live at SGSSLC or the expectations as outlined in the Settlement Agreement.

2. Quickly establish an appropriate format for comprehensive assessments and interim updates. The poor quality of the documentation submitted calls into question all existing screenings and evaluations completed to date related to accuracy, appropriateness, and thoroughness. All individuals will likely require re-evaluation as soon as possible.

3. Provide continued opportunities for continuing education 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. The monitoring team recognized that DADS provided opportunities for continuing education, however, as reported throughout the baseline reviews, there was not a hands-on component to these programs.

4. Ensure that AAC provided is functional and meaningful for individuals. Many devices seem to be discontinued. As the decision-making with regard to AAC had been based on inadequate evaluations, this would not be a surprise. There needs to be many more appropriate devices available to many more individuals as soon as possible but in a manner that is thoughtful and well-planned.

5. SLPs should take an active role the day program areas. There are many lost opportunities to evaluate, model and design communication

strategies and systems that are functional in the environments that individuals are participating daily.

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

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

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

9. Increase the intensity of monitoring of AAC to ensure appropriateness of devices issued and to more quickly identify needs for revision and repair.

10. The SLPS should become more involved in the development of training objectives to enhance social engagement, language, and making requests or choices in a variety of settings and contexts, such as in the day activity programs and during meals.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** <u>Documents Reviewed:</u> o Day Habilitation Program Services (undated) o Personal Support Plans (PSPs) for: • Individual #292, Individual #114, Individual #81, Individual #231, Individual #211, Individual #232, Individual #97, Individual #389, Individual #218, Individual #184, Individual #191, Individual #17, Individual #162, Individual #48, Individual #59, Individual #219 Individual #127, Individual #334, Individual #291, Individual #2, Individual #302, Individual #34, Individual #276, Individual #259 o Individual Education Plans (IEPs) for: • Individual #292, Individual l#114, Individual #81 o Training Objectives for: • Individual #97, Individual #231, Individual #211, Individual l#389, Individual #232, Individual #78, Individual #18, Individual #1, Individual #398, Individual #153, Individual #40, Individual #251, Individual #328, Individual #59, Individual #2, Individual #317, Individual #14, Individual #67, Individual #365, Individual #265, Individual #396 o Service Objectives for: • Individual #389 o Qualified Mental Retardation Professionals (QMRP) Progress Notes for: • Individual #40, Individual #51, Individual #271, Individual #107, Individual #237, Individual #325, Individual #78, Individual #18 o PSP Quarterly Reviews for: • Individual #174, Individual #116, Individual #339, Individual #85, Individual #265, Individual #205, Individual #208, Individual #132, Individual #202, Individual #219 o Six months of Training Objectives data for: • Individual #232, Individual #389, Individual #231, Individual #97, Individual #211 o IEP progress notes for: • Individual #162, Individual #249 <u>Interviews and Meetings Held</u>: o John Church, MA, Associate Psychologist o Dana Roberts, MA, Associate Psychologist o Amanda Rodriquez, MS, Associate Psychologist o Michael Davila, QMRP Coordinator o Noel Zapata, Vocational Training Director o George Wilks, WISD special education teacher

	• Students in WISD program, Individual #162, Individual #249 <u>Observations Conducted</u>: o Observations occurred in various day programs and residences at SGSSLC. 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 educational, recreational and leisure activities, • Providing training (e.g., skill acquisition programs, vocational training), and • Implementation of behavior support plans o Workshop o Day habilitation building o Building Imaginations program building, sensory rooms o Gym o WISD school program on SGSSLC campus building #533
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: The skill acquisition programs at SGSSLC contained some of the components necessary for learning and skill development. They did not, however, contain all of these components and the training methodology was limited to training one step at a time, and using only least-to-most prompting. The skill acquisition programs at SGSSLC would benefit from expanding the training methodology, including graphing of acquisition data, and adding assessments of treatment integrity. Additionally, the selection of specific training objectives should be based on each individual's needs identified in the functional assessment or PBSP, psychiatric assessment, language and communication assessment, Personal Support Plan (PSP), or other habilitative assessments. Replacement behaviors were included in PBSPs, however, no training instructions for replacement behaviors were presented. Programs specifying the acquisition of replacement behaviors need to contain all of the components necessary for learning and skill development. The facility was involved in establishing active treatment. The actual measures of individual engagement collected by the monitoring team, however, indicated that improvement in individual engagement was needed in many settings. Although there was evidence of many community activities, no individuals were employed in the community at the time of the on-site tour. Additionally, there was no evidence that training in the

	community was developed to address individuals' needs for service or 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 Programming</u> Skill acquisition plans at SGSSLC consisted of: • Training objectives (SPOs) that were written and monitored by qualified mental retardation professionals (QMRPs). SPOs were implemented by direct care professionals (DCPs) • Medical desensitization programs written and monitored by the psychology department, and • Replacement behaviors written by the psychology department. Desensitization plans designed to teach individuals to tolerate medical and/or dental procedures had just recently begun to be developed by the psychology department and, therefore, are not included in this baseline review. The monitoring team will be reviewing desensitization plans in subsequent tours to the facility. SGSSLC included replacement behaviors in each PBSP. As discussed in K4, replacement behavior data were not collected at the time of the on-site review. Additionally, as discussed in K5, many replacement behaviors appeared to be general and unrelated to the hypothesized function of the behavior. Additionally, there were no descriptions of teaching conditions, no specific teaching instructions, and it was not clear how, or if, staff were trained to teach the replacement behaviors. It is important that replacement behaviors be functional, and their implementation documented (i.e., data collection). Further, these replacement behavior training procedures should be incorporated into the general training objective methodology, and conform to the standards of all skill acquisition programs listed below. An important component of an effective skill acquisition plan is that it is based on each individual's needs identified in the functional assessment or PBSP, psychiatric assessment, language and communication assessment, Personal Support Plan (PSP), or other habilitative assessments. In other words, for skill acquisition plans to be most	

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		useful in promoting an individual's growth, development, and independence, they should be meaningful to the individual and represent a documented need. The process for identifying specific skill acquisition plans at SGSSLC for an individual began with the completion of the personal focus worksheet (PFW) and the completion of the Positive Adaptive Living Survey (PALS). Interviews with the QMRP coordinator and PSP team members indicated that they attempted to incorporate preferences and needs in the development of each individual's SPOs. In reviewing 24 PSPs, the monitoring team noted a few SPOs that were the result of individual preference (e.g., Individual #291's "Learning to write letters" SPO), but the vast majority of SPOs appeared to be based exclusively on needs identified by the PALS. Skill acquisition plans should address needs identified in each individual's assessments. These assessments should represent more than just the PALS (e.g., psychological assessment, psychiatric 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 facility. Once developed, skill acquisition plans need to contain some minimal components to be most effective. The field of applied behavior analysis has identified several components of skill acquisition plans that are generally acknowledged to be necessary for meaningful learning and skill development. These include: • well-written behavioral objectives that define behavior and training conditions, • operational definitions of target behaviors, including a task analysis when appropriate, • specific instructions, • relevant discriminative stimuli, • detailed and clear teaching instructions (e.g., shaping, prompting, fading of prompts), • specific consequences for correct and incorrect responses (including individualized use of positive reinforcement), • a plan for generalization and maintenance of the skill once mastered, • regular monitoring of results, and • modification or discontinuation of skill acquisition plans if objectives are met or if progress has stalled. The SPOs at SGSSLC included some of these components. On the other hand, none of the SPOs reviewed included relevant discriminative stimuli or a plan for maintenance and generalization of achieved skills. Additionally, although all of the SPOs reviewed indicated that individuals should be encouraged and praised, specific consequences for	

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		correct responding were not included in the plans. The training methodology for every SPO at SGSSLC was identical. It included the training of one step of a task analysis, for example, turning on the water, for a goal of washing hands. When turning on the water was accomplished, then putting hands under the water might represent the next SPO. Additionally, all the SPOs reviewed used a least-to-most prompting procedure. That is, the training of each SPO started with the opportunity to complete the task independently, then moved to verbal prompts, then gestural prompts (e.g., gentle nudge of the arm), and finally to physical guidance, if necessary, to ensure that the individual completed the training step. Least-to-most training procedures can be very effective, however, they are not generally effective with every individual across all desired skills. In fact, several training objectives reviewed did not demonstrate clear progress. Twenty-six SPOs were reviewed across six months to access progress. Eighteen of these training objectives showed no progress or a decline in progress over this six month period. These results support the need for SGSSLC to expand its training methodology to other procedures shown to be effective in developing new behavioral repertoires. These methods include total-task chaining (i.e., the learner receives training on each step in the task analysis during every session), backward training (i.e., all the steps in the task analysis are initially completed by the trainer, except for the final behavior in the chain), and shaping. Skill acquisition plans should be reviewed regularly and plans should be modified if goals have been achieved, or due to lack of progress. QMRPs at SGSSLC summarized SPO data monthly and presented those data at quarterly meetings. The monitoring team noted several examples where SPO modifications occurred following the quarterly meetings, due to lack of progress or the achievement of goals. Nevertheless, as discussed above, several individual's SPOs had demonstrated a lack of progress, or regression, without a revision in the SPO. Additionally, the monitoring team noted examples of SPOs that were achieved, but the plans were not modified to include the next training step (e.g., Individual #232 achieved a social skills goal on 9/11/09, but continued with training on that step for three additional months). The monitoring team believes that the overall quality of skill acquisition plans at the facility would be improved if the individuals writing the plans were expanded beyond the QMRPs. As discussed above, the psychology department should write replacement and desensitization plans. Additionally, it was not apparent during the on-site tour that there were specific vocational goals. The vocational department should write vocational SPOs.	

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		Engagement in Activities: As a measure of the quality of individuals' lives at SGSSLC, special efforts were made by the monitoring team to note the nature of individual and staff interactions, and individual engagement. Engagement of individuals in the day programs and homes at the facility was measured by the monitoring team in multiple locations, and across multiple days and times of the day. Engagement was measured simply by scanning the setting and observing all individuals and staff, and then noting the number of individuals who were engaged at that moment, and the number of staff that were available to them at that time. The definition of individual engagement was very liberal and included individuals talking, interacting, watching TV, eating, and if they appeared to be listening to other people's conversations. Specific engagement information for each residence and day program is listed below. The monitoring team was encouraged to observe that during evening hours, many of the individuals at the facility were participating in one of a variety of group activities (including socializing) at the Recreation Center. Overall, the average engagement level across the facility was 60%. As can be seen in the table below, there was considerable variability across settings. An engagement level of 75% is a typical target in a facility like SGSSLC, indicating that the engagement of the individuals had room to improve. The next step is for the facility is to work on individualizing the activities scheduled, provide additional staff training, initiate data collection, and actively manage individual 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.	

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		Engagement Observations:	

Location	Engaged	Staff-to-individual ratio
511 A	4/4	2:4
511 A	1/1	0:1
511 A	2/3	2:3
511 B	1/2	1:2
511 B	0/1	0:1
511 B	1/1	2:1
Vocational workshop	13/15	5:15
Vocational Workshop	6/10	3:10
Vocational workshop	3/3	2:3
Recreational/Gym Building	3/3	2:3
516 West	1/3	0:3
516 West	1/1	1:1
516 East	1/3	2:3
516 East	1/4	2:4
516 East	0 /6	1:6
516 East	2/5	2:5
502 A	1/2	0:2
502 A	1/3	2:3
502 A	2/5	2:5
510 A	1/2	1:2
510 B	1/1	1:1
508 A	1/3	1:3
508 A	1/6	1:6
508 B	1/3	2:3
501 A	0/3	1:3
501 B	1/2	1:2
509 A	2/2	1:2
509 B	2/2	2:5
509 B	2/3	2:3
505 A	1/2	0:2
505 B	2/3	1:3
504 A	1/1	1:1

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504 B	5/6	2:6

Educational Services
Twenty-eight individuals at SGSSLC were under age 22. Thirteen of these individuals had graduated, and one who was over age 18 chose to no longer attend school. The other individuals qualified for educational services. Of these, four attended classes at the local school district, Water Valley Independent School District (WISD), and the remaining students received their education at SGSSLC under the direction of a WISD special education teacher who worked in a building designated by SGSSLC to house the WISD program. He had responsibility for overseeing the educational program. His supervisor was the principal at the WISD high school. He had been working in this program at SGSSLC for more than 10 years and appeared to have a good relationship with the students who were observed in the program on the day of observation by the monitoring team.

Six of these students had obtained enough academic credits to graduate in the month subsequent to the on-site tour. This indicated that educational services were occurring and the monitoring team was pleased to see that individuals were obtaining high school diplomas. This could only be beneficial to them as they entered adulthood.

Even so, the monitoring team had a number of concerns that are appropriate to raise in this report and are listed below.

- During the observation of the school program, two students were asleep, one on the floor in the library, and one on a couch at the building's entrance (Individual #391, Individual #114); and one student had left the program to go somewhere on campus. The school program was apparently not responsible for him any longer that day (Individual #53). These observations raised a question regarding the amount of student active participation in educational activities from day to day and over the entirety of the school year.
- The monitoring team reviewed the IEP and IEP reports for two students (Individual #162, Individual #249). There were 20 or more objectives in each IEP. The objectives sampled from a variety of relevant areas, but none were written in a format that was measureable or that gave any indication of what the student was to demonstrate to indicate mastery.
- Further, the six-week data in both IEP reports indicated an increase in performance for every objective for every reporting period (e.g., 70, 71, 72, 75, and 78 for an objective written to develop survival skills and knowledge necessary for daily living including health and safety practices). The school

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		teacher reported that these grading numbers were not based on objective assessment, but rather on more subjective and intuitive processes that were unclear to the monitoring team. The monitoring team wishes to support the positive relationship between SGSSLC and WISD, however, the quality and appropriateness of the educational services received by SGSSLC students may need to be looked at more closely. SGSSLC and DADS need to assess and determine if these students are receiving the educational services to which they are entitled by state and federal law. This issue has been brought to the attention of DADS and it is expected that more actions will be taken regarding this area across all facilities where relevant, including the facility's role in addressing issues, such as those raised above.	
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.	As discussed above in section S1, SGSSLC conducted annual assessments of preference, strengths, skills, and needs. It is suggested that the facility incorporate the results from multiple assessments and evaluations (e.g., psychological, psychiatric, language and communication, medical) to choose individual skills to be trained. Additionally, while the PSP and PFW attempted to identify preferences, no evidence of systematic preference and reinforcement assessments was found. Subsequent monitoring visits will continue to evaluate the tools used to assess individual preference, strengths, skills, needs, and barriers to community integration. The monitoring team 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 provisions F and T of this report, but also represents a source of information relevant to the choosing of skills that might be addressed for each individual using systematic instructional methodology.	
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,	As discussed in section S1, quarterly PSP reviews resulted in few data-based revisions or	

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	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	termination of SPOs. Review of six months of SPO data revealed several examples of SPOs that were successfully achieved, however, the majority of six month reviews revealed no progress (see S1). The monitoring team observed a DCP conducting a SPO for an individual in 505B. The DCP was able to articulate the SPO, the rationale for its use, the steps of the SPO, and the data collection procedure. She was not able, however, to explain what she should do if the individual didn't, or wouldn't, complete a step he already mastered. The DCP indicated that this has occurred several times in past. None of the SPO data were graphed and no direct measure of integrity of implementation of the plan was observed. The monitoring team believes that the graphing of individual skill acquisition data would aid the QMRPs in data-based decision making. Additionally, the inclusion of measures of integrity of implementation of plans would better ensure that SPOs were consistently implemented as written. Subsequent on-site visits will focus on the outcomes of SPOs, that is, whether or not the skill acquisition plans producing meaningful behavior change.	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the on-site tour, no individuals at SGSSLC worked in the community. The facility should strive to improve employment opportunities for individuals in the community. Many individuals at SGSSLC enjoyed various recreational activities in the community. It was not clear, however, if these community activities were developed to address specific individuals' needs for services or their preference. Subsequent tours to SGSSLC will further evaluate the training individuals receive in the community.	

Recommendations:

1. All replacement behaviors should be individualized, based on the results of the functional assessment, and represent behaviors that serve the same function as the undesired behavior.

2. Replacement behaviors should include specific training procedures that are incorporated into the general SPO training methodology.

3. Ensure that all SPOs are based on needs/preferences documented in assessments.

4. Ensure that all skill acquisition plans (SPOs and replacement behaviors) contain the following components for learning and skill development:
    - well-written behavioral objectives that define behavior and training conditions,
    - operational definitions of target behaviors, including a task analysis when appropriate,

- specific instructions,
- relevant discriminative stimuli,
- detailed and clear teaching instructions (e.g., shaping, prompting, fading of prompts),
- specific consequences for correct and incorrect responses (including individualized use of positive reinforcement),
- a plan for generalization and maintenance of the skill once mastered,
- regular monitoring of results, and
- modification or discontinuation of skill acquisition plans if objectives are met or if progress has stalled.

5. Extend the training methodology of the SPOs from least-to-most training procedures to other procedures demonstrated to be effective in developing new behavioral repertoires.

6. SPOs should be modified based on the effectiveness of the plans.

7. Expand the individuals that write and monitor SPOs

8. Develop a plan to address, monitor, and maintain reasonable levels of individual engagement in all settings.

9. SPO and replacement data should be graphed to aid in treatment decisions.

10. Develop a method to monitor if SPOs and replacement behavior trainings are implemented as they were written (treatment integrity).

11. Ensure that each individual is provided with training in the community that appropriately addresses his or her needs and preferences.

12. Improve community employment opportunities for individuals at SGSSLC.

13. Determine role in evaluating educational services provided by WISD.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: <u>Documents Reviewed</u>: o Texas DADS SSLC Policy: Most Integrated Setting Practices, numbered 018.1, updated 3/31/10, and six attachments (exhibits) o DADS Promoting Independence Advisory Committee reports, January 2010, April 2010 o SGSSLC Policy, Continuity of Service policy, 5/11/04, updated most recently 7/10/09 o List of all individuals at SGSSLC that indicated the individual's preference for community living (if the individual was able to do so), the primary correspondent's preference (e.g., LAR), whether or not referred, and the reason if not referred o List of only those individuals who themselves said they wanted placement in the community o Community placement referral list: a table listing each individual, referral date, status of CLDP, and move date, since 7/1/09 o Identified obstacles to individual's movement, 17 forms from 2/3/10 to 3/10/10 o PSP addendum meeting documentation for four individuals for whom their referral was rescinded • Individual #68, Individual #213, Individual #247, Individual #193 o Job descriptions for APC and PMM o List of all trainings and educational opportunities provided to individuals, families, LARS, and staff o Community tours and individuals participating: o Individuals assessed for placement, 7/1/09 through 3/25/10 o SGSSLC Community Placement Process description o SGSSLC Community Integration Assessment o Community Placement Referral Pre-Placement Packet Information Checklist o Community Referral Progress Checklist o CLOIP worksheet for: • Individual #351 o LOD meeting monitoring checklist for PSP LOD for: • Individual #351 o Community placement report, 7/1/09 through 2/29/10 o List of alleged offenders, as of 3/29/10 (juvenile and adult) o List of individuals considered to have had an alternate discharge, 7/1/09 through 3/31/10 o PSPs for: • Individual #351, Individual #284, Individual #258, Individual #364, Individual #4, Individual #218, Individual #184, Individual #191, Individual #17, Individual #162, Individual #48, Individual #231, Individual #211, Individual #232, Individual #97, Individual #389, Individual #292, Individual #114, Individual #81, Individual #222, Individual #14, Individual #107, Individual #318, Individual #396, Individual #53,

	Individual #26, Individual #236, Individual #12, Individual #241, Individual #273, Individual #148, Individual #96, Individual #243, Individual #345, Individual #390 o CLDPs for: • Individual 115, Individual #342, Individual #77, Individual #4, Individual #176, Individual #284, Individual #258, Individual #364 o Post move monitoring checklists for: • Individual #115, Individual #77, Individual #4, Individual #176, Individual #284, Individual #258, Individual #364 Interviews and Meetings Held: o Tim Welch, Admissions and Placement Coordinator o Denise Copeland, Post Move Monitor o Philip Baugh, Ph.D., Facility Director o Roy Smith, Rights Officer o Individual #172, Leader, Self-Advocacy Group o Discussions with numerous individuals during various meetings and tours of facility buildings, residences, and programs. Observations Conducted: o PSP Meeting for: • Individual #351 o Community group home visit, post-move monitoring for • Individual #115 o Many residences and day programs o Self-advocacy meeting o Home meetings: 505B, 511B
	Facility Self-Assessment: A facility self-assessment was not provided because this was a baseline review.
	Summary of Monitor's Assessment: Overall, SGSSLC was engaged in a number of activities related to the movement of individuals to most integrated settings, that is, to placements in the community. Overall, very few individuals were in the referral process, however, that number appeared to be increasing over the past few months. An assessment of obstacles and a plan to address those obstacles did not exist, or was scattered in various PSPs and documents at the facility. SGSSLC had a number of staff who were dedicated to providing most integrated setting options to individuals. The Admissions and Placement Coordinator, and Post Move Monitor had many years of experience at SGSSLC.

	Overall, the process and interactions observed between staff, family members, individuals, and non-facility providers were guided by respect for the individual. 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. Some of the discussions appeared to be brief and/or done in a rote manner, however, others appeared to be individualized and to begin to refer to optimistic visions for the individual. The CLOIP was implemented for every individual reviewed. As indicated below, it should not be considered an assessment for placement, and further work will need to be done to create an assessment for each individual. SGSSLC conducted a number of educational activities and participated in regular meetings with local MRAs. The facility also had the opportunity to add to the content of the self-advocacy groups and home meetings to include community placement, decision-making, and problem-solving as regular topics for discussion. Modifications were recommended for improvements to the post-move monitoring process, including ensuring that an on-site face-to-face visit occurs at the residence for all three of the post move monitoring periods.

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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	SGSSLC engaged in activities to encourage and assist individuals to move to the most integrated setting. These activities appeared to be consistent with the determinations of professionals that community placement was appropriate, and consistent with the individual's PSP (although see comments below regarding CLDPs and post-move monitoring). These activities were, as required, not opposed by the individual or the individual's LAR, and appeared to be made by taking into account the greater issues of state-provided services. Referral and placement activities were overseen by Tim Welch, the Admissions and Placement Coordinator (APC). He was assisted by the newly assigned post move monitor, Denise Copeland. She was in that role for about four months at the time of the on-site tour. The APC had more than 10 years of experience in admissions and placement, and the post move monitor had worked at SGSSLC in a variety of capacities for more than 25 years, including as a therapy technician and caseworker. Thus, the department lead staff had years of experience and knowledge of the SGSSLC facility, systems, and practices. Since 7/1/09, 17 individuals had moved to community placements as per the facility's	

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	accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	process. In addition, at the time of the on-site tour, 19 individuals were at different points in the process of referral and transition, with some scheduled to move over the subsequent month or so. Once a referral had occurred, the PST and the APC were required to make the placement happen within 180 days. The APC reported that in the past (i.e., a year ago or so), there were only four or five referrals at any one time. PSTs had become better at referring individuals, especially as they were learning about community providers and the potential benefits of placement for many individuals. Members of PSTs visited sites and were involved in preparations and planning for moves to the community. The APC noted that about half of the placements were local in the San Angelo area, whereas the others occurred across the state. Four referrals had been rescinded since 7/1/09. The accompanying documentation indicated a thoughtful team process regarding the decision to initially have made the referral, the decision to rescind the process, and steps and actions that would occur to keep the individuals focused on the possibility of successful transitions to the community in the future. The four individuals are listed below, along with a summary of the serious behavioral actions that led to the rescinding of the referral. • Individual #247: escalation in seriously aggressive behaviors that injured staff and other individuals, threats of suicide, and attempted unauthorized departures from the facility. • Individual #68: recent escalation in psychiatric symptoms, serious self-injurious behaviors, suicidal threats and actions, and serious aggression towards staff. • Individual #213: recent escalation in violent behavior, homicidal threats, and unauthorized departures from facility. • Individual #193: serious aggressive behavior and dangerous behaviors exhibited towards staff at a proposed provider while in the community. Many of the individuals placed at SGSSLC, approximately 60 to 70, had histories of sexual offense and/or violent behaviors. Some had been formally charged and were placed at SGSSLC through the legal system. Others had not come into contact with the courts and were placed via the state's MRA system. All of these individuals presented complicated and unique challenges and their placements required thoughtful planning, including ensuring that community providers had the capacity and experience to properly support the specialized needs of each individual. For those who were court-involved, notification of the court was required prior to placement. In two cases, the court said no to placement. Overall, SGSSLC was sensitive to the issues surrounding placement of individuals with challenging histories (but see the discussion below regarding CLDPs and post move monitoring).	

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		SGSSLC prided itself on its specialization as a provider of supports to adolescent females with these types of challenging behavioral histories. In addition, many adult females, and adult males were also being served at SGSSLC. The state had a plan to eventually transfer all court-involved (i.e., forensic) individuals to the Mexia SSLC. Given the characteristics of the population at SGSSLC, it was not surprising to find that many individuals wanted to be placed in the community. The monitoring team was presented with two documents listing individuals and their preference (if expressed) for community placement. One document listed approximately 65 individuals, the other approximately 80 individuals. The difference in number was possibly attributable to the time of the assembling of the list, that is, the list with 80 individuals appeared to be more up to date. About half of these individuals were not referred for placement due to behavioral, psychiatric, and/or legal concerns. Very few were due to preferences of the guardian or LAR (approximately five). Surprisingly, however, according to the documents submitted to the monitoring team, a number of individuals were not referred solely because a staff person from the MRA was not present at the annual meeting. If this was indeed the only reason that the referral did not occur, it should be corrected immediately and not create an obstacle for placement. This was noted for: • Individual #107 • Individual #321 • Individual #368 • Individual #389 • Individual #34 It was not clear to the monitoring team as to whether SGSSLC senior management received regular reports and updates regarding referral status of each individual (as well as all of the ongoing activities related to most integrated setting practices, including, for example, educational activities, community tours, rescinded referrals, and obstacles to placement). This should occur regularly if it is not already in place. One way to do so is to have referral information be part of the facility's quality assurance program (but as noted above in section E of this report, SGSSLC did not have a comprehensive QA program). 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.	

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		Overall, funding did not appear to be an obstacle to individual's transitions. The APC reported that there were no instances of a placement being delayed or prevented due to lack of funding. 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, 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 SGSSLC.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	The monitoring team looked to see if policies and procedures had been developed to encourage individuals to move to the most integrated settings. The state developed a policy regarding most integrated setting practices and it addressed this provision item. It was numbered 018.1 and was dated 3/31/10. This policy was updated from a previous version. The updates were relatively minor, primarily regarding methods of reporting facility information to the state central office. 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,	

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		note that part of its purpose was to bring the state into accordance with the Olmstead decision. That decision specifically referred to these considerations and, therefore, these aspects did not need to be identified specifically in the policy. The APC reported that SGSSLC had adopted the state policy and was beginning to work under the policy. The facility had its own policy regarding admissions and placement. It was called "Continuity of Service" and was dated 5/11/04, with the most recent revision dated 7/1/09. This policy included a description of facility admission and discharge processes. It also described a process for alternate discharges for individuals with violent or sexually violent histories. SGSSLC should (a) review this policy to ensure that it is not in disagreement with any of the contents of the DADS policy, (b) evaluate whether this policy, or any aspects of it, could be eliminated because of the existence of the DADS policy #018.1, and (c) obtain some type of documentation of approval of these policies from the DADS central office discipline head. The monitoring team also looked to see if the policies and procedures were being implemented consistently. SGSSLC staff were beginning to implement the DADS policy #018.1 and expected to eventually implement the policy in full. The Admissions and Placement Coordinator reported that they were part way through implementation and would continue to work towards full implementation. The Admissions and Placement Coordinator was familiar with the new policy and its components.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify,	Thirty-five PSPs were reviewed for the individuals listed in the Documents Reviewed list at the beginning of this section of the report. All of these individuals resided at SGSSLC or had recently transitioned to community placements. The sample included individuals representing different levels of referral for placement, need for extensive supports, language abilities, medical needs, and family involvement. <u>Protections, Services, and Supports</u> The PSP for each individual noted a variety of needs, required supports, and objectives for the individual while he or she lived at SGSSLC. Information regarding the PST's review, consideration, and discussion of movement to the most integrated setting was found in the Living Options Discussion Record (LODR) section of the PSP. The PSP meeting, including the living options discussion (LOD) was led by the QMRP. The post move monitor sat in on approximately 20 LODs per month, often taking notes and completing a checklist in order to monitor and provide feedback to the QMRP. The comprehensiveness of the discussion reported in the LODR varied across these 35	

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	and implement, strategies intended to overcome such obstacles.	PSPs. For example, in some cases, the report was multiple pages and included a lot of information about the individual's needs and preferences and, moreover, indicated that there was some individualized discussion about the individual (e.g., Individual #218, Individual #97, Individual #396, Individual #53, Individual #345). In other cases, the LODR was brief and included information that was perhaps taken from other reports and assessments and, overall, did not indicate that extensive, individualized discussion occurred during the LOD (e.g., Individual #12, Individual #241, Individual #236, Individual #81). All PSPs contained in the LODR some indication of what the individual would need if a community placement were to be sought. Most of the more recent (beginning in February 2010) LODRs referred to an "optimal living options vision" and included some individualized detail regarding the individual's preferences. This was also good to see and indicated that the QMRPs had likely received some training in this area. The majority of the items were related to leisure preferences and safety. These are important aspects to consider when considering the most integrated setting for an individual, however, more in depth discussion was required. 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. Successfully facilitating this type of discussion will require additional specialized training of the person responsible. At SGSSLC, each PSP meeting was facilitated by QMRPs. They had many job responsibilities in addition to facilitating this discussion. At the PSP meeting for Individual #351, the living options discussion occurred at the beginning of the meeting. The individual's parent participated via speakerphone. The LOD was animated, active, and included a great deal of participation by the individual, her parent, and many team members. Individual #351 was able to clearly articulate some of the characteristics of a setting that she wanted. For example, she stated that she wanted to live in an active group home, where there were things to do every day, not just at the house, but also in the community. She also talked about her need to have help when she was having a difficult time emotionally, or when interacting with others. Her parent was very supportive. Both talked about problems they observed when they had visited other group homes on tours. The parent even noted that, "(Individual #351) knows what she wants." There was discussion about the importance of proper medication, social skills, properly trained staff who were active and interactive, and ear infections. All in all, many important topics were discussed.	

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		Even so, there wasn't much discussion about an overall vision of the type of placement that would be best for this individual. That is, a lot of information was presented, primarily by the parent and the individual, but it wasn't incorporated into an overall vision. Also, this was a great opportunity to fully delineate a long list of essential and nonessential supports so that the individual, her parent, and her PST could use this list as they searched for an appropriate community provider. In other words, this was an example of where initiating components of the CLDP process earlier (as discussed below) would be extremely beneficial for the individual's ultimate placement. Further, a representative of the MRA was not present and, therefore, could not participate nor could an official referral occur. Unfortunately, very few PSP meetings were scheduled during the week of the on-site tour and, consequently, observations of LODs were limited. The monitoring team hopes that more PSP meeting LODs can be directly observed during the next on-site visit. At SGSSLC, the post move monitor observed many of the PSP meetings and monitored the performance of the PST regarding the living options discussion. The observation tool looked at important aspects of the living options discussion. The completed tool for the above PSP LOD was reviewed by the monitoring team and indicated that some components of the LOD were done exceptionally well, others satisfactorily, and others needed improvement. The monitoring team was not in disagreement with these ratings. SGSSLC should take advantage of these data and the system of monitoring that was already in place. The monitoring team learned that DADS was developing new policies, practices, and training regarding Integrated Protections, Services, Treatments, Supports (section F of the Settlement Agreement) and the person-directed planning process. The monitoring team looks forward to implementation of these revised practices. Deserving of mention was the transition process for Individual #364 as described in documents regarding his transition, such as his CLDP. The review by the monitoring team showed a strong consideration for the individual's preferences as well as his needs. The documents described that he had begun the process of exploring community placements more than one year ago. During the process, however, he decided that he did not want to move (the reasons were unclear). The PST then discontinued the process and re-presented it to him four months later. He was again receptive, and a successful transition was conducted. Obstacles to Movement There was no coordinated plan or approach to address obstacles to movement to the	

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		most integrated setting across the facility. The facility, however, maintained a record of the obstacles on an individual basis. Seventeen of these forms were submitted to the monitoring team. The form was in a state-provided format and included individuals whose PSP meeting occurred between 2/3/10 and 3/10/10. The forms indicated the following obstacles (some individuals had more than one obstacle noted). • Behavioral or psychiatric issues: 11 • Individual preference: 5 • LAR preference: 4 • Medical: 1 • Habilitative therapies: 1 • Pending community risk assessment: 1 • Blank form: 1 (Individual #390, however, a review of his PSP indicated that medical reasons were likely to be obstacles cited by his PST) • MRA not present: 4 (for 2 of the 4, this was the sole obstacle listed: Individual #107 and Individual #389) Many of the PSPs contained an action plan for helping the individual meet a goal of moving to the community. Typically, these action plans included the individual's participation in his or her PBSP, counseling and clinical program, and continued visiting of community providers. Keeping a focus on working towards a most integrated setting was good to see in these PSPs. Although this approach did not specifically address each obstacle, it was an interesting way to include a plan to support the individual work towards moving to a most integrated setting. If this is to be SGSSLC's approach to addressing obstacles on an individual basis, it will likely require oversight and direction from DADS' central office and SGSSLC senior management. If so, all obstacles must be addressed, the methodology must be appropriate and comprehensive, and the outcomes must be measureable and clear. 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. 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, the overall integration of services.	
	2. The Facility shall ensure the	SGSSLC was engaged in a number of activities to educate individuals and their families or	

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	provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	guardians to make informed choices. The facility had engaged in, or was planning to engage in, each of the five activities listed in the DADS policy. A document provided to the monitoring team listed training and educational opportunities for individuals, families, and LARs. Additional information provided to the monitoring team, in addition to this list, was very sparse and gave the monitoring team little detail. First, a provider fair was held in October 2009. Individuals, families, and LARs were invited to attend. No family members or LARs attended. Many individuals and staff, however, attended. The provider fair (and visits to community providers) also may educate PST members and staff members about community providers and, thereby, be helpful for future living option discussions. SGSSLC should explore the role of the provider fair for LARs and whether there are additional ways of informing LARs of community options. Further, the facility's location may have made it difficult for family members or LARs to attend this type of activity. Therefore, SGSSLC should try to inform family members and LARs about other provider fairs that might be occurring at facilities or MRAs closer to where they reside. Second, a community living options inservice occurred in 12/7/09. It was organized by the three local MRAs. They presented information about services in the community, including services that they provided as MRAs. Only four family members or LARs attended this presentation. It was unclear as to whether these attendees were from four different families. Further, it was unclear as to whether any SGSSLC staff or individuals attended this presentation. Again, SGSSLC should examine this activity and try to make it more meaningful for family members and LARs, including, for example, why family members attended this activity rather than the provider fair. Third, a Community Living Options Information Process (CLOIP) or Permanency Planning Process (for individuals under age 22) was also in place for each individual. The process was intended to provide information to individuals and LARs. The MRA contracted for the CLOIP at SGSSLC was MHMR Services for the Concho Valley. There was four or five full time MRA staff responsible for this process at SGSSLC. The MRA staff attempted to educate each individual by establishing a relationship, doing interviews, showing pictures, and working with SGSSLC to set up the visits to community providers. Letters were sent and phone calls were made to family members to discuss the process and community options. The CLOIP was to inform and educate. Fourth, the facility took individuals on visits to community providers. These tours had been occurring since September 2009 and information was presented to the monitoring team listing the number of visits each month through March 2010 and the number of individuals participating. There were three tours each month (except February in which there were six). Each tour appeared to include three to six individuals. The total was	

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		listed as 94 individuals who had gone on tours. The report also noted that there were an unduplicated number of 32 individuals. This indicated that a number of individuals had gone on more than one tour. It was good to see that some individuals were able to tour multiple locations, however, the number also indicated that very few individuals were able to participate in this activity at any level. Consequently, some type of summary data or tracking database was needed to determine if all individuals who were supposed to have these opportunities were indeed presented with these opportunities, the number of times each individual went on a visit, the goal and outcome of the visit for each individual, and whether the visit was in line with the information in the living options discussion section of the PSP. Fifth, a living options discussion was required to occur and this, as noted above in this report, was occurring at every annual PSP, however, more work was needed to have these discussions be more comprehensive and meaningful. Finally, although not solely related to education about community placements and providers, SGSSLC had an active self-advocacy group and each home had an active weekly home meeting. The activities of the self-advocacy group, and the content of the home meetings, can play a large role in educating members of the group, as well as the greater population of individuals at SGSSLC, about community living options. If the SGSSLC self-advocacy group and home managers are to include this topic, the groups will need guidance and direction from the facility's rights officer and residential senior managers in order to be successful. In summary, SGSSLC 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 the DADS policy on most integrated setting practices, section III, paragraphs 1-7. LARs and PST members must be knowledgeable and assured that the community has the resources to support individuals in the individualized ways they require. Safety, medical care, independence, and socialization are of the most importance to most family members and LARs. The APC reported that the community providers were working hard and that they had a good working relationship with SGSSLC. Most placements were into HCS group homes. Fortunately, few individuals had failed in the community requiring a return to the facility over the past 10 years, and none had occurred in the recent past (i.e., over the past year). He noted that there were no major issues in placements. This was the case even though providers had not become "specialized" in dealing with the types of issues presented by SGSSLC referrals. He noted that one helpful aspect appeared to be that individuals could come back to SGSSLC campus for day programming. This was occurring for about a dozen individuals who attended on campus sessions for two to	

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		three hours, two to three times per week.	
	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 SGSSLC assessed an individual for placement. There did not seem to be a simple description of how SGSSLC assessed an individual for placement. The Admissions and Placement Coordinator stated that the process was handled by residential services during the LOD and was done at PSP meeting. There was no tool used at SGSSLC for this purpose. A document titled "Individuals assessed for placement" listed all of the individuals at the facility, the date of the discussion, the type of meeting (e.g., annual), the individual's preference if given, the correspondent's (e.g., family member, LAR) preference if given, and whether or not the individual was referred by the PST for placement. This was a listing of status, but not an assessment for placement. SGSSLC's policy on continuity of service described the process once a referral was made, but not how an individual was to be assessed for placement. Another SGSSLC document titled "Community placement process" had a section labeled "Living options staffing with individual/LAR and designated MRA" that had two subsections to it. One referred to actions that were to happen during the LOD, such as determining the most appropriate living environment, supports and services that needed to be in place for a successful transition, barriers to movement and plan to overcome the barriers, geographic location, and type of community placement (e.g., HCS, ICFMR, foster care). The second subsection noted that the PST should review the most current PSP, the current PBSP, all existing restrictive practices, and the ICAP results to ensure that the assessment was not only current, but also representative of the medical and behavioral supports of the individual served. Then, the document continued on to describe forms and meetings. There was another related document. It was titled "Community Integration Assessment." It listed preferences, strengths, needs, and barriers to community living, community employment, and community leisure. It included a section to record the supports needed to overcome these barriers, and a place to describe optimal integrated community living, employment, and leisure activities. Although the monitoring team was given this blank form, no examples of completed versions were submitted for review, so it remained unclear as to whether this form was in use at SGSSLC. The activities presented in these documents were certainly related to assessing an individual for placement, however, they did not appear tied into an overall assessment process or to be implemented consistently across all individuals. Therefore, the facility	

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		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 in this report, some aspects of this process existed at SGSSLC, such as some of the components of the PSP process, the living options discussion, and parts of the CLDP. The Monitors have raised this topic with the parties and expect there to be resolution in the near future. 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. Nevertheless, as noted above, the monitoring team expects the referral process and all of the activities related to this section of the Settlement Agreement to continue to develop.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:		
	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 DADS policy on most integrated setting practices #018.1 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. At SGSSLC, the CLDP was developed after a provider was chosen and a specific home was identified. This was typically only two to three weeks prior to the individual's move. Although activities had occurred prior to the CLDP meeting (e.g., referral, home visits,	

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		exchange of information), some of the CLDP topics might be better addressed, or at least initiated, much earlier to allow team members more time to participate and plan, especially, in regards to the development of lists of essential and nonessential supports. The CLDP activities were coordinated and managed by the APC. He gathered documents, put together a draft CLDP, and organized and ran the meeting. The monitoring team was not able to observe a CLDP meeting because none of the members were scheduled for the week of this on-site tour. The monitoring team requests that the facility work with the monitoring team to schedule a CLDP meeting at a time during the early part of the week of the next on-site tour. Recently, the CLDP was revised to include updates of assessments, completed by discipline department heads or therapists. Full assessments, records, and reports were still included in the overall referral packet (as indicated on SGSSLC's Community Placement Referral Pre-Placement Packet Information Checklist), but the CLDP document itself now only included updates. This was an improvement over the previous system that often included lengthy and somewhat outdated information that was not helpful to the CLDP process. Eight CLDPs were reviewed for the individuals listed under the "Documents Reviewed" list at the beginning of this section of the report. This included the most recently completed CLDPs.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	The CLDPs included indication that the APC and facility director had responsibility and had agreed to the contents of the CLDP. Each CLDP also referred to a specific date for moving to the new placement and that staff would have the individual ready at that time. The CLDP essential and non-essential supports page listed specific actions that were required, but did not indicate whether any facility staff were responsible in any way. It did include the provider staff responsible and it did include timelines.	
	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 were found for all of the eight CLDPs. Signatures indicated that guardians or LARs (when any existed or were appointed) were informed of the CLDP and participated in the process. Signatures of individuals were on each of the CLDPs, too, indicating their participation.	

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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 DADS policy #018.1, current comprehensive assessments were provided to the receiving agency or provider as per report of the Admissions and Placement Coordinator. The documents for three of the individuals were reviewed in detail. Although numerous assessments were included, it was not possible for the monitoring team to determine if these assessments represented the full set of assessments relevant for the individual. The APC reported that he knew which assessments were required and that discharge summaries were also required for all disciplines (this was a new requirement). That is, even if an assessment had been done within the past year, an updated summary was required, too. The APC was knowledgeable about the documents and assessments required. He maintained a checklist.	
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.	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. The MRA was responsible for ensuring that all essential supports were in place prior to the day of the individual's move. This responsibility was to soon become the facility's. This is likely to be more beneficial for the individual and for the transition process because of the facility's extensive knowledge about the individual, and because the facility will continue to be responsible for the post move monitoring of these supports. Each of the eight CLDPs had a 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 pages were completed similarly, but not identical, across all CLDPs. Some of the supports were the same in every CLDP (e.g., 24 hour staff) and some referred to bureaucratic processes (e.g., site review by MRA, trust fund money forwarded). There was some individualization in these lists of supports. For example, for Individual #342, the list included that she maintain a daily organizer, keep a checklist for lengthy tasks, be prepared by staff for schedule changes, and have help with communication exchanges. These were taken directly from the recommendations of the SGSSLC rehabilitation therapy department. Lists for other individuals included location of an	

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		Alcoholics Anonymous group, having a specialized wheelchair available, and spending time with family. Nevertheless, SGSSLC should take steps to ensure that the list of essential and nonessential supports is comprehensive, clear, and complete. This is especially important because the essential and nonessential supports section of the CLDP provides the facility with its one chance to ensure that certain aspects of support will be provided to the individual. If an important support is left out this listing, the facility has no way of following up on it and requiring the provider to put the support in place. Therefore, this component of the CLDP is very critical to the ongoing success of each individual's placement. This will require a thorough reading of all assessments and assessment updates in addition to the current procedure of developing the list from CLDP meeting participants' discussion during the CLDP meeting. For instance, the monitoring team noted some items that should have been included in the CLDPs review. Some of these are listed below. • Adapted spoon • Ground food texture • Skill training programs • Use of token reinforcers • Treatment of GERD, seizures, and lactose intolerance • Crisis intervention • Employment opportunities • Finishing high school, obtaining diploma Moreover, many supports were written in a way that made them difficult, if not impossible, to measure or observe. As a consequence, the ability of the post move monitor to objectively determine their presence or absence became similarly difficult and certainly unreliable (also see section T2a of this report). Some examples are listed below. • Active in life in the community • Staff support to abstain from substance abuse • Access to a counselor • Staff trained on CLDP • Have assistance with financial matters • Suitable transportation • Structure and consistency in daily life Improvements to this portion of the CLDP process might include a more detailed listing of essential and non-essential supports during the living options discussion at the PSP meeting for those individuals who have been, or are likely to be, referred for placement.	

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		The CLDP process must be modified at SGSSLC to: • ensure that all needs identified in the individual's current assessment are indicated as essential or non-essential supports. • define each of these essential and non-essential supports in more detail, and • specify the support in a manner that can be measured or verified.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	There was no quality assurance process in place at SGSSLC regarding this section T of the Settlement Agreement. Even so, the APC reported that he implemented a monitoring tool regarding the placement process that was titled "Community Referral Progress Checklist." It included the steps of the referral process. In addition, as noted above, the post move monitor recorded and maintained some data regarding the LOD at each PSP. Data were not submitted to the monitoring team for these two tools, so the results and breadth of implementation could not be reviewed. These data were obtained and kept by the admissions and placement department and not used elsewhere in the facility. These recording systems and data would likely be very useful to the QA department as it develops a comprehensive plan for the facility as well as a plan to address this provision item of the Settlement Agreement.	
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	SGSSLC was not gathering and analyzing information related to identified obstacles to individuals' movement to more integrated settings. Please see the discussion in section T1b1 above. SGSSLC did not have a facility-wide needs assessment related to the provision of community services to people with developmental disabilities and obstacles to such placements. As indicated in this provision item T1g, a comprehensive assessment of obstacles is required, rather than solely a listing of obstacles for individuals. There was no indication that DADS had taken any appropriate steps to overcome or reduce these identified obstacles.	

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	their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this	SGSSLC presented a document called, "Community Placement Report, 7/1/09 through 2/29/10." It listed individuals who had been transferred to community settings (13 individuals). It also listed 16 individuals who were in the referral process.	

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	paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	SGSSLC had recently initiated the post-move monitoring process, including the recent appointment of the post-move monitor. The post-move monitor was knowledgeable about many of the individuals, the local providers, and the CLOIP process. The facility did not maintain a schedule of post move monitoring visits. Completed post move monitoring checklists were reviewed for the individuals listed under Documents Reviewed in the Steps Taken section at the beginning of the report on this provision T. Overall, the reports indicated that essential and nonessential supports were in place or there was a plan for them to be put in place. All post move monitoring was done within the required timelines. There were no individuals placed from other SSLCs within SGSSLC's catchment area who required post move monitoring by SGSSLC. Only two issues were noted in the post monitoring move checklists that were of concern to the monitoring team. • Individual #176: At her 90-day review, the report noted that she was hospitalized for three weeks for behavioral and psychiatric reasons. The post move monitoring report, however, doesn't indicate any detail about what led up to the hospitalization, whether it was due to any errors in support or services by the community provider, and whether any follow up was going to occur by the post move monitor or SGSSLC. • Individual #4: His 7-day review indicated that the essential support of staff training regarding his behavioral needs was not in place. This was an essential support and the individual should not have moved if it was not in place. All post move monitoring was done on-site (i.e., not via telephone) and included a face-to-face observation of the individual. The practice at SGSSLC was to do at least one post move monitoring visit at the residence, and at least one at the day program. This was problematic because it allowed for the first home observation to not occur until the third post move monitoring visit (i.e., the monitor might not see the home until 90 days after the move). SGSSLC should change this practice and include a home visit for all three post move monitoring visits even if this requires a visit to both the day and residential sites during the same post move monitoring visit.	

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		The post move monitor should have the opportunity to network with other post move monitors and with DADS central office to ensure support, exchange of ideas and best practices, and problem solving. Completed post-move monitoring forms were reviewed for each of the individuals listed above in the "Documents Reviewed" list at the beginning of this section of the report. Overall, the completed forms listed the essential and non-essential supports directly from the CLDP (but as noted above, some important supports were never included on the list). An additional problem with the post-move monitoring process requires mention. That is, the manner in which the post-move monitor should determine the presence or absence of each essential and non-essential support needed to be specified. For example, the presence of the support was often determined based upon staff or individual report rather than on any type of documentation (e.g., 24 hour staff). For another example, transportation may have been considered present if a van was at the home rather than a determination as to whether the individual had access to activities that required transportation, or whether the van was available for individualized activities. The CLDP should be modified to include the type of evidence so that the post-move monitor knows how to assess its presence or absence.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	The monitoring team had the opportunity to accompany the post-move monitor on a visit to the home of an individual, Individual #115, who had moved to the community within the previous two weeks. The 7-day had already been completed, therefore, this was not an official post move monitoring visit. The monitoring team thanks the post-move monitor and the community agency for making arrangements for this visit to occur and for talking with the monitoring team about the individual's transition. The purpose of this visit was to learn about the post-move monitoring process, see the community home, meet the individual, learn about transition and services, and see the status of some of the essential and non-essential supports. This individual's transition and placement demonstrated an example of individualization and respect for his preferences. The individual lived at SGSSLC for many years, but had no instances of serious behavior problems in more than 10 years. He fully participated in the transition process, including visiting more than one provider, and visiting at least two different homes that the chosen provider offered to him. He chose this older home, even though the other home offered was brand new. The new provider adapted the home's staffing schedules so that he could keep his afternoon and evening job in the community (which he'd had for some time while still residing at SGSSLC) as well as attend a day	

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		workshop. He preferred to work at the workshop even though the new provider told him that he could stay home during the morning hours before going to his afternoon and evening job. Moreover, two of the provider's staff knew the individual for many years because they had worked at SGSSLC. He talked about wanting more opportunities for transportation into town and the provider staff told me that this was available to him. In general, he was getting used to having new and different freedoms in this new setting. The monitoring team wishes him well in his new home. The monitoring team looks forward to an improvement in the post-move monitoring process during the next on-site tour (e.g., improved lists of supports, specification of supports, specification of the manner in which the post-move monitor is to determine the presence or absence of a support).	
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.	A number of alleged offenders resided at SGSSLC; 26 male, 9 female. At the time of the on-site review, this provision item did not apply to any of these individuals.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state;	Four names were presented in a list titled, "Alternate discharges 7/1/09 through 3/31/10." Three were noted as "discharge with reassignment, and one was noted as "24-Waiver Own Home/Family home."	

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	(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 on most integrated setting practices.

2. Ensure facility policies are in line with state policies, and obtain documentation from state office regarding the approval of state policies that add to, or supplement, state policies.

3. Ensure that senior management at SGSSLC is regularly informed of the status of referrals, move dates, CLDPs, rescinded referrals, and other actions of the APC and the admissions and placement department.

4. Review and modify how the living options discussion occurs at the PSP meeting regarding the optimistic vision for the individual's placement in the community.

5. Address the identified obstacles to individuals' movement
    a. within the PSP meeting for each individual
    b. across the facility by conducting an assessment and by developing action steps from DADS.
    c. review and revise what is considered an obstacle (e.g., MRA attendance at meetings did not appear to be an obstacles, but was listed as such).

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

7. Improve the way important essential and non-essential supports are included in the CLDP:
    a. Consider ways to begin developing the list of supports prior to the CLDP meeting (which typically occurs only two to three weeks prior to the move to the community).
    b. Ensure all important supports are directly taken from professional assessments and recommendations, discussions at relevant PST meetings, and the individual's records.
        i. define each support in observable and measureable terms.
        ii. define the manner in which the presence of each support will be verified.
    c. Ensure all professional disciplines are included in the transition and placement process, including, but not limited to, physicians and psychiatrists.
    d. Add a component to the CLDP process to ensure that the above recommendations (a-c) occur, such as through actions of the QA department or senior management.

8. Develop a quality assurance process.

9. Utilize the data collected by the APC and the post move monitor regarding CLDP and transition process and regarding the living options discussion of the PSP meetings.

10. Continue to work on education of individuals and LARs regarding most integrated setting practices.
    a. Ensure that all individuals have the opportunity to go on tours unless there is a specific reason why this should not occur.
    b. Track the individuals who go on specific tours to ensure that the tour is an appropriate one given the needs of each individual.
    c. Examine effect of the provider fair and MRA community living presentation on LAR involvement in the referral process.

11. In the self-advocacy meetings, include discussion regarding choices, decision-making, and problem solving related to, at a minimum, rights and community placement. Consider doing the same, or similar, at home meetings.

12. Include an on-site visit to the residence for all three post move monitoring visits. Therefore, some post move monitoring visits will require a visit to both the residence and the day program.

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: <u>Documents Reviewed</u>: o Draft DADS Policy: Consent-Guardianship #019, dated 1/15/10 o SGSSLC Policy: Informed Consent: Explanation, Education, and Due Process 5/10/02 Priority Listing for Adults without guardians o Rights Assessment for Individuals #230, #222, and #21 o DADS 2009 "Your Rights in a State Supported Living Center" Booklet o PSPs listed in Section F of this report <u>Interviews and Meetings Held</u>: o Interview with Roy Smith, Rights Officer o Interview with James Reid, Residential Plan of Improvement Coordinator o Annual PST meetings for Individual #146 <u>Observations Conducted</u>: 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 policy addressing guardianship was developed in January of 2010 and was in draft format at the time of this on-site tour. The facility planned to adopt the state policy that addressed assessing each individual for the need for guardianship and referring individuals for guardianship. The facility had begun developing a list of individuals in need of a guardian. There were only eight individuals identified on the list as Priority I for guardianship. There were 10 identified as Priority II and 13 as Priority III. PSTs at the facility determined the need for guardianship and made referrals to the Guardianship Coordinator.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and	The state had developed a draft policy entitled "Consent and Guardianship" (Policy #019 dated 1/15/10) to address this provision of the Settlement Agreement. SGSSLC planned to adopt this policy without revision. The state policy mandated that the facility appoint a Guardianship Coordinator to maintain and update, semiannually, a list and	

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	update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	prioritization of individuals who lack both a functional capacity to render a decision regarding the individual's health or welfare, and an LAR to render such a decision. The facility was in the initial stages of meeting this provision. At the annual PST meeting for Individual #146, there was discussion regarding the need for guardianship. The individual did not have a LAR in attendance at the meeting. The team agreed that the individual was unable to make an informed decision and, therefore, she at least needed an advocate. It was agreed that the team would request an advocate for her. Individual #345's PSP stated that she had a diagnosis of severe mental retardation and no known family/correspondent. The team agreed that she should be a Priority I for guardian. Individual #243's PSP stated that she "does not need a guardian at this time. However, when she is ready to move to the community, PST agreed to make a referral for a guardian at that time." It was not clear why she would need a guardian if living in the community, but not one if living at the facility. If the team determines that an individual cannot give informed consent and does not have a guardian or advocate, they should be considered Priority I regardless of where they currently reside. The facility should continue to develop a list of individuals who need LARs and begin pursuing guardianship for those individuals according to assigned priority.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities	The state policy addressed efforts that should be made to obtain LARs for individuals when the PST has determined there is a need for a LAR. There was little evidence that the facility was actively pursuing guardianship for those identified as needing a guardian. For example, Individual #389's PST indicated that a referral had been made to the Guardianship Coordinator on 2/11/09. At the time of the monitoring visit, he still did not have a guardian, LAR, or advocate. This provision will be further reviewed during upcoming monitoring visits as the facility develops a system for pursuing LARs for individuals determined to need them.	

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	seeking to advance the rights of persons with disabilities.		

Recommendations:

1. Continue identifying individuals in need of an LAR and prioritize the individuals based on ability of each individual to make informed choices regarding their health and welfare.
2. Develop a list of LAR providers in the area.
3. Provide information to primary correspondents/families of individuals in need of an LAR regarding local resources and the process of becoming a LAR.
4. 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.

<table>
<tr><th>SECTION V: Recordkeeping and General Plan Implementation</th><th></th></tr>
<tr><td rowspan="3"></td><td>Steps Taken to Assess Compliance:

<u>Documents Reviewed</u>:
o Texas DADS SSLC Policy: Recordkeeping Practices, #020.1, dated 3/5/10
o SGSSLC document, Home clerk duties, prepared by Marsha Jones
o SGSSLC document, Duties for Personnel at SGSSLC client records department
o SGSSLC document, Master file order for SGSSLC records
o SGSSLC visitors pass information sheets
o CEU listing from American Health Information Management Association for Director of Client Records
o Active records of various individuals on the residences or pulled for review by the monitoring team.

<u>Interviews and Meetings Held</u>:
o Juanita Brake, Director of Client Records
o Marsha Jones, Unified Records Coordinator

<u>Observations Conducted</u>:
o Records storage rooms</td></tr>
<tr><td>Facility Self-Assessment:

A facility self-assessment was not provided because this was a baseline review.</td></tr>
<tr><td>Summary of Monitor’s Assessment:

SGSSLC 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 Director of Client Records and the Unified Records Coordinator were both very experienced at SGSSLC, as well as with SGSSLC operations, and the record keeping functions of the facility.

The monitoring team looks forward to SGSSLC’s implementation of the new record keeping policy and practices.</td></tr>
</table>

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	DADS had developed a policy on recordkeeping called Recordkeeping Practices. It was numbered 020.1 and was dated 3/5/10. It was slightly updated from a previous version in order to more thoroughly define each of the components of the unified record for each individual. SGSSLC had some of its own documents as noted above in the listing of Documents Reviewed. If the facility management decides to maintain an additional policy or procedures, they should ensure that the contents are in line with the DADS policy and, further, approval from DADS central office should be obtained. The monitoring team looked to see if SGSSLC 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, SGSSLC had not implemented and addressed 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. The facility, as noted above, had taken some steps to prepare for meeting this provision. First, they recently assigned a unified record coordinator who will have responsibility for overseeing the new systems, including conducting the review of records as required in section V.3. She will report directly to the Director of Quality Enhancement. The unified records coordinator had attended a statewide training in Austin in March 2010 and learned about the new records systems and ways to provide support to facility staff by making the records as user-friendly as possible. SGSSLC was fortunate to have an experienced staff as its unified records coordinator who had experience as a records clerk on one of the SGSSLC units. Moreover, the Director of Client Records had 28 years of experience at SGSSLC and was also a Registered Health Information Technician. She also served as the facility's HIPAA coordinator. The facility was very fortunate to have two experienced and knowledgeable professionals in these roles. In addition to the Unified Records Coordinator, the department had two other staff. Both provided clerical support, maintained master records, and helped with home record maintenance activities. One of the two was also the facility's guardianship coordinator. She kept a record of important guardianship-related dates and whether there had been any lapses. She sent out referral packets and profiles to community providers as per PST instructions. The other staff member tracked and filed population reports, thinned records, and arranged for long term storage of documents. There were nine home clerks (i.e., one for each building). The home clerks worked for the unit directors, not for the records department. This arrangement appeared to be working fine at SGSSLC. The home clerks' duties included every day filing, thinning	

#	Provision	Assessment of Status	Compliance
		records, sending records in for long term filing, and doing other clerical tasks, such as printing out and distributing monthly instructional procedure data sheets and diet management sheets. The home clerks were to create the new records once trained by the Unified Records Coordinator. The Director of Client Records maintained a master record for each individual, including all individuals who had ever resided at SGSSLC, back to 1969. The Director also received annual plans and physicals. She was responsible for coding them into the state's electronic database system. Storage areas were fairly well organized and the department was managing the daily influx of documents that needed to be filed or stored. Efficiency will always be important for a recordkeeping department. One process, however, appeared to be overly cumbersome. It had to do with the recording of visitors and visitor passes and required what seemed to be duplicative information. An alternative method should be explored so that valuable time of the record department staff is not wasted. As SGSSLC implements the new policy, individual notebooks will be created. 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	A quality assurance and quality enhancement procedure to ensure a unified record was not in place. SGSSLC's quality enhancement department should be involved in addressing this provision item.	

#	Provision	Assessment of Status	Compliance
	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.		
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	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.	

Recommendations:

1. Implement the new policy, including, but not limited to:
    - creating records following the new record guidelines order (table of contents),
    - developing and implementing quality assurance and quality enhancement process, and
    - ensuring records are used in making care, medical treatment, and training decisions.
2. Modify facility policy and procedures to be in line with state policy. Obtain approval for facility policy from DADS central office.
3. Incorporate record keeping quality enhancement activities into the facility's overall QE plan.
4. Review and consider the comments made above regarding aspects of the proposed new record keeping practices at SGSSLC, including, but not limited to, safeguards for the possible loss of the contents of an individual notebook.
5. Address the cumbersome system of managing visitor logs and passes.

Health Care Guidelines

* Below, additional information is provided regarding some of the health care guidelines.

SECTION I: Documentation		
		Steps Taken to Assess Compliance: Record Reviews for: Individual #214, Individual #215, Individual #69, Individual #59, Individual #127, Individual #301, Individual #346, Individual #102, Individual #25, Individual #78, Individual #385, Individual #281, Individual #247, Individual #94, Individual #146, Individual #222, Individual #122, Individual #124, Individual #203, Individual #112, Individual #137, Individual #40, and Individual #60
		Summary of Monitor's Assessment: The Integrated Progress Notes were segregated into Medical and Program sections, therefore, the records were not total integrated. Nursing staff failed to consistently document in the SOAP format. Nursing signatures and titles were not always legible. Documentation of acute illnesses and injuries assessments and interventions were not consistently documented through to resolution.
#	Item Summary	Assessment
I1f	Documentation: consultations (2 items)	Consultations were consistently listed on the Annual and Quarterly Nursing Assessment. The outcome of the consultations were not consistently summarized.
I1g	Hospitalizations, transfers, readmits (8 items)	Review of Serious Incident Reports indicated that individuals were assessed before and after emergency room visits and hospital admissions.
I1h	Annual plan of care (4 items)	Refer to Section M 4
I2a	Nursing documentation consistent with standards	The Nursing staff failed to consistently document in the SOAP format as required by the HCG. Heading to record did not always contain individuals' identification information.
I2b	Nursing entries are legible etc.	Nursing signature and titles were not always legible.
I2c	Nursing entries fully completed	Nursing entries were fragmented. Information regarding assessments, treatments, was not consistently documented through to resolution.
I2d	Follow up documentation from integrated prog. Notes	Same as above.
I2e	Nursing documentation of IDT communication	The Integrated Progress Notes seldom revealed communication with other disciplines. The Infection Control Nurse and Hospital Liaison did not document in the Integrated Progress Notes.
I2f	Late entry notes only acceptable if labeled	Late entries were noted as such. Late entries were rarely found in the records reviewed.
I2g	Integrated prog. Notes in SOAP or DAP format	The Nursing staff failed to consistently document in the SOAP format as required by the HCG.
I2h	All nursing actions promptly documented	Assessments of acute illnesses and injuries in the records reviewed appeared to be documented promptly. Plan of intervention and follow up could not always be discerned.
I2l	Documentation of completion of treatment	Reviews of the ACPs were not consistently signed as resolved.
I2m	Nursing review quarterly and ann. Contents (4 items)	Refer to Section 2 and 3

I2n	Skin integrity assessments and responses	Review of skin assessments and responses were consistently documented and followed through to resolution. Individuals with skin integrity issues were consistently referred to the Skin Integrity Committee and followed by the committee through to resolution.

Recommendations:

1. The state and facilities need to evaluate the Record Keeping System in order to ensure integration of progress notes are in alignment with the SA and HCG.
2. The facility's Nursing Department needs to ensure that nurses document using the SOAP format.
3. The facility's Nursing Department needs to ensure that nursing staff sign their signatures and initials legibly.
4. The facility's Nursing Department needs to ensure that nursing staff assessments of acute illnesses and injuries and interventions are documented through to resolution according to standards of professional practice and in alignment with HCG.

SECTION II: Seizure Management		
		Steps Taken to Assess Compliance: Records Reviewed: Individual #385, Individual#203, and Individual #222 Documentation of seizure management for the six months prior to the on-site tour for Individual #164, Individual #203, Individual #249, Individual #383, Individual #385, Individual #390
		Summary of Monitor's Assessment: The individuals reviewed had Seizure HMPs that met standards of professional practice. The inefficient conveyance of information to the psychiatry staff regarding the outcome of neurology consults was the sole significant problem noted. The nursing assessments and interventions were appropriate to meet the individuals' needs. The nursing staff occasionally failed to respond and assess individuals' seizure activity. The initial sections of the Seizure Records were not consistently completed by the staff observing the seizure activity. Cumulative Seizure Records were not kept up to date. Outdated Seizure Records, POR-MR-18 were still being used and were inadequate for documenting comprehensive assessments and interventions in the management of seizure activity. Individual #222 had not had a seizure since 2000.
#	Item Summary	Assessment
II1a	Documentation of seizure freq., dur., characteristics	Records were kept regarding frequency, duration, and characteristics for all individuals reviewed. For individual #164, for example, descriptions included staring, lipsmacking, rigidity, twitching of the arms, eyelids and legs, and postictal drowsiness.
II1b	Evaluation of initial or change in seizure pattern	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.
II1c	Neurologist is involved	The neurologist, Dr. Chris Vanderzant, was easily accessible at the Shannon Clinic. The medical director indicated that he was available between clinic visits for telephone consultation as needed.
II1d	See neurologist at least 1x year if poorly controlled	The records reviewed indicated that these individuals were generally seen more often than annually. For Individual #203, for example, Dr. Vanderzant saw her on 6/5/09, 10/30/09, and 1/22/10, with a plan for follow up two months thereafter.
II1e	See neurologist at 1x every 2 years if controlled	This appeared to be occurring, but was based on a small sample reviewed.
II1f	PCP and pharmacist evaluate medical regimen	All medication changes recommended by the neurologist were reviewed by the PCP the day the individual was seen in the neurology clinic. As mentioned in section N above, however, there was suboptimal communication of this with the psychiatrist.
II1g	Monotherapy is preferred mode of treatment	The PCPs, when interviewed, 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 appeared to be consistent in the records reviewed.
II1i	Consideration of other treatments if not controlled	This also appeared to be occurring. In individual #385's record, for example, Dr. Vanderzant's consultation on 2/12/10 recommended, "He is still having a lot of brief blank spells that I suspect are small seizures. I think we will have to see if we can equilibrate his situation on a combination of Lamictal and Depakote."
II2a	Prompt intervention when seizure occurs	Review of individual #385's seizure records, 7/9/09 through 5/5/10, revealed that the individual had 94 episodes of seizures where the DCPs documented the time, duration, and description of the seizure activity.

		The nursing staff assessed, monitored, and documented 87 of the 94 seizure episodes. The promptness of response to care could not be discerned from the retrospective record review. Review of individual #203's seizure records, 6/23/09 through 1/20/10, revealed that the individual had 33 episodes of seizures where the DCPs documented the time, duration, and description of the seizure activity. The nursing staff assessed, monitored, and documented 27of the 33 seizure episodes. The promptness of response to care could not be discerned from the retrospective record review. The staff observing and completing the initial sections for the Seizure Form did not consistently sign their name or consistently complete the line indicating the name of the nurse and time notified. Frequently, a discontinued Seizure Form – POR-MR-18 that did not include check boxes for rhythmic movements, recover period, vital sign, including O_2Sats, nursing assessment/action assessments, and medication given/time was used. The facility's Nursing Department needs to re-train the DCPs in completing the revised Seizure Form, N-21a.
II2b	Nursing interventions are individualized (7 items)	Review of Individual #385's and Individual #203's seizure records indicated that the nurses assessed the individual and provided the support necessary to keep the individuals safe from harm, however, nurses did not respond to every seizure episode. The facility's Nursing Department need to ensure that Nurse Case Managers train the DCP in their seizure HMP responsibilities and the DCP Supervisors sign the HMP verifying that DCPs were trained.
II2c	Individual able to resume normal activities	The nurses' documentation contained in individual #385's seizure record indicated that the individual was able to recover and resume normal activities in all but one seizure episode where he fell. The nurse notified the physician. Individual #203 was occasional drowsy for a short period after the seizure activity. After sleeping he was reported as returning to normal activities.
II2d	RN informed of all seizures directly or indirectly	Review of individual #385's seizure records indicated that the nurses responded, completed, and documented a full assessment in all but seven of the 94 seizure episodes. Review of individual #203's seizure records indicated that the nurses responded, completed, and documented a full assessment in all but six of the 33 seizure episodes.
II2e	RN assessment for seizures that are atypical, etc.	According to Individual #385's seizure records, he experienced a series of clustered seizures while anticonvulsant medications were being adjusted. On 1/22/10, the neurologist began increased valproic acid. Unbeknownst to the neurologist, the facility physicians had increased the Lamictal. Consequently, he developed Lamictal toxicity due to the drug-to-drug interaction. Once this was discovered, his medication was adjusted and seizure activity returned to a normal pattern of seizures of less than 5 to 15 seconds. Individual #385 sustained falls without serious injury during the time his medication was being readjusted. Most of the seizure activity assessments were completed by LVNs. According to the HCG, RNs are to complete the seizure assessments, however, the facility nursing staff is comprised of both RNs and LVNs. The Nursing Department needs to evaluate their ability to consistently have RNs available to complete seizure assessments. The facility's Nursing Department needs to ensure that nurses respond when notified by DCPs of individuals' seizure activity and follow protocol for assessing and managing seizure activity. The facility's pharmacist needs to consistently check medication for drug-to-drug interaction, particularly new medication and/or when dosages are adjusted. Individual #203 did not experience any atypical seizure activity during the reporting period.
II2f	Nursing assessment for seizure mgmt (4 items)	According to Individual #385's and Individual #203's seizure records for which nurses responded, individuals were assessed, monitored, and findings documented for: vital signs, including O_2Sats, and

		physical and behavioral status.
II2g	Nursing care plan contents	Individual #385's and Individual #203's seizure HMPs were completed according to professional standards of practice, except for maintaining the Cumulative Seizure Record. The Cumulative Seizure Record for Individual #203 was not properly documented; the last seizure episode in the documents reviewed occurred on 5/5/10, the last entry for seizure activity entered in the Cumulative Seizure record was dated March 2010. Cumulative Seizures Records were requested, but not received for individual #203. Cumulative Seizure records are vital for the physical and neurology consultant to evaluate in making clinical decisions regarding seizure management. The facility's Nursing Department needs to ensure that Cumulative Seizure Records are kept current.
II2h	RN ensures staff is trained	Individual's #385's seizure HMP did not contain the date and signature of the DCP Supervisor verifying that the DCP had received training on the HMP. The Nursing Department needs to evaluate their ability to consistently have RN available to complete seizure assessments.

Recommendations:

1. All prescribing physicians should consult each other about any planned changes in the medication regimen of individuals, in advance of making any change.
2. The facility's Nursing Department needs to re-train the DCPs in completing the revised Seizure Form, N-21a. The outdated Seizure Record, POR-MR-18 needs to be removed from supply.
3. The facility's Nursing Department needs to ensure that Nurse Case Managers train the DCP in their seizure HMP responsibilities and the DCP Supervisors sign the HMP verifying that DCPs were trained.
4. The facility's Nursing Department needs to ensure that nurses respond when notified by DCPs of individuals' seizure activity and follow protocol for assessing and managing seizure activity.
5. The facility's pharmacist needs to consistently check medication for drug-to-drug interaction, particularly new medication and/or when dosages are adjusted.
6. The facility's Nursing Department needs to ensure that Cumulative Seizure Records are kept current.
7. The Nursing Department needs to evaluate their ability to consistently have RN available to complete seizure assessments.

SECTION III: Psychotropics/Positive Behavior Support		
		Steps Taken to Assess Compliance:
III1a	Initial psychiatric eval contents (7 items)	As described in section J, Dr. Sikes completed initial evaluations for all new admissions. He indicated that if anyone else were to do psychiatric admissions, the same template would be used. The Initial Comprehensive Psychiatric Evaluation template met the standards described in the Health Care Guidelines, and those that the monitoring team reviewed were completed thoughtfully and thoroughly. For example, there was a completed Initial Comprehensive Psychiatric Evaluation in the record for Individual #381. It included identifying information, chief complaint and behavioral concerns, developmental history, past psychiatric history, telephone interview with guardian, previous psychological testing, family and social history, medical history, allergies, substance abuse history, metabolic and lab data, legal history, current psychoactive medication, non-psychiatric medication, mental status exam, adverse effects assessment, five axis diagnosis, bio-psychosocial spiritual formulation, and comprehensive plan.
III1b	General monitoring documentation (3 items)	Rationale for the psychotropic medication plan was documented in the "90 day combined assessment and case formulation." Until it's introduction, such rationale was documented in the "90 day review of psychoactive medication." In the case of Individual #250, for example, on 2/3/10 the psychiatrist wrote, "Individual #250 is on two medications. Attempts to reduce each one individually have resulted in more symptomatic behavior and aggression." All individuals on psychotropic medications were seen at least quarterly, and psychotropic medications were reviewed and updated at that time. Evidence of adverse effects was consistently documented on the 90 day review in all records reviewed.
III1c	Monitoring for anti-epileptics used for psych	There was a section for metabolic and lab data on the 90 day review; the records reviewed by the monitoring team did not include an individual who was taking an antiepileptic used as a psychotropic medication. This will be reviewed at the next on-site visit.
III1d	Monitoring for lithium	In the case of Individual #68, in the context of recently having refused a number of doses, then having returned to full compliance, there was evidence of appropriate monitoring. The 90 day review note stated, "Lithium 0.79 on 11/27/09 and 1.07 on 12/7/09." There was also an example of monitoring that was not fully in line with the Health Care guidelines. In the case of Individual #132, for example, who was on Lithium, the 90 day review on 2/11/10 noted "Lithium 0.64 on 7/24/09 two weeks after the last dose increase." There was no reference to when the next level would be drawn, despite more than six months having passed since the last level.
III1g	Monitoring for antipsychotics (6 items)	There was compliance with the healthcare guidelines in the records reviewed. In the case of Individual #21, for example, who was taking Zyprexa, the 90 day review dated 5/11/10 had a grid that tracked weight and blood pressure every month, glucose and lipid profile every 6 months, and an EKG annually.
Recommendations: There are no further recommendations beyond those in the above sections of this report.		

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACLS	Advance Cardiac Life Support
ACP	Acute Care Plan
ADA	Americans with Disabilities Act
ADSO	Additional Duty Service Operation
ADR	Adverse Drug Reaction
AED	Automatic External Defibrillator
AIMS	Abnormal Involuntary Movement Scale
AN	Abuse, Neglect
AP	Alleged Perpetrator
APC	Admissions and Placement Coordinator
APN	Advance Practice Nurse
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctorate
BID	Bis In Die (Twice a Day)
BMI	Body Mass Index
BSN	Bachelors of Science, Nursing
C. difficile	Clostridum difficile
CAP	Corrective Action Plan
CCC	Clinical Certificate of Competency
CDC	Centers for Disease Control
CEU	Continuing Education Unit
CIT	Crisis Intervention Team
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardio Pulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CTD	Competency Training and Development
CV	Curriculum Vitae
CVA	Cerebral Vascular Accident
DADS	Texas Department of Aging and Disability Services
DBT	Dialectical Behavior Therapy

DCP	Direct Care Professional
DDS	Doctor of Dental Surgery
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
DUR	Drug Utilization Review
e.g.	exempli gratia (For Example)
EMPACT	Empower, Motivate, Praise, Acknowledge, Congratulate, Thank
EMR	Electronic Medical Record
ER	Emergency Room
FAOTA	Fellow, American Occupational Therapy Association
FAST	Functional Analysis Screening Tool
FTE	Full Time Equivalent
FY	Fiscal Year
G-tube	Gastrostomy Tube
GERD	Gastroesophageal reflux disease
GI	Gastrointestinal
GM	Grams
HCG	Health Care Guidelines
HCS	Home and Community-based Services
HDL	High Density Lipoprotein
HMP	Health Maintenance Plan
HPV	Human Papillomavirus
HRC	Human Rights Committee
HST	Health Status Team
ICD	International Classification of Diseases
ICFMR	Intermediate Care Facility/Mental Retardation
IDT	Interdisciplinary Team
i.e.	id est (In Other Words)
IEP	Individual Education Plan
IOA	Inter Observer Agreement
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LD	Licensed Dietitian
LOD	Living Options Discussion
LODR	Living Options Discussion Record
LRA	Labor Relations Alternatives
LVN	Licensed Vocational Nurse
MA	Master of Arts
MAR	Medication Administration Record
MAS	Motivation Assessment Scale

MBA	Masters, Business Administration
MBS	Modified Barium Swallow
mEq	Milliequivalent
MD	Medical Doctor
MG	Milligrams
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-Resistant Staphyloccus aureus
MS	Master of Science
MSN	Masters in Science, Nursing
NANDA	North American Nursing Diagnosis Association
NMC	Nutritional Management Committee
NMT	Nutritional Management Team
NP	Nurse Practitioner
NPO	Nil Per Os (nothing by mouth)
O_2Sat	Oxygen Saturation
OIG	Office of Inspector General
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
OTRL	Occupational Therapist, Registered, Licensed
P&T	Pharmacy and Therapeutics
PALS	Positive Adaptive Living Survey
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PDP	Person Directed Planning
PEG	Percutaneous Endoscopic Gastrostomy
PET	Performance Evaluation Team
PFW	Personal Focus Worksheet
Ph.D.	Doctor, Philosophy
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMM	Post Move Monitor
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)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team

PT	Physical Therapy
PUSH	Pressure Ulcer Scale for Healing
QA	Quality Assurance
QABF	Questions About Behavioral Function
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
Rev.	Revised
RNC	Registered Nurse, Certified
RN	Registered Nurse
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self Administration of Medication
SGA	Small for Gestational Age
SGSSLC	San Angelo State Support Living Center
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/analysis, Plan
SPCI	Safety Plan for Crisis Intervention
SPO	Structured Program Objective
SPO2	Saturation of Peripheral Oxygen
SSLC	State Supported Living Center
STACS	Specialized Treatment and Consultative Services
STEPP	Specialized Teaching and Education for People with Paraphilias
TIMA	Texas Implementation of Medication Algorithms
UA	Urinalysis
UI	Unusual Incident
UTI	Urinary Tract Infection
WISD	Water Valley Independent School District