United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
July 26-30, 2010

Date of Report: August 29, 2010
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Introduction

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

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three Monitors responsible for monitoring the Facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the Facilities assigned to him/her every six months, and detailing his/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, were considered baseline reviews. Compliance reviews begun in July, 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Brenham State Supported Living Center

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in 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 a section of the report for which another team member had primary responsibility. For this review of Brenham SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Scott Umbreit reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Michael Sherer reviewed psychiatric care and services; Rod Curtis reviewed medical care and pharmacy services; Dwan Allen reviewed nursing care, dental services, and safe medication practices; Douglas McDonald reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; James Bailey reviewed minimum common elements of physical and nutritional supports, as well as physical and occupational therapy, and communication supports; Rebecca Wright reviewed serving individuals in the most integrated setting and consent; and Michael Davis reviewed record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

The Monitor's role is to assess and report on the State and the Facilities' progress regarding compliance with provisions of the Settlement Agreement. Part of the Monitor's role is to make recommendations that the Monitoring Team believes might help the Facilities achieve

compliance. It is important to understand that the Monitor's recommendations are suggestions, not requirements. The State and Facilities are free to respond in any way they choose to the recommendations, and to use other methods to achieve compliance with the SA.

II. **Methodology -** In order to assess the Facility's status with regard to compliance with the Settlement Agreement and Health Care Guidelines, the Monitoring Team undertook a number of activities, including:

(a) **Onsite review** – During the week of July 26-30, 2010, the Monitoring Team visited Brenham SSLC. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

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

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Positive Behavior Support Plans (PBSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

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

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) **Facility's Self-Assessment:** No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. The Facility provided a Plan of Improvement, which served as the Facility Self-Assessment. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof;
(c) **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;
(d) **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 Health Care Guidelines (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;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") will be stated for reviews beginning in July, 2010; 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. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the 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, Individual #45, Individual #101, etc.). 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

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Brenham State Supported Living Center for their welcoming and open approach to this visit. It was clear that the State's leadership staff and attorneys as well as the

management team at BSSLC had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. Moreover, the facility made a number of staff members available to the monitoring team in order to facilitate the many activities of the monitoring team, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations. This was much appreciated and made possible an efficient and accurate review.

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 numerous 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 did each day to support the individuals at BSSLC. Many positive interactions occurred between staff and monitoring team members during the weeklong onsite tour. All monitoring team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist BSSLC in meeting the many requirements of the Settlement Agreement.

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at BSSLC:

Abuse, Neglect and Incident Management

- BSSLC has a good process for the review of all injuries, including discovered injuries. Documentation is generally complete and the multiple layers of review observed during this review were noteworthy,
- The number of injuries, serious injuries, and allegations of abuse, neglect, and exploitation have all reduced.

Quality Assurance

- Since the baseline visit, BSSLC has implemented additional monitoring tools and developed a more organized and systematic approach to their use. There is a substantial amount of evidence that these monitoring tools are in regular use and that at least in some instances data is aggregated, analyzed, and presented to the Performance Improvement Council (PIC). The PIC appears to have been designated as the group to facilitate interdisciplinary discussion of QA data.
- Additional program auditors have been added to the QA department and the QA nurse is now part of the QA department.. Program auditors are assigned to specific provisions of the SA.

Integrated Clinical Services

- Processes to promote integrated clinical services have begun. The collaboration among disciplines was evident in the structure of the PTR.

Psychiatric Care and Services

- The Facility had already modified and improved the template used by professional staff as they prepared for and then documented the results of PTR meetings. The staff psychiatrist had joined meetings of the BSRC committee and began to attend neurology clinic appointments for individuals jointly supported by herself and the neurologist. These steps helped to integrate psychiatric, psychological and neurological care.

Psychological Services

- BSSLC successfully recruited for and filled the position of Chief Psychologist. She will sit for the BCBA exam later this year.

Medical Care

- BSSLC has made significant improvements in their emergency response system. Mock Medical Emergency Drills were conducted quarterly according to procedure.

Nursing Care

- Progress was being made by the adoption of the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses for the development of chronic and acute care plans.
- Progress has been made with regard to completing the Braden Scale for skin integrity assessments as part of the Annual and Quarterly Nursing Assessment.
- Improvements were beginning to increase collaboration between the RN, PCP and interdisciplinary team.
- Coverage across campus on the 10-6 shift has improved; there was at least one RN available on campus each night in addition to the other staff nurses.

Pharmacy Services and Safe Medication Practices

- The Center has made significant strides to ensure a quality review of medication related issues. A Clinical Pharmacist has been hired by the center to enhance outcomes.

Dental Services

- BSSLC has begun developing and implementing desensitization plans since the baseline visit.

Physical and Nutritional Supports

- BSSLC has improved their overall monitoring system for physical and nutritional management through the development of a database that will assist in the ability to assess the acquired data and establish trends for future training and interventions.
- BSSLC has improved their overall monitoring system through the development of a database that will assist in the ability to assess the acquired data and establish trends for future training and interventions. BSSLC has also consolidated their bathing, and mealtime /snacks forms into a single comprehensive tool. This consolidation should assist in streamlining the monitoring process.

Habilitation, Training, Education, and Skill Acquisition Programs

- BSSLC had conducted an audit of skill acquisition programs and assessments, training had been provided on the PSP and PSPA process, and workgroups were continuing the review of assessment procedures.

Most Integrated Setting

- There was also a better process for ensuring the required 45-day comprehensive assessment documents were obtained and reflected in the CLDP documentation.

Recordkeeping and General Plan Implementation

- Conversion to the new record system is in process.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at BSSLC:

Restraints

- The frequency of use of restraint at BSSLC has increased significantly when comparing the six month period July, 2009 through December, 2009, with the six month period January, 2010, through June, 2010. This 63% increase received little or no discussion in either the Restraint Reduction Committee (RRC) meeting minutes or the Performance Improvement Council (PIC) meeting minutes. The majority of restraints are due to a few individuals and teams need to meet and develop better plans; however, there is no indication in the April or May minutes that there was any follow up to this concern.

- The use of pretreatment sedation for medical procedures, particularly dental, is of concern.
- The tracking of the use of medical restraints has only recently begun.

Abuse, Neglect and Incident Management

- The BSSLC policies that govern this section of the Settlement Agreement (SA) are in draft form and appear to be substantially the same as the DADS policies with little content that makes the policy specific to Brenham.
- There were several instances of what appeared to be late reporting from data entered on Unusual Incident Reports (UIRs). This is of concern because it potentially exposes individuals to an alleged perpetrator longer than necessary or allowed by policy. It also has the possibility of contaminating evidence particularly in the area of witness collaboration. There was nothing discovered in the documentation or QA tools that identified this problem although the monitoring team was informed the QA department will soon be initiating a process to sample UIRs to check for accuracy of information and completeness.
- The monitoring team is concerned with bedrail use and safety. A document request was made for a list of injuries where a bedrail may have been a cause or contributing factor. This data could not be produced except for a few anecdotal references by unit administrative staff.

Quality Assurance

- There is little evidence of any medical review process or QA activity that is called for in sections J and L of the Settlement Agreement.
- BSSLC is awaiting additional technical support from DADS in developing an organized approach to a QA plan. The Facility lacks a QA policy and is using the DADS QA policy and a BSSLC draft policy to guide its operations at this time. There is not yet in place a process for corrective action planning as called for in the Settlement Agreement.

Integrated Protections, Services, Treatments and Supports

- Although the structure of an interdisciplinary team is in place at BSSLC, most involvement is multidisciplinary, and decisions about treatment are made in a number of different forums. There was little detected that would indicate change since the baseline review.

Integrated Clinical Services

- The lack of objective and reliable data also meant that even though many interdisciplinary meetings took place, meaningful integration of information from the key disciplines was not possible. This was true across most opportunities for planning, including PSP and PSP addendum meetings.

Minimum Common Elements of Clinical Care

- There was a great deal of variability across disciplines and areas of support needed as to whether assessments were performed regularly at an acceptable frequency, whether assessments were triggered by changes in an individual's status, and whether assessments included all necessary components.
- There were numerous examples in which changes in an individual's health status did not trigger timely and effective change in treatments and interventions.

At-Risk Individuals

- The system for identifying individuals who are at risk and why, and to plan, implement, and monitor measures to put in place to reduce risk for these individuals, is rudimentary. This item was difficult to assess due to the way individuals are assessed for risk. State policy identifies people whose risk is being managed effectively as medium risk, even if significant resources are needed on a consistent basis; even so, many of these people are rated as low risk.

Psychiatric Care and Services

- Clinicians often did not designate the particular psychiatric symptoms or behavioral characteristics that were the targets of medication treatments. There was no formal collection of psychiatric data, with which to track an individual's response to medications.
- In the area of dental pre-treatment sedation, informal procedures were described for the monitoring team, but these procedures were not formalized.

- Several evaluations that had been mandated by the SA, such as the use of the REISS Screen, and the mandated format for psychiatric evaluations, had either been postponed or were only partially in place.

Psychological services
- Data collection continues to lack demonstrable reliability and validity. It is also unclear that existing data are used to make data-based treatment decisions.
- Intellectual assessments are not completed at BSSLC and adaptive assessments are not consistently completed on an annual basis.
- Some improvement has been made in functional assessment, but these efforts were preliminary at the time of the site visit.
- For the majority of individuals participating in counseling or psychotherapy, the treatment plans did not reflect an evidence-based approach to treatment and lacked clear, objective and measurable goals.

Medical Care
- There is a lack of appropriate qualitative and quantitative documentation in all areas reviewed for health care compliance. Throughout the monitoring team's on and off site review, documentation was either lacking, or inadequate to assess compliance.
- The lack of integration of clinical practice into the team process is significant, and limits delivery of quality health care.
- Follow-up to resolution of clinical issues and incorporation of new medical conditions are not routinely observed by review of the clinical record.

Nursing Care
- Medication administration observations documented problems with privacy, infection control, and delivery. The improper administration of medications without the MARs present to perform the required three medication checks during medication administration could lead to medication errors.
- The Infection Control Program needs continued improvement. The Nursing Department needs to develop and implement a formal procedure for reporting infections to the Infection Control Nurse.
- The Quality Assurance Nurse was developing a computerized program and using data generated from the Medication Error Report forms to perform a "root cause analysis". Once this system becomes operational the quality of the trend analysis should provide more comprehensive information to apply toward developing and implementing corrective action plans.

Pharmacy Services and Safe Medication Practices
- Each QDRR reviewed demonstrated completeness based on the centers drug review "tool" that is used to facilitate Pharmacy reviews. Each review was completed within expected time frames, laboratory diagnostics were appropriately assessed, side effects allergies were noted, and recommendations were documented for the prescribing physicians review. However, the Quarterly Medication Review Worksheet which is used to complete each QDRR review is limiting and does not enable a comprehensive review, if strictly adhered to.
- Recommendations to the physicians were noted to be present on each QDRR reviewed; however, when potentially serious issues, such as when commenting on toxic drug levels, assertive action was not evident, by review of the QDRR form.
- Other than the quarterly review, there is no apparent tracking mechanism, for the pharmacist, to ensure that critical drug monitoring is completed when necessary, or when laboratory data is returned abnormal. In the context of the quarterly review, the process for review of laboratory data is functional, and considered adequate; however, because there is no meaningful method for the pharmacist to track important laboratory data, outside of the quarterly review, the process does not meet the needs of individuals served.
- In all cases reviewed, MOSES assessments and when appropriate DISCUS assessments were noted within the clinical record. It was noted, however, that a substantial number of DISCUS and MOSES assessment forms were not appropriately completed by the prescribing physician. Additional assessments for medication side effects, other than routine MOSES and DISCUS assessments, were not noted when clinically indicated.

Physical and Nutritional Management

- A combination of the Health Status Team (HST) and Nutritional Management Team (NMT) is considered to function as the PNM team at BSSLC. While this team has all the needed members, there is still not a single team that focuses on PNM issues. There is still not a policy that speaks to the need to have a single cohesive team or meeting that reviews all aspects of physical and nutritional management.
- Nutritional assessments are not being provided at a frequency that is sufficient to meet the individuals' needs.
- Supports regarding the areas of oral care and medication administration are missing from the assessment process and are not included in the PNMP.
- PNMPs are not regularly reviewed in the occurrence of a change in status and are not comprehensive due to the plans lacking information regarding oral care and medication administration.
- PNMPs are not developed with clear input from the PST.
- There was not evidence that staff or the individual were being monitored in all aspects in which the individual was determined to be at increased risk. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoringIndividuals were routinely being provided with enteral nutrition while positioned in bean bags and recliners. Recliners and beanbags are soft in nature **and are not mad**e to adequately support an individual over an extended period of time. Providing nutrition while using these supports resulted in a poor ability to maintain appropriate positioning.

Physical and Occupational Therapy

- Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
- Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans.
- A system does not exist that ensures staff responsible for positioning and transferring high risk individuals, receive training on positioning plans prior to working with the individuals.

Dental Services

- Dental services were documented on numerous records. The duplication of dental services' documentation on numerous forms and/or records has the potential to provide fragmented information and has the potential to interfere with of continuity of care.
- Annual dental examinations were recorded in the dental progress notes and did not represent a comprehensive dental examination. Individuals' annual examinations need to be as comprehensive as the initial dental examination.

Communication

- The Communication Assessment did not consistently address expansion of current abilities and development of new skills.
- AAC devices are not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs.
- BSSLC was monitoring the presence and working condition of the AAC device s but was not monitoring whether or not the device was effective and or meaningful to the individual. BSSLC has hired an AAC consultant to assist them in developing new system wide AAC strategies and to assist in expanding the knowledge base of their clinicians relevant to augmentative communication.

Habilitation, Training, Education, and Skill Acquisition Programs

- Assessments are not adequate to guide provision of effective and meaningful training opportunities that promote the development of personal adaptive skills,.
- Training programs did not include task analyses or methodologies that would be expected to be effective.

Most Integrated Setting

- The Facility continues to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting and development of individualized strategies for education about community living options to promote informed choice.

- Very significant health and safety issues, that could put an individual moving to the community at increased risk, were not adequately identified in the 45-day assessment nor in the resulting CLDP.
- Although the PMM Checklists reviewed were being completed in a timely manner in general, the process used to complete them was not thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. The PMM visits observed during the compliance visit did not adequately confirm the presence of these supports.

Consent

- While the Facility does maintain a prioritized and updated list of individuals needing an LAR, there is no standard approach to assessing and determining the actual need for an LAR on an individualized basis.
- The Facility reported no activity or planning to solicit guardians for those determined to be in need. It is, however, appropriate that the Facility has not undertaken a large-scale effort to solicit guardians until it can be assured that its processes for assessing the actual need for guardianship are individualized and completed in a manner in accordance with commonly accepted professional standards of practice.

Recordkeeping and General Plan Implementation

- Current records do not meet all requirements of Appendix D. Records in the new format that were reviewed met requirements of Appendix D, but the names of documents did not always match the Table of Contents.
- Quality assurance reviews of unified records have been suspended due to the rollout of the revised format. Records Coordinators have been added; they will monitor and provide training. They currently are providing training as part of the rollout.
- Examples of inaccurate Active Records were found. Data documenting that individuals met goals did not result in using these data to prompt a change in goals.

V. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td>Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.</td><td>Steps Taken to Assess Compliance:
Documents Reviewed:
1. BSSLC Draft Restraint Policy (no date) provided on 7/26/10
2. Log of all restraint use from 1/1/10 to date
3. Sample of Restraint Records: Individual #11 (7/14/10 and 3/16/10), Individual #61 (6/23/10 and 5/25/10), Individual #399 (6/20/10), Individual #493 (6/13/10), Individual #173 (5/29/10, 5/17/10, 4/6/10, 3/3/10, 2/19/10, 2/15/10, 2/4/10, 1/28/10, and 1/21/10), Individual #467 (5/6/10), Individual #62 (4/23/10), Individual #3 (4/14/10 and 6/18/10), Individual # 380, Individual #494, Individual #438, and Individual #9 (2/8/10).
4. Restraint Checklist for Medical Restraints for Individual #494 (6/17/10), Individual #438 (6/23/10), and Individual #380 (6/18/10)
5. Sample of Restraint Quality Assurance (QA) Monitoring Checklists (20)
6. Minutes of Restraint Reduction Committee (3/4/10, 4/22/10, and 5/27/10)
7. Restraint Checklist form as modified 6/3/10
8. Log of restraint related injuries, both to individuals and to employees
9. PSP's and related documents for Individuals #3, #31, #52, #61, #70, #122, #139, #173, # 181, #377, #390, #399, #400, #417, and #598.
10. BSSLC Trend Report 6/30/10
1. BSSLC Plan of Improvement (POI), dated 5/17/10
11. BSSLC Supplemental POI, not dated

People Interviewed:
1. Debra Kollman, Assistant Director of Programs
2. J. Bret Hood, M.D., Medical Director
3. Kim Littleton, QA Director
4. Susie Johnson, Settlement Agreement Coordinator
5. Terry Hancock, PhD, Chief Psychologist
6. Caitlin Connor, Program Compliance Auditor
7. Shawn Cureton,M.S. Psychology Manager
8. Kathleen Williamson, M.Ed., Psychologist Manager

Meetings Attended/Observations:
1. Facility-wide Interdisciplinary meeting held 7/27/10 regarding dental processes, especially pre-treatment sedation practices
2. Facility Incident Management Team 7/26/10 and 7/29/10
3. Program Improvement Council 7/26/10</td></tr>
</table>

	4. PSP Meeting for Individuals #390 and 181 5. PSPA Meetings for Individuals #4, #31, #52 and #61
	Facility Self-Assessment: The Facility stated it was in compliance with provisions of this Section involving monitoring and assessment of individuals in restraint and review of restraints to determine whether changes in PSPs should be made. Documentation reviewed by the monitoring team did not support the accuracy of these ratings. For other provisions, the Facility reported that some requirements but not all were in compliance. The monitoring team findings were congruent with some reports, such as the prohibition of prone restraint. The monitoring team findings were not congruent with other reports, such as level of supervision, for which the monitoring team found documentation did not support substantial compliance.
	Summary of Monitor's Assessment: The frequency of use of restraint at BSSLC has increased significantly when comparing the six month period July, 2009 through December 2009 (average of 8.8 non-medical restraints per month) with the six month period January 2010 through June 2010 (average of 14.3 non-medical restraints per month). This 63% increase received little or no discussion in either the Restraint Reduction Committee (RRC) meeting minutes or the Performance Improvement Council (PIC) meeting minutes. The minutes of the RRC March 4, 2010 make note that the majority of restraints are due to a few individuals and teams need to meet and develop better plans; however, there is no indication in the April or May minutes that there was any follow up to this concern. The monitoring team identified three individuals who account for 62% of the restraints, with one individual accounting for 38% of the restraints. Improvement in the documentation of restraint use (Restraint Checklist, Face-to-Face Assessment, and Debriefing) was evident but it is apparent additional training, auditing, and oversight is needed. The use of pretreatment sedation for medical procedures, particularly dental, is of concern and is addressed in the medical care (L), dental care (Q), and nursing care (M) sections of this report. The use of mechanical devices such as belts (such as seat belts and abdominal belts), helmets, and mittens are not sufficiently scrutinized to determine if their use in a particular situation would be considered a restraint in the context of the definition of mechanical restraint in the SA. For example, a seat belt used to keep someone from standing up from a wheelchair to prevent falling would, in most cases, be considered a restraint, whereas a seatbelt used to maintain a stabilized position for dining ordinarily would not. The tracking of the use of medical restraints has only recently begun. Finally, in the six month period of January, 2010 through June, 2010 three individuals had two or more restraint-related injuries d with one having six injuries. While the monitoring team acknowledges the efforts undertaken by the Psychology Department since the

	baseline visit, including the addition of Board Certified Behavior Analysts, it is apparent a great deal of work lies ahead to improve services that result in less frequent use of restraint. These needed improvements are discussed in detail in the Psychiatric Care (J), Psychological Care (K), and Habilitation, Training, Education, and Skill Acquisition (S) sections of this report. The BSSLC Plan of Improvement (POI) asserts substantial compliance with four provisions of the Settlement Agreement, specifically provisions C2, C5, C6, and C8. The monitoring team is not able to validate compliance with these provisions in part because of the absence of approved policy guiding facility operations. In addition there are specific compliance related issues in each provision noted in this report.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	There was no evidence of the use of prone restraints and such use is clearly prohibited in policy and in training curriculum. There are the following two areas of concern: • A restraint checklist (Individual #11 restraint episode on 7/14/10) included a checkmark in the "method of restraint other" noting "back". The psychology manager, who conducted the post restraint debriefing, indicated that in the process of using a horizontal side-lying hold the individual's combativeness resulted in the individual wiggling and moving towards a supine position, which like a prone position is prohibited by policy. Staff immediately released the individual once it was evident that he was going to be successful in being on his back. The staff person acknowledged knowing that supine restraint was prohibited and included this notation as a precaution. There was no information in the face-to-face assessment or the debriefing that explained these circumstances, or in any way acknowledged the use of the term "back" on the restraint checklist, and what it meant. • A restraint face-to-face assessment (Individual #173 restraint episode on 5/17/10) includes confusing language and entries. Item 2.2 states "Not face down or face up physical restraint? Not face down mechanical restraint?" No is checked. No probably means the person was not face down however, if yes was checked it could mean the person was not face down. In other words there is not an entry to indicate the person was face down. A similarly confusing question is in item 3.4 which states "Not for punishment or convenience of staff?" BSSLC reported 90 instances of the use of non medical restraint since January 1, 2010. A sample of 18(20%) restraint records was reviewed. The most recent episodes of restraint were reviewed first in the belief that as time goes on correct completion of restraint documentation would be expected to improve. For the most part documentation was	N

#	Provision	Assessment of Status	Compliance
		complete; however, every record reviewed contained at least some unclear or apparently inaccurate information. For example, Individual #61 for a restraint episode on 6/23/10 has the level of supervision marked as routine when 1:1 is required by policy. There is no indication on the restraint checklist of a mental status check for Individual #399 for a restraint episode on 6/20/10. There is no information in the post-restraint assessment section of a restraint episode for Individual #493 on 6/13/10 denoting whether or not an injury resulted from the restraint. The BSSLC policy governing restraints is undergoing revision and is in draft form. It is unclear whether previously approved policy, or the current draft under review, is to be considered the operative policy. From comments made by BSSLC administrative staff it appears elements of the previously approved policy and elements of the draft under review both guide facility operations. Because of this the monitoring team could not assess BSSLC operations as being compliant with BSSLC policy because of the uncertainty of what elements of what policy were expected to be complied with. The BSSLC Plan of Improvement (POI) asserts substantial compliance with four provisions of the Settlement Agreement, specifically provisions C2, C5, C6, and C8. The monitoring team is not able to validate compliance with these provisions in part because of the absence of approved policy guiding facility operations. In addition there are specific compliance related issues in each provision noted in this report. DADS issued a new restraint checklist (dated June 3, 2010) which slightly reorganized some of the data entries to improve information flow. It also changed some of the Event Codes and Action/Release Codes. Nine event codes were reduced to five. Fourteen Action/Release Codes were increased to seventeen. None of the restraint records reviewed had yet used this new checklist and the monitoring team did not inquire about a specific implementation date at BSSLC or any training that might go along with implementation. This will be probed at the next compliance review. Of significant concern are the elements of this provision requiring restraint use in a clinically justifiable manner and not in the absence of or as an alternative to treatment. Because of the deficits in behavior and other programming described in sections J, K, and S the BSSLC cannot assure restraint is always used in a clinically justifiable manner. The monitoring team is concerned that the use of mechanical devices such as belts, helmets, and mittens are not sufficiently scrutinized to determine if their use in a particular situation would be considered a restraint in the context of the definition of mechanical restraint in the SA. From observation, record review, and interview these types of devices are routinely not classified as restraints.	

#	Provision	Assessment of Status	Compliance
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	BSSLC reported 90 instances of the use of non-medical restraint since January 1, 2010. A sample of 18(20%) restraint records was reviewed to validate the POI report of substantial compliance with provision C2. The most recent episodes of restraint were reviewed first in the belief that as time goes on correct completion of restraint documentation would be expected to improve. Four of the first six records reviewed contained documentation problems. For example, Individual #399 was restrained on 6/20/10. The restraint code for release is J, indicating the individual met the safety plan criteria for calm; however, a safety plan was not provided leaving the impression she did not have a safety plan. Individual #173 was restrained on 5/29/10. There are no event codes or action/release codes entered on the restraint checklist.	N
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The BSSLC policy governing restraints is undergoing revision and is in draft form. It is unclear whether previously approved policy, the current draft under review, or a hybrid of the two, is to be considered the operative policy. From comments made by BSSLC administrative staff it appears elements of the previously approved policy and elements of the draft under review both guide facility operations. Because of this the monitoring team could not accurately assess BSSLC operations as being compliant with BSSLC policy. It should be noted from the baseline review, and information gathered during this review, most elements of this section of the SA seem to be in place but are not always documented correctly (refer to C2) which may reflect on staff training needs. Additionally, the level of monitoring of restraint documentation at the supervisory level is apparently not catching errors, or if catching errors there is little documentation that forms are corrected so records are accurate. Through interview the psychology manager indicated that when significant errors are discovered a duplicate form (e.g. restraint checklist) will be completed and both are maintained in the record. The monitoring team did not discover any examples of this in the sample of 18. It should be noted that a review of restraint record monitoring done by the Quality Enhancement Department identified many errors in documentation. There was not any indication as to what happens with this information. In response to a document request it was indicated that a system for Corrective Action Plans (in general, not limited to restraints) has not yet been implemented. Of significant concern is the element of C.3 requiring that restraint is used as the least restrictive intervention necessary to manage behaviors. Because of the deficits in behavior and other programming discussed in sections J, K, and S of this report BSSLC cannot ensure restraint use is always the least restrictive intervention.	N
C4	Commencing within six months of the Effective Date hereof and with	A review of non medical restraint records indicates use is limited to crisis intervention. There is considerable concern, as noted in C1 and C3 that deficits in behavioral and other	N

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	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.	programming may not reduce the need for crisis intervention and, in some instances may accelerate the need for crisis intervention. As a result restraint may be used in lieu of effective behavioral programming. The monitoring team did not identify any instances where restraint was prohibited by the individual's medical orders or PSP. The monitoring team found little evidence of effective treatments or strategies to minimize or eliminate the need for medical restraint. This topic is discussed more thoroughly in sections M and Q of this report. Tracking the use of medical restraints was initiated several months ago and from interviews it was apparent the BSSLC acknowledges that significant effort needs to occur in this area. Extensive review of use of chemical restraints is found in the assessment of Provision J3.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed	BSSLC reported 90 instances of the use of non medical restraint since January 1, 2010. A sample of 18(20%) restraint records was reviewed to validate the POI report of substantial compliance with provision C5. The most recent episodes of restraint were reviewed first in the belief that as time goes on correct completion of restraint documentation would be expected to improve Two of the first four restraint records reviewed document a face-to-face review no later than 15 minutes from the start of the restraint. However, three of the first four records reviewed contained documentation problems. For example, individual #11's face-to-face assessment (restraint 7/14/10) indicated the restraint stopped when he was no longer a danger to himself or others. This is technically correct but a bit misleading because the physical restraint stopped after he received a chemical restraint. This should have been noted in the comments section under item 2.6 of the face-to-face assessment. Without an explanatory note it appears the physical hold was effective when it was not. There was also no entry indicating whether anyone was injured as a result of this restraint episode. The restraint documentation for individual #493 (6/13/10) did not include a face-to-face assessment. The restraint documentation for individual #399 (6/20/10) did not include a mental status check. The restraint documentation for individual #61 (5/25/10) did not include a face-to-face assessment. The restraint checklist does not include any entry in the injury section but the debriefing document notes "multiple bruises were found." The restraint documentation for individual #173 (3/3/10) does not indicate the time the restraint monitor arrived at the site of the restraint on the face-to-face assessment. In the case of chemical restraint, nurses provided physical assessments for safety, and documented individual's vital signs, as required.	N

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	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.		
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	BSSLC reported 90 instances of the use of non medical restraint since January 1, 2010. Of the sample of 18 restraint records reviewed to validate the POI report of substantial compliance with this provision four of the first six records reviewed contained documentation problems. For example, for individual #61 (6/23/10) the restraint checklist indicates a routine level of supervision when policy requires 1:1. Individual #493 (6/13/10) received a chemical restraint. The restraint checklist does not contain an entry for level of supervision and the nurse monitoring ceased after 1 hour and 45 minutes, not 2 hours as required by policy.	N
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 monitoring team identified three individuals who met the criteria for this in-depth treatment team review for restraint applications between January 1, 2010 and June 30, 2010. They are individuals #61, #173, and #399. Individual #61 met the criteria on two occasions and individual #173 met the criteria on three occasions. Through interview a psychology manager indicated the BSSLC does not yet have a structured process to conduct a review that would meet the specific and detailed requirements in subsections a-g. Instead, when someone meets the 3+/30 day criteria a PSP Addendum meeting is held,	N

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		information is discussed, and any changes in the persons plan are documented. Documentation reviewed by the monitoring team, primarily PSP Addendums, did not indicate substantive data review or consideration of environmental or other antecedents. The documentation of these discussions lacked substance and the type of analysis called for in the SA . Lack of a specific process and checklist to ensure each element (a-g) is substantively addressed inhibits efforts to achieve compliance with this provision. More critical are the deficits in behavior and other programming addressed in sections J, K, and S of this report as they discuss the standards of care and treatment, and related assessment tools, needed to effectively manage difficult, and frequently restrained, individuals.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Refer to C7.	N
	(b) review possibly contributing environmental conditions;	Refer to C7.	N
	(c) review or perform structural assessments of the behavior provoking restraints;	Refer to C7.	N
	(d) review or perform functional assessments of the behavior provoking restraints;	Refer to C7.	N
	(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	Refer to C7.	N

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	designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(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	Refer to C7.	N
	(g) as necessary, assess and revise the PBSP.	Refer to C7.	N
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	BSSLC reported 90 instances of the use of non medical restraint since January 1, 2010. A sample of 18 (20%) restraint records was reviewed to validate the POI report of substantial compliance with provision C8. The most recent episodes of restraint were reviewed first in the belief that as time goes on correct completion of restraint documentation would be expected to improve. In attempting to validate SA substantial compliance with provision C8 the monitoring team asked in a document request for "whatever documentation you consider as evidence to demonstrate compliance with 1) review within 3 business days, and 2) ISP revisions as appropriate." This was to be provided for the 18 restraint episodes in the sample. The information provided consisted of unit incident management team minutes (for some but not all 18), PSP Addendums (for some but not all 18), and facility incident management team minutes (for some but not all 18). Based on the documentation provided it appears there is not a consistent administrative practice in place to validate compliance. Some of the descriptions of circumstance were vague or incomplete. For example, Individual #11 (7/14/10) "displayed challenging behavior of self abuse before being placed into a personal hold." A description in behavioral terms of what he was actually doing would be more useful information for decision-making than a catchall phrase like "self abuse." Another example is Individual #493 (6/13/10) where the meeting minutes note "engaging in self-injurious behavior, slapping her chest and legs." There was no indication this resulted in restraint even though the individual received a chemical restraint. The BSSLC restraint policy currently under review should establish an administrative mechanism to ensure compliance with this section of the SA.	N

Recommendations:

1. Complete the BSSLC Restraint Policy and ensure staff receive appropriate training and instructions. Ensure the policy addresses each component of the Settlement Agreement (SA).
2. Ensure a BSSLC self assessment process correctly identifies provisions of the SA that are believed with a high degree of certainty to be in compliance.
3. Ensure that data and other information that identifies significant trends gets presented to the Restraint Reduction Committee and the Performance Improvement Council and that these groups identify needed corrective actions such as policy revision, procedural changes, modified QE activity, resource issues, and/or additional staff training.
4. Review the use of mechanical devices that restrict movement or access to an individual's body to ensure documentation reflects the purpose of their use and the documentation can lead to a logical conclusion that the use of the device is or is not a restraint.
5. Continue the tracking of medical restraints, develop trend reports, and develop more creative approaches to obtaining individuals' cooperation with medical procedures to reduce reliance on the use of medical restraints.
6. Develop a systematic process for supervisory review of restraint documentation to minimize errors and omissions.

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:** **Documents Reviewed:** 1. Criminal Background Checks for nine volunteers 2. Criminal Background Checks for 104 employees 3. SSLC Turnover Report dated 6/17/10 4. BSSLC Draft Policy Incident Management (not dated or labeled draft) provided 7/26/10 5. BSSLC Draft Policy Protection from Harm-Abuse, Neglect, and Incident Management (not labeled draft) provided 7/26/10. 6. List of all unusual incidents 1/1/10 – 6/22/10 7. Unusual Incident Reports (UIRs) 10-184, 10-189, 10-185, 10-186, 10-172, 10-173, 10-174, 10-165, 10-169, 10-086, 10-089, 10-088, 10-166, 10-164, 10-142, 10-139, 10-154, 10-106, 10-158, 10-159 and 10-156 8. Log of reassigned employees 9. Log of individuals assigned 1:1 level of supervision 10. Log of Department of Family and Protective Services (DFPS) case dispositions 1/1/10 to date 11. DFPS Cases 35877649, 36715989, 36630209, 36067987, 34839389, 34590810, and 35284372 12. Office of Inspector General (OIG) Case 05195-10 13. List of abuse/neglect investigations from 1/1/10-6/28/10 14. List of reassigned employees pending investigation outcome 15. Incident Management Team meeting minutes (and Campus Logs) from 6/14/10, 6/21/10, 6/28/10, 7/5/10, 7/12/10, and 7/19/10, 16. Log of all injuries 1/1/10 to 7/23/10 17. Campus Logs for 7/23/10, 7/24/10, 7/25/10, and 7/27/10 18. List of the ten most injured individuals 1/1/10 to date 19. List of the peers who caused the most injuries 1/1/10 to date 20. BSSLC Trend Report 6/30/10 21. BSSLC Plan of Improvement (POI), dated 5/17/10 22. BSSLC Supplemental POI, not dated 23. Discovered Client Injury Investigation for Individual #514 (2/26/10) **People Interviewed:** 1. Debra Kollman, Assistant Director of Programs 2. Kim Littleton, QE Director 3. Susie Johnson, Settlement Agreement Coordinator 4. Cheryl Powell, Incident Management Coordinator 5. Darla Winkelmann, Assistant Director of Administration 6. Kristen Huff, DADS Attorney

7. Caitlin Connor, Program Compliance Auditor
8. Michael Johnson, Facility Investigator

Meeting Attended/Observations:
1. Facility Incident Management Team 7/26/10 and 7/29/10
2. Program Improvement Council 7/26/10
3. Personal Support Plan (PSP) Meeting for Individuals #390 and #181
4. Personal Support Plan Addendum (PSPA) Meetings for Individuals #4, #31, #52 and #61

Facility Self-Assessment:
The Facility stated it is not in compliance with the provisions of this Section. The Facility reported, and the monitoring team agreed, that investigators have received appropriate training and are not in the line of supervision of alleged perpetrators.

The Facility reported, and the monitoring team determined, that alleged perpetrators are removed from client contact.

The Facility reported it is in compliance withtimely initiation and completion of investigations. The monitoring team confirmed that this is generally the case; however, there was no documentation provided of approval of extensions when an investigation took longer.

The Facility reported, and the monitoring team confirmed, that policy development is in process but not yet completed.

The Facility reported that although policies are not completed, background checks are completed on employees and volunteers before they are permitted to work directly with individuals. The information presented to the monitoring team did not permit that to be confirmed. DADS is developing a process that may provide the needed information while still respecting the legal requirements for confidentiality of this information.

Summary of Monitor's Assessment:
The BSSLC policies that govern this section of the Settlement Agreement (SA) are in draft form and appear to be substantially the same as the DADS policies with little content that makes the policy specific to Brenham. The Incident Management Coordinator (IMC) has been tasked with further development of these policies. In the absence of a Brenham specific policy comments made by the monitoring team will be reflective of the DADS policy. The incident management process observed during baseline continues to mature. This was most notable in the degree of interdisciplinary discussion at the daily facility incident management meetings. Trend data also suggests improvement in various protection from harm indicators; however, caution must be taken into reading too much into the data too soon. Trend data should be continually reviewed by facility leadership and to the extent possible subjected to reliability checks.

	Injuries for the period July 1, 2009 through December 2009 averaged 288 per month. This was reduced to 238 per month for the period January 1, 2010 through June, 2010. This 17% reduction is significant. The majority of injuries were abrasions, bruises, and scratches. While these can all occur through the normal activities of daily living they can also occur as a result of mistreatment by staff or other individuals. It is important that the Facility maintain its vigilant oversight. BSSLC has a good process for the review of all injuries, including discovered injuries. Documentation is generally complete and the multiple layers of review observed during this review were noteworthy, Allegations of abuse, neglect, and exploitation are also down significantly. For the period July 1, 2009 through December, 2009 there was an average of 30 allegations per month. For the period January 1, 2010 through June, 2010, there was an average of 11 allegations per month. This is a reduction of 63%. The number of DFPS cases has decreased by 50% during this same timeframe from 14.2 per month to 7.3. BSSLC leadership should examine these data and engage in thoughtful discussions to satisfy themselves that these data represent real improvement rather than underreporting. The number of serious injuries has decreased by 26% from 6.5 per month to 4.8 per month and the number of serious individual to individual injuries has decreased 80% from 1.5 per month to .3 per month. Because the frequency of restraint increased significantly for these same data points (63%), it may be staff intervened more quickly in situations that could have resulted in more serious injuries to an individual inflicted by another individual. This should be examined more closely by facility leadership. There were several instances of what appeared to be late reporting from data entered on UIRs. This is of concern because it potentially exposes individuals to an alleged perpetrator longer than necessary or allowed by policy. It also has the possibility of contaminating evidence particularly in the area of witness collaboration. There was nothing discovered in the documentation or QA tools that identified this problem although the monitoring team was informed the QA department will soon be initiating a process to sample UIRs to check for accuracy of information and completeness. The tool presented is labeled "Post Investigative Report Review" but it does not contain queries related to the timeliness of reporting. Finally, the monitoring team is concerned with bedrail use and safety. Anecdotal information gathered by several members of the monitoring team, along with the discussion at the facility incident management review team on July 29, 2010 (1 injury where bedrail safety may have been a cause or contributing factor was formally reviewed and during the discussion at least 2 more were referenced) suggest the BSSLC should examine this subject more closely. A document request was made for a list of injuries where a bedrail may have been a cause or contributing factor. This data could not be produced except for a few anecdotal references by unit administrative staff.

#	Provision	Assessment of Status	Compliance

#	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.	BSSLC policy presented a draft policy during this review, labeled "Protection from Harm – Abuse, Neglect, and Incident Management" does not contain unequivocal language forbidding abuse as part of the initial policy statement or purpose statement. It does also not include mandatory reporting language up front. Instead, it is not until page eight of the policy that a statement of "zero tolerance" appears and page nine that a statement of strict prohibition and mandatory reporting appears. The policy and purpose statements at the beginning of the policy should clearly set the tone for zero tolerance and strict prohibition of abuse, neglect, and exploitation. Although the SA does not speak to the location within policy of this language, the monitoring team recommends placing the language at the beginning. Because the policy was still in draft form, the Facility does not yet comply with this provision.	N
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	As noted in the Summary of Monitors Assessment the BSSLC has what, from interviews, document review, and meeting observations, appears to be becoming an effective process for incident management, although policies and procedures are still in process of development. The monitoring team cannot yet conclude that the process works correctly consistently but does want to commend the facility for the process that is in place as it provides for many of the safeguards that are necessary to protect individual from mistreatment.	N
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	Allegations of abuse and other reportable incidents are not always reported timely. Three of the first 5 incidents reviewed by the monitoring team discovered information that indicated possible untimely reporting. For example, UIR 10-164 (incident date 6/16/10) is an allegation of physical abuse. At 11:45 AM the individual alleged to staff that she was slapped by a teacher at the school she attended earlier in the day. Notes indicate the DFPS was called at that time although in the notifications section of the UIR the time of reporting to DFPS says "unknown" with no further explanation of the contradictory information. UIR 10-089 (incident date 1/6/10) is an allegation of sexual abuse. It is unknown when the incident was reported to DFPS; however, DFPS notified BSSLC of the report on 1/6/10 at 4:58PM. Notes in the UIR indicate the injury that eventually led to the DFPS report was first observed by staff at 3:45PM on 1/4/10. Approximately 48 hours elapsed between the time the injury to the genital area was first observed and a report was eventually made to DFPS. UIR 10-169 (incident date 6/20/10) is an allegation of physical abuse. The UIR indicates this was reported to DFPS at 9:04PM. The chronological notes indicate that unit staff notified the duty officer of the allegation at 7:53PM and the alleged perpetrator was placed on non-direct care contact status at 7:56PM. The allegation was not reported to DFPS within the one hour required timeframe.	N

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		DFPS case 36630209 (incident date 6/10/10) is a confirmed case of physical abuse. The cover page of the report indicates the allegation was made at 2:30PM and DFPS was notified at 3:57PM. The allegation was not reported to DFPS within the one hour timeframe.	
	(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.	BSSLC has a practice of always, and immediately, removing an alleged perpetrator from client contact. From document review, interview, and meeting observations it is apparent appropriate additional steps to protect individuals involved in incidents are generally taken and taken in a timely manner. As noted in the Summary of Monitors Assessment, there is considerably interdisciplinary discussion at the facility incident management team daily meetings which facilitates this process.	C
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	The monitoring team did not review training records this visit. The small sample checked during the baseline review indicated training had been done and signed staff statements were in place. The monitoring team was pleased to learn that the QA department has implemented a process where QA staff visit living areas and test staff knowledge on abuse/neglect signs and symptoms, reporting requirements, and other topics and this process will be part of a regular system of QA checks and will produce documentation that can be reviewed at future reviews. BSSLC refers to these as "competency checks."	Not Rated
	(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	Documentation reviewed did not identify any instances of staff failure to report although this was not probed in depth. Through interview it was clear staff understood that the consequence of not reporting was likely to be termination from employment.	N

#	Provision	Assessment of Status	Compliance
	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.		
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	The incident management coordinator reported in the entrance meeting that a "preventing abuse guide" has been added to the personal support plan process (which involves annual meetings that are usually attended by the individual and LAR), and the Facility has plans to create a focused training session on this topic for guardians, LARs, and individuals. The monitoring team did not review these materials this visit.	N
	(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.	Postings were noted throughout the Facility. Additionally, a brightly colored poster that is very eye-catching has been produced and expected to be posted in the very near future.	N
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	DADS' changes to the state policy on abuse/neglect/protection from harm that were distributed in June put in place a standardized process for notification of law enforcement. Because this policy was newly implemented, it is not yet possible to determine compliance. As in the past, the SSLC reports allegations to DFPS. The new policy requires DFPS to determine whether the incident should be reported to law enforcement. There is an interagency agreement between DFPS and DADS to guide this process. The DFPS Investigative Report cover sheet includes a place for date and time of law enforcement notification. A review of DFPS cases indicated some were referred to law enforcement and some were not. This would be appropriate. It may be useful if this cover sheet identified the law enforcement agency that received the notification to facilitate follow up by either DFPS or the SSLC. It would also be helpful if there was a standardized place in the report to	N

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		indicate if the referral to law enforcement resulted in an investigation and if so what the disposition of that investigation was if determined by the law enforcement agency. Alternatively, the Facility may want to establish some form of tracking that displays all investigatory activity, and the status, regarding each specific incident.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The monitoring team did not conduct any review activity directed at this provision this visit.	N
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	As noted in the document request response BSSLC has not yet implemented any process directed at this provision.	N
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 BSSLC Policy directed at incident management is in draft form and under review. The comments contained in the subsections of this provision are directed towards current practice and may or may not be supported by policy. This provision of the SA directs itself to serious injuries and incidents. The monitoring team has previously expressed concern with the degree to which non-serious injuries, particularly discovered injuries, are scrutinized to ensure they are not the result of abuse, neglect, or mistreatment. DADS recognized this concern and in its revised policy issued in June, 2010 requires each SSLC to have a process directed at the review of all injuries, not just serious injuries. The BSSLC has a system in place for the review of all discovered injuries, including those injuries not classified as serious. A discovered client injury calls for the completion of a "Client Injury Report" followed by an "Initial Investigation Checklist" completed by the unit supervisor or home leader. This must be completed within one hour of discovery. The initial investigation checklist documents which employees were on duty and whether or not they were interviewed or provided a written statement accounting for their whereabouts and activity; the residents' explanation of how the injury occurred; and, a listing of documents	N

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		reviewed such as shift logs, behavior logs, nursing notes, and observation notes. The checklist affords the supervisor the choice of identifying a probable cause based on the evidence gathered, or continuing to classify the cause as unknown. If the supervisor identifies a probable cause, a "Probable Cause and Contributing Factors" checklist must be completed which documents the information that led the supervisor to their conclusion. If the supervisor indicates the cause as unknown, a "Secondary Investigation Checklist" is initiated. The outcome of the initial investigation checklist process is reviewed in the unit morning meeting and documented on a checklist entitled "Client Injury Report – Dept IR Team Review and Follow Up". All of this is subsequently reviewed at the daily facility-wide incident management team meeting. If a secondary investigation checklist is initiated it is also completed by the supervisor or home leader and must be done within one day of injury discovery. A secondary is much more thorough than the initial and attempts to identify what activities the individual was involved in during the 72 hours prior to injury discovery. If this analysis results in a probable cause being identified a "Probable Cause and Contributing Factors" checklist is completed. If no probable cause is identified the client injury report for the discovered injury, and all the documentation gathered in the initial and secondary investigations, is referred to the facility investigator for further investigation. This entire process is managed by the facility incident management team, chaired by the incident management coordinator. From interview and observation the process appears to be well organized, thorough, and timely. This review focused on developing an understanding of the process for the review of discovered injuries and did not include a detailed review of documents of actual discovered injuries. This will occur in subsequent monitoring visits. The documentation for the investigation of one discovered client injury was reviewed (Individual # 514, injury discovered 2/26/10). The injury was an abrasion to the knee (non serious). The investigation included interviews with three staff and the injured individual. Written statements were taken from13 staff, The investigation checklist, client injury report, probable cause and contributing factors checklist, and secondary investigation checklist were all completed correctly and led to a logical conclusion that the individual accidentally fell and that abuse, neglect, or mistreatment was not a factor in the injury.	
	(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	Education, training, and experience data were provided to the monitoring team for each BSSLC employee authorized to perform formal investigations, including campus administrators. Similar data were provided for the DFPS investigators assigned to the BSSLC. This information indicates the investigators were qualified through training and experience. However, training records indicate all BSSLC investigators have received DADS mandated training on investigations. There does not appear to be a consistent requirement for DFPS investigators with respect to SSLC investigations. Two of four investigators took a class entitled "MH&MR Overview – APS Investigator Role". One took PMAB training. One took "MH&MR Investigations ILSD" which included 91 hours of Continuing Education Units	C

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	within the direct line of supervision of the alleged perpetrator.	(CEUs). It is recommended that DADS and DFPS review this topic and determine whether there should be minimum training requirements for DFPS investigators. There is a minor concern with respect to the datedness of investigator training. The chief investigator received comprehensive training in 2004. DADS should assess the curriculum content of the comprehensive training and determine if mandatory refreshers of some type should be required at predetermined intervals for all investigators. There was nothing detected in the work of the investigator to indicate lack of knowledge or any other problem but it would seem that best practice would include periodic additional training. Investigation staff is not in the direct line of supervision of unit staff and there was no evidence of any alleged perpetrator being in the direct line of supervision of any investigator.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Through interview and document review the monitoring team did not detect any issues related to interagency cooperation. BSSLC has initiated a process whereby key staff from DFPS, BSSLC, and OIG meets quarterly to review issues of mutual concern. A review of the meeting minutes for January and April, 2010 validated attendance and participation.	N
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	Refer to D.2.g and D.3.b	N
	(d) Provide for the safeguarding of evidence.	BSSLC reported a written protocol is in the process of development which would guide facility investigations. This protocol will include provisions for the safeguarding of evidence. In the interim, the incident management coordinator has a locked cabinet that she has sole access to for this purpose. She reported she has used it twice to secure evidence in the last couple months.	N
	(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,	From document review, interview, and meeting observations, incidents under the jurisdiction of BSSLC routinely commence immediately. BSSLC has campus administrators, trained in incident investigations, onsite during all non- business hours for this purpose. From a limited document review incidents reported to DFPS generally commence in a timely manner. For example, the incident for case 35877649 was reported at 6:58AM and the initial face-to-face interview occurred at 1:48PM the same day. The incident for case 34839389 was reported at 7:53AM and the initial face-to-face interview occurred at	N

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	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.	4:30PM the same day. The incident for case 360679876 was reported at 2:30AM and the initial face-to-face interview occurred at 1:45PM the same day. The incident for case 36715989 was reported at 9:05PM and the initial face-to-face interview occurred at 11:05AM the next morning. Investigation reports reviewed in this visit indicated that investigations are usually done within 10 calendar days or the report provides some documentation explaining the delay, e.g. new evidence is discovered. This documentation does not meet the intent of the SA as it usually is noted by the investigator without a written extension approved by the Facility Director or APS Supervisor. DFPS case 36630209 is an example of a case meeting the 10 day timeline. It is a confirmed abuse allegation requiring multiple interviews and document reviews which was completed in 8 days. DFPS case 36067987 is an example of a case not meeting the 10 day timeframe. It is an unconfirmed case of abuse/neglect reported on 4/24/10 and completed on 6/2/10. The report notes a 5day status was faxed to the Facility on 4/30/10 and an extension was requested on 5/5/10 and again on 5/19/10 although nothing was provided in the case file to note written approval of these extension requests.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the	Reports prepared by DFPS and Facility Investigators were prepared in a standardized format, included the names of alleged victims, alleged perpetrators, witnesses, witness summary statements, other documents or characterizations of evidence relevant to the investigation, and other information required by this provision. From a limited sample the reports reviewed from both BSSLC Investigators and DFPS were well written, comprehensive, easy to follow, and drew reasonable conclusions from the fact patterns that were established and logical inferences that were deduced from the review of all available evidence.	N

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	investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.		
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	DFPS reports are reviewed by a BSSLC A/N/E Committee consisting of the Assistant Director of Programs, the QE Director (or Incident Management Coordinator), the Residence Director from the affected unit, and others determined to be necessary given the nature of the investigation. There is a report used to document this process. One was provided to the monitoring team as an example. It includes committee recommendations. In the example provided the committee recommended to the Facility Director that a DFPS disposition of unconfirmed abuse be changed to confirmed. The report also provided the rationale for the recommendation. The incident management coordinator reviews all BSSLC investigation reports. She reports her findings to the Facility daily incident management review team which she chairs. The review team discusses the report and determines what type of additional follow up which may be needed. Additional examples were provided to the monitoring team to validate these review processes take place and that subsequent action is directed as a result of review.	N
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Refer to D.3.g	N
	(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	From a limited review of files it was apparent both disciplinary and programmatic actions were taken to correct situations. The system to track and document actions taken and corresponding outcomes was not examined closely during this review. In response to the document review, BSSLC stated that the system of Corrective Action Plans (CAPS) is not yet in place. Through meeting observation it is evident that some of documentation of follow up occurs at the incident management meetings but much of this consists of verbal reports rather than written documentation. The BSSLC needs to develop administrative mechanisms to achieve the intended outcome of this provision.	N

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	actions and the corresponding outcomes.		
	(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.	The monitoring team reviewed the record keeping system for investigations and found them easily accessible. Data bases to track investigations involving specific individuals and specific staff were not examined during this review.	N
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	There has been improvement in the timeliness of Trend Reports preparation from the baseline visit. While the basic trend report provides useful data there is a need for some of the data to be regularly displayed that can show trends over time. For example, the report identifies employees and individuals who are the subject of an ANE investigation for the report month. It would be useful for the report to note how many times these specific employees and individuals were the subject of an investigation over the last year (or maybe longer). The trend report is a good starting point but the BSSLC leadership need to examine the data elements that exist and develop ways to array and present data that enable it to be useful inputs into decision making and organizational performance improvement.	N
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	DADS and the monitors have had discussions regarding how this provision of the Settlement Agreement will be assessed in light of the confidential nature of criminal background information and the limited documentation that the state is allowed to maintain regarding the findings of the background checks. Pursuant to those discussions, DADS will provide the monitoring teams with names of staff with a working knowledge of all due diligence checks, as well as spreadsheets for each Facility containing registry checks for history of abuse and neglect, to assess compliance with D5. However, the BSSLC POI asserts compliance with this provision of the SA. Therefore, it is important to identify issues currently remaining that DADS expects will be resolved with the process identified above.	Not Rated

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	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.	With respect to employees, the monitoring team found it very difficult to understand the documentation that was provided, primarily records from the AccessHR system. This is likely due to system requirements and limitations resulting from date of hire, date of promotion, and data input terminology. From document review and interview the monitoring team believes that at least for new employees the following is required: 1) a Criminal Background Check (CBC) which keys off an employee social security number and would disclose infractions in Texas, 2) a fingerprint check (FP) which accesses an FBI data base and would disclose infractions anywhere in the United States, 3) a check of a Texas abuse registry labeled in the AccessHR system as IMPACT/CARE/CANRS, and 4) an employee misconduct verification labeled in the AccessHR system as NAR/MSC. Approximately 100 employee records were checked and 25 contained all four elements. All were people hired recently. The remaining records contained information that appeared to be incomplete or missing. It was further explained that in the fall of 2009 every employee went through a fingerprint process in an effort to identify any current employee that may not have been previously subjected to all the required background checks, or, who had a subsequent infraction and failed to self-report to BSSLC management as required by policy. It was reported this process resulted in multiple employee discharges, all of which were upheld through the grievance process. The monitoring team probed the mechanism(s) that exist to identify employees who have infractions subsequent to their employment date (who were presumably "clean" as of date of hire). DADS' policy clearly requires employees to self report every arrest and there was documentation provided that verified instances of self reporting. Through interview it was reported that a process is in place for reporting of infractions upon occurrence if a Texas issue and a process is planned for periodic re-checks if not a Texas issue. As a result of the issues identified above the monitoring team cannot provide a rating for this provision. Until such information is made available, this indicator will not be rated. With respect to volunteers a sample of 9 (of 27 volunteers) was identified and a document request was made asking for documents that would validate completion and a PASS on the same four data checks required for employees. The monitoring team was provided with what looked to be individual cards for each of the nine volunteers. These cards included entries for 1) Background Check, 2) Emp Misc Chk, and 3) Nurse Aid Reg Chk. Entries under the Background Check heading included the word "Fingerprint" and a handwritten date (although one record did not have a date noted). Entries under the Emp Misc Chk and Nurse Aid Reg Chk headings contained a date. In no case was there any notation of PASS as was common to find in the employee record.	

Recommendations:

1. Complete the policy review and issue policy for abuse, neglect, exploitation, and incident management.
2. Closely examine data related to abuse and neglect reporting to ensure data represents real improvement and not underreporting.
3. Initiate actions to improve timeliness of reporting.
4. Initiate a Corrective Action Plan process to ensure necessary follow up occurs and is documented, including tracking of incident management follow up including both programmatic initiatives and employee discipline.
5. Conduct a bedrail safety assessment using nationally recognized criteria.
6. BSSLC leadership need to examine the data elements that exist in the trend report and develop ways to array and present data that enable it to be useful inputs into decision making and organizational performance improvement.
7. Work with DFPS on issues effecting SA compliance, i.e. timeliness of report preparation, documentation of preparation extensions, more detail on law enforcement referrals, and required investigator training.
8. The Facility may want to establish some form of tracking that displays all investigatory activity, and the status, regarding each specific incident.
9. Determine if BSSLC investigators should be required to undergo additional training and if so in what content areas and at what prescribed intervals.

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:** 1. DADS Nursing Services Policy 010, dated 1/31/10 2. DADS Nutrition Management Team Policy 013, dated 1/31/10 3. DADS Physical Nutrition Management Policy dated 1/31/10 4. Medication Error Committee minutes 5/26/10 and 6/29/10 5. Medication Error Report, June, 2010 6. Sample Monitoring Checklists and Observation Checklists used by QE Department 7. Completed Monitoring Checklists and Observation Checklists used by QE Department 8. BSSLC Draft Quality Assurance Policy dated 7/8/10 24. BSSLC Plan of Improvement (POI), dated 5/17/10 9. Brenham SSLC Supplemental POI 10. BSSLC Trend Report 6/30/10 11. Program Improvement Council meeting minutes 2/22/10, 3/29/10, 4/26/10, and 5/25/10 **People Interviewed:** 1. Kim Littleton, QA Director 2. Susie Johnson, Settlement Agreement Coordinator 3. Cheryl Powell, Incident Management Coordinator 4. Jill Quimby, QE Nurse 5. Debbie Williams, Chief Nurse Executive 6. Sarah Colvin, Nursing Operations Officer 7. Caitlin Connor, Program Compliance Auditor 8. Shawn Cureton, M.S. Psychology Manager 9. Kathleen Williamson,M.Ed., Psychology Manager **Meeting Attended/Observations:** 1. Facility Incident Management Team 7/26/10 and 7/29/10 2. Program Improvement Council 7/26/10 3. Facility-wide Interdisciplinary meeting regarding dental processes, especially pre-treatment sedation practices 4. PSP Meeting for Individuals #181 and #390, 5. PSPA Meetings for Individuals #4, #31, #52 and #61
	Facility Self-Assessment: The Facility reported it was not in compliance with any provisions of this section The Facility indicated all actions are pending policy development.

	The monitoring team found the Facility tracked much data but improvements are needed in data organization to improve its usefulness in decision-making. A process for data analysis is in the developmental stage. A process for Corrective Action Plans has not been developed and is not in place.
	Summary of Monitor's Assessment: Since the baseline visit, BSSLC has implemented additional monitoring tools and developed a more organized and systematic approach to their use. There is a substantial amount of evidence that these monitoring tools are in regular use and that at least in some instances data is aggregated, analyzed, and presented to the Performance Improvement Council (PIC). The PIC appears to have been designated as the group to facilitate interdisciplinary discussion of QA data. Additional program auditors have been added to the QA department and the QA nurse is now part of the QA department.. Program auditors are assigned to specific provisions of the SA. Over time, and with proper training and support, each program auditor should become very knowledgeable in the content areas of the SA they are assigned to. The nursing department engages in a significant of QA activity which is reviewed and supplemented by the work of the QA nurse in the QA department. There is little evidence of any medical review process or QA activity that is called for in sections J and L of the Settlement Agreement. BSSLC is awaiting additional technical support from DADS in developing an organized approach to a QA plan. The Facility lacks a QA policy and is using the DADS QA policy and a BSSLC draft policy to guide its operations at this time. There is not yet in place a process for corrective action planning as called for in the Settlement Agreement.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	BSSLC tracks data that meet most of the specified data elements in E1 of the SA. There are improvements needed in data organization and presentation. For example, the trend reports do not contain data on medical restraints. The Facility acknowledges this and has started a process to track these data. The non-medical restraint data tracked do not specifically identify restraint episodes that meet the 3+ in a 30 day rolling period criteria called for in the SA. Individuals meeting this criterion would be expected to present significant challenges and should be identified in the tracking and trending reports. There are several data elements that are tracked for a rolling 12 month period, for example injuries by unit and home. These data could be more useful if totals were included for the 12 month rolling period in addition to the month by month tallies. This would provide a more longitudinal perspective on areas that are experiencing high frequencies of injuries. Similar data presentation might be useful in other areas of the	N

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		report such as restraints and UIR's. Tracking and trending reports are being produced on a timelier basis that what was observed in the baseline review.	
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.	Data analysis remains in a very early stage of development and through document review and interview the Facility acknowledges that it as yet has not implemented a process of corrective action planning resulting from data analysis. At this time the Facility has not demonstrated the ability to review and assess data to identify systemic issues that may need to be addressed through policy change, procedural change, targeted and focused monitoring, or other administrative mechanisms. In reviewing a sample of completed monitoring tools it is apparent program auditors, and others who use the tools, are identifying problems requiring attention. The tools do not lend themselves to identifying who, and how, those problems should be addressed. Through interview it was reported the monitoring tool information is provided to the appropriate department head for follow-up. At least for now the QA department does not routinely get additional follow up related information from the department head. As a result it very difficult to know what happens to this information and whether it actually serves the purpose of improving services and supports. Through interview the monitoring team was informed that Facility would have a method to address this in early fall. Substantial improvement is needed in this process to ensure a closed loop system of information processing is developed. A simplistic description of a closed loop system essentially consists of (1) identify the problem, (2) assign responsibility for fixing the problem, (3) identify evidence of validation and validate the problem was fixed, and (4) if not fixed, begin the loop again. This is what the SA provisions regarding Corrective Action Plans are intended to address. From meeting minutes review and meeting observation the Performance Improvement Council (PIC) has assumed some responsibility for reviewing data trends at least quarterly. This should be a good forum for interdisciplinary discussion and identification of systemic issues. This process has only recently started and the monitoring team looks forward to future observations as the process matures.	N
E3	Disseminate corrective action plans to all entities responsible for their implementation.	BSSLC does not as yet have a process in place for Corrective Action Plans.	N
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely	BSSLC does not as yet have a process in place for Corrective Action Plans.	N

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	manner, to meet the desired outcome of remedying or reducing the problems originally identified.		
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	BSSLC does not as yet have a process in place for Corrective Action Plans.	N

Recommendations:
1. Develop a BSSLC QA plan and the necessary administrative processes to implement it, most importantly a Corrective Action Plan process designed to meet the conditions specified in the Settlement Agreement.
2. Review the SA to ensure any section that includes a quality assurance activity is incorporated into the overall facility plan, including medical and psychiatric services.
3. Develop a strategy for continued training of program auditors to ensure they are sufficiently knowledgeable in the content areas of the SA they are assigned to monitor.
4. Through BSSLC leadership discussion (e.g. brainstorming), and if necessary with external assistance, begin a process of figuring out how to assess all the information flowing from QA reports into a meaningful identification of systemic issues and decision-making to correct those issues.

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:** **Documents Reviewed:** **1.** PSPs and related documents for Individuals #3, #31, #52, #61, #70, #122, #139, #173, # 181, #377, #390, #399, #400, #417, and #598 2. BSSLC Policy and Procedure Volume 2, Section 3 Program Planning Process 3. BSSLC Plan of Improvement (POI), dated 5/17/10 **People Interviewed:** 1. Debra Kollman, Assistant Director of Programs 2. Kim Littleton, QE Director 3. Susie Johnson, Settlement Agreement Coordinator 4. Jill Quimby, QE Nurse 5. Caitlin Connor, Program Compliance Auditor 6. Shawn Cureton, Psychologist Manager 7. Kathleen Williamson, Psychologist Manager **Meeting Attended/Observations:** 1. Facility Incident Management Team 7/26/10 and 7/29/10 2. Program Improvement Council 7/26/10 3. Facility wide Interdisciplinary meeting regarding dental processes, especially pre-treatment sedation practices 4. PSP Meeting for Individuals #52, #181, and #390 5. PSPA Meetings for Individuals #4, #31, #52 and #61
	Facility Self-Assessment: The Facility reported it is not in compliance with either provision of this Section. The monitoring team found this to be accurate. Based on interviews with staff and review of documents DADS has recently issued a new comprehensive policy on Personal Support Plan development that applies to all SSLC's. DADS created comprehensive training to go with this policy. This training is scheduled to roll out beginning in September. This is intended to address the little improvement found in the PSP planning process at the BSSLC compared to the baseline report.
	Summary of Monitor's Assessment: In the baseline review, the monitoring team reported "interdisciplinary planning is more than the

	development of an annual plan at an annual meeting that involves reports from several disciplines. It requires integrated decision making in which the information provided by several disciplines serves as the basis for discussion by all members of the interdisciplinary team. It also involves integrated discussion and decision-making whenever decisions about treatment and care are being made. Although the structure of an interdisciplinary team is in place at BSSLC, most involvement is multidisciplinary, and decisions about treatment are made in a number of different forums. One of the greatest challenges for Brenham will be how it transitions to a more integrated interdisciplinary work process. On the whole, the PST members do not understand the concept of providing integrated services, the need for a comprehensive PSP that gives a good overview of the individuals' total needs, and the ability to provide quality planning that Team members can fully appreciate and implement. They do attempt to discover and meet the preferences and needs of individuals; however, they do not use a fully interdisciplinary process." From meeting observation and document review there was little detected six months later that would indicate positive change. Much of this section of the report reiterates the issues identified in the baseline report. Absent new policy direction, little would be expected to change and little has changed. Hopefully the new DADS policy, and the accompanying training, will begin to address these substantive issues.

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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:	Although the structure of an interdisciplinary team process is in place, most involvement is multidisciplinary. From document review and meeting observation it is evident that different disciplines do separate assessments and decision-making, reporting information and decisions but not routinely integrating information to make joint or shared decisions.	N
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.	The PST is facilitated by a Team Leader who is a QMRP but little interdisciplinary activity occurs. From document review and meeting observation it is apparent many decisions are made during other meetings or without active PST involvement. For example, decisions about psychotropic medication are made at the PTR meetings, and dental staff may make decisions about pre-treatment sedation without PST involvement. It is unclear whether the PST has any process to monitor and revise these treatments and services in between annual meetings. For example, PBSP changes are not made timely based on review of data, and the need for changes does not seem to be brought routinely to the PST.	N
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs,	The teams consist of the individual and/or LAR or a family member who does not have guardianship, clinicians representing specific services, and direct care staff. Habilitation therapies (PT, OT, SLP, and RD) have limited to no involvement in PSP annual meetings. Per interview, therapists stated that they only attend PSP meetings if they are invited however there are no criteria present to guide the QMRP in making the decision as to	N

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	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.	whether or not therapies are needed at the meeting. Refer toProvision 0.1. Additionally, it is apparent there is not an expectation of direct involvement from other significant disciplines at the PSP meeting. A physician and psychiatrist are rarely at a PSP meeting. The monitoring team did not identify a single instance of their presence at a PSP meeting. It appears input from the nurse case manager and a psychiatric aide is deemed sufficient. For individuals with complex medical management issues or significant behavioral/psychiatric needs the presence of the actual professional clinician at the PSP meeting would be expected to be necessary for good decision making.	
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.	Some assessments are done routinely, such as DISCUS and MOSES assessments of medication side effects. Others are done annually as part of the PSP process. Others, such as formal preference assessments and functional analyses, are done intermittently. Assessments must be done not only as scheduled but also in response towhat might be significant changes in an individual's life. Refer to Provision H1 for examples.	N
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.	Although data and information from assessments are likely available at planning meetings, they frequently are not discussed; instead, they are reported or summarized, and a clinician makes a decision. From record review and interview the quality of behavioral and other data continues to be questionable. For example: • The lack of objective psychiatric data also meant that even though many interdisciplinary meetings took place, meaningful integration of information from the key disciplines was not possible. This adversely effected the functioning of the interdisciplinary team process. Review of clinical records also showed that required clinical elements, such as PST considerations of treatment options and alternatives, risk/benefit analyses of treatment options, and outlines of plans for the use of medication, were either poorly documented or absent. • In 20 of 20 records reviewed (100%), data collection consisted primarily of narrative reporting initiated upon the display of an overt behavior. Data and other information quality need to improve to facilitate improved decision-making by the team.	N
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in	As described in Section T, PSP development does not generally address barriers to movement to community living other than training or therapy needs of the individual. Goals are not selected with an eye toward the supports available from community living providers or development of skills that are relevant to increasing opportunity to move to a preferred environment.	N

#	Provision	Assessment of Status	Compliance
	Olmstead v. L.C., 527 U.S. 581 (1999).		
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:	The PSP document includes a plan of treatment but it is difficult to follow. There is no single place in which all services and supports to be provided are listed, along with goals and objectives, names of persons responsible, and data to be gathered.	N
	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;	Formal assessments of preference do not always occur and were not noted to be used in PSP planning. For example, in individual #390's PSP meeting there was no PALS summary presented or discussed. Barriers were often viewed as being issues the person presents (e.g., behavior problems, medical concerns) rather than supports that are currently unavailable or other issues that enhance quality of life and/or prevent community living.	N
	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;	These were generally present. However, there is no single place in which all goals, treatments, and strategies are to be found. This makes it difficult to determine whether there are adequate efforts to meet preferences and needs and to overcome barriers to living in the most integrated setting.	N
	3. Integrates all protections, services and supports, treatment plans, clinical care	When planning is done, it is generally discipline specific rather than integrated. From observation of meetings, it is apparent that the goals, treatments, and strategies are not determined in a manner that integrates them so they complement and build upon each	N

#	Provision	Assessment of Status	Compliance
	plans, and other interventions provided for the individual;	other. Instead, one discipline presents a report that includes recommendations; usually, with little discussion, the PST is asked to approve (and usually does). Then, the next discipline reports and presents recommendation. The monitoring team did not observe instances in which PST members took information from another discipline and related it to other recommendations. For example, from document review, PSPs contained reference or a brief statement of an individual's communication skills; such as, "communicates with facial expressions" or in other cases would simply stated "the individual uses a communication board." Action Plans do not consistently integrate information from the communication assessments (for example, development of communication as replacement behaviors in PBSPs intended to reduce problem behaviors or as a component of leisure skills to be developed) nor was there a process in place that ensures action plans are developed that correspond and include the training of the communication device. See Section R.3 Although psychiatry supports are included in PSP planning, there is little in PSPs to document discussion among the PSP of psychiatric diagnosis and treatment and their relationship to other issues (including behavioral interventions and health issues), and comments need to be more specific (refer to Provision J8 for examples).	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Methods are not written in a manner that is clear. Objectives and data to be taken are often defined in ways that do not make reliable implementation and observation likely. Refer to sections K and S.	N
	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	Although BSSLC provides opportunities for community involvement in both work and leisure, many interventions, strategies, and supports need improvement. For example, at the PSP meeting for individual #52 "resistance to change" was identified as an obstacle to movement to community living. The action plan to overcome this obstacle involved improving "safety in the community" which is unrelated to the obstacle. The intervention involved an objective to "identify pictures of safety signs" which is not a functional activity (as opposed to going into the community and training the individual to obey safety signs). A nonfunctional activity was selected to train a skill that was unrelated to an identified obstacle to community living.	N
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the	Objectives and data to be taken are often defined in ways that do not make reliable implementation and observation likely. Refer to sections K and S.	N

#	Provision	Assessment of Status	Compliance
	objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.		
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.	There is no single place in which all goals, treatments, and strategies are to be found. This makes it difficult to determine whether there are adequate efforts to meet preferences and needs and to overcome barriers to living in the most integrated setting. It is not clear that all decisions by clinicians (e.g., dental pretreatment sedation) are reflected in the PSP.	N
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.	PSPs are accessible in the active record. However, they do not clearly specify the services and supports to be provided and who is responsible. Services are found in various sections of the active record. For example, skill acquisition/ habilitation goals are separate from PBSP goals, which limit the holistic understanding of how these relate to each other. Habilitation Therapy information is referenced in the PSP, however the rationales and descriptions of interventions regarding use and benefit are not clearly integrated into the PSP therefore resulting in an incomplete document that is difficult to understand and not functional for staff or the individual.	N

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	There were numerous examples of individuals meeting objectives without review and identification of new objectives as well as lack of expected progress continuing for an extended time without program revision.
		
		• For Individual #31, there were several objectives for which criteria were met but the same objective remained for an extended time. Out of the first 5 ITP goals reviewed, four had met criterion but were not changed.
		    ○ ITP 1B1 met criterion March, 2010, but the objective remained through June, 2010. This ITP has been changed for reasons unrelated to meeting the criterion.
		    ○ ITP 1C1 relate to compliance with instructions met criterion in April, 2010, but the objective remained through June, 2010. Per QMRP interview, what is to be complied has changed, which is not clear in
			N

#	Provision	Assessment of Status	Compliance
	occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	objectives. o ITP 1D1 met criterion in January, 2010, but the objective remained through June, 2010. This ITP was discontinued in July, 2010 as no longer a priority need. o ITP 1E1 met criterion in December, 2009 but the objective remained through June, 2010. The criterion was changed in July, 2010 to reduce the prompt needed for a successful instance of the behavior.	
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.	General training is provided to staff through classes conducted by the Facility's training department. The method for training staff on a specific individuals plan is dependent on the plan component. Through interview the processes described varied by plan component. When staff receives training on an individual's skill acquisition plan the general method is for the QMRP to meet with the home leader and whatever staff are available to review the program and data sheets. The home leader is expected to train remaining staff. This training effort was characterized as somewhat informal. It was reported that the QMRP maintains a training roster which can validate that training occurred. When staff receive training on an individual's behavior support plan, psychologists do what QMRPs do for skill acquisition plans. The process used by psychologists was described as more systematic than that used in skill acquisition plans. Training in nursing care plans follows protocol similar to QMRP training in skill acquisition programs although from what was reported through interview it appears that training occurred is not documented in a central location. It was also reported nurses will follow up a few days after the training is provided to ensure staff are doing the procedure correctly.	N
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	PSP's were reviewed for seven new admissions that occurred since 1/1/10. Three of the records indicated compliance with a PSP being developed within 30 days of admission and being put into effect with 30 days of preparation (individuals #321, #139, and #400). The other four records had missing, confusing, or contradictory information making it impossible to confidently validate compliance. For example, for individual #377 the date of admission on consent forms had both 4/16 and 4/19 listed. An admission schedule	N

#	Provision	Assessment of Status	Compliance
	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.	shows 4/19. The record itself did not have a date. If the individual was admitted 4/19 the 30 day timeline was met. If admitted 4/16, the timeline was not met.	
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.	There are quality assurance processes to monitor certain aspects of PSP development and implementation however because of the lack of integrated planning discussed throughout this document they are not adequate in their present form to ensure compliance with the SA.	N

Recommendations:

1. Implement the new DADS policy as soon as possible after receiving training.
2. In implementing the new policy consider some type of peer review process to facilitate good learning across teams facilitated by the Facility's master trainer.
3. In addition to whatever is required in the new policy consider criteria and methods by which to include necessary professional clinicians in some PSP meetings.
4. Improve methods for data collection, tabulation, and use for all program plans.
5. Review the assessment process to ensure individuals receive necessary assessments and reassessments as their circumstances change.

<table>
<tr><th>SECTION G: Integrated Clinical Services</th><th></th></tr>
<tr><td>Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.</td><td>Steps Taken to Assess Compliance:
Documents Reviewed:
1. BSSLC Plan of Improvement (POI), dated 5-17/10
2. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in sections below.
People Interviewed:
Interviews with various discipline staff by the members of the monitoring team, as identified in sections below.
Meeting Attended/Observations:
1. PSP Meeting for Individuals #52, #181, and #390
2. PSPA Meetings for Individuals #4, #31, #52 and #61</td></tr>
<tr><td></td><td>Facility Self-Assessment:
The Facility reported it was not in compliance with either provision of this Section.

BSSLC reported that it has reached compliance with the following Action Steps:
• The physician was notified timely upon an individual's return from hospitalization.
• Nursing staff were familiar with signs and symptoms and communicated abnormal results to the PST and clinical staff.
• Preventive health services are established collaboratively.
• Records include documentation of informing PST of abnormal findings, modifying PSTs as needed, and training support staff.
All Action Steps identified as in compliance related to medical services. No Action Steps related to other clinical services were rated as compliant. The monitoring team did not confirm that these actions were in compliance but did note improvements for each of them.

The Facility reported that some actions were in compliance, including documentation that Facility clinicians documented whether they accepted recommendations from non-Facility clinicians and if not, why not. BSSLC accurately reported that sub-items involving notice to or involvement of the PST were not compliant.</td></tr>
<tr><td></td><td>Summary of Monitor's Assessment:
BSSLC does not comply with provisions in this section.

The lack of objective and reliable data also meant that even though many interdisciplinary meetings took place, meaningful integration of information from the key disciplines was not possible. This was true across most opportunities for planning, including PSP and PSP addendum meetings.</td></tr>
</table>

	Processes to promote integrated clinical services have begun. The collaboration among disciplines was evident in the structure of the PTR.

#	Provision	Assessment of Status	Compliance
G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	BSSLC does not comply with this provision. According to the response to the Document Request, policies related to integrated planning are undergoing revision and are not currently in place. There were not any Health Status Team meetings scheduled during the week of the review so it was impossible to gauge any improvement in the quality of interdisciplinary discussion and integration of decision-making and treatment planning. The lack of objective and reliable data also meant that even though many interdisciplinary meetings took place, meaningful integration of information from the key disciplines was not possible. This was true across most opportunities for planning, including PSP and PSP addendum meetings. Results of assessments do not always affect PSP decisions. For example, strategies that arise out of communication assessments may be mentioned in the PSP but these strategies are not consistently integrated into Action Plans or activities of daily living. Lack of integration results in a lack of generalization of objectives. Nevertheless, processes to promote integrated clinical services have begun. The collaboration among disciplines was evident in the structure of the PTR. At that meeting the psychologist provided the psychiatrist with behavioral tracking data, including graphs of behavioral data for the preceding period. Additional information was provided, including information regarding whether or not any form of restraint had been used. More general descriptions were also provided by the psychologist, regarding additional events in the individual's life that had occurred during the preceding period. Presentations were also made by the QMRP and RN, who reviewed information on side effects and general medical issues. Quarterly Drug Regimen Review (QDRR) information review provided information from the pharmacy, and general discussion followed. Another example involves integrated review related to psychotropic medication. Review of individual #403's record demonstrated active participation by the Nurse Case Manager in identifying signs and symptoms of possible ADRs related to the new administration of Buspar. The Nurse Case Manager researched the potential Buspar had	N

#	Provision	Assessment of Status	Compliance
		for causing ADRs, and discovered it had the remote potential to cause blistering of the feet, such as individual #403 began experiencing soon after taking Buspar. This information was related to the Physician, the medication was stopped, and the blistering stopped shortly afterwards. The Nurse Case Manager also worked collaboratively with the Facility's Pharm.D. in problem solving the ADR to Buspar, a good example of integrated services. Members of the monitoring team attended the annual PSP meeting for Individual #52 on 07/29/10, and the psychiatric issues identified above received no attention.	
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.	Although procedures were in place for Facility clinician review of recommendations from non-Facility clinicians, there was not procedures to bring these to the PST when appropriate. There was no process in place for monitoring to ensure reviews took place.	N

Recommendations:

1. Ensure that all policies regarding treatment planning reflect the need for integration across disciplines.
2. Establish a process and guidelines for referral of recommendations from non-Facility clinicians to the PST.
3. Develop and implement policy and procedures for review and decisions regarding recommendations from non-Facility clinicians.
4. Implement quality assurance monitoring to assess both that recommendations from non-Facility clinicians are reviewed by Facility clinicians and the PST as appropriate and that these reviews involve thoughtful evaluation to ensure that treatment meets the needs of individuals served.

<table>
<tr><th>SECTION H: Minimum Common Elements of Clinical Care</th><th></th></tr>
<tr><td rowspan="3">Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance:
Documents Reviewed:
1. BSSLC Plan of Improvement (POI), dated 5/17/10
2. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in sections below.

People Interviewed:
Interviews with various discipline staff by the members of the monitoring team, as identified in sections below.

Meeting Attended/Observations:
3. PSP Meeting for Individuals #52, #181, and #390</td></tr>
<tr><td>Facility Self-Assessment:
The Facility reported that it was not in compliance with any of the provisions of this Section.

The Facility reported that assessments in all disciplines are performed on a regular basis and in response to changes in individuals' status; the findings of the monitoring team review did not support that this complies. The Facility reported that the nurse participated in quarterly reviews, updated nursing care plans, and reviewed the effectiveness of the plan on a quarterly basis; the monitoring found significant improvement in content of the reviews but did not find them to be in compliance.

The Facility reported that implementation of treatments and interventions are timely and appropriate; the findings of the monitoring team review did not support that assessment.

The Facility reported clinical indicators of effectiveness are determined in a clinically justified manner. The monitoring team did not find adequate evidence of use of clinical indicators of effectiveness.

For Provision H5, BSSLC reported compliance with the establishment of a system to effectively monitor health status of individuals, no preventable changes in health status, and early recognition of signs and symptoms of several conditions. The monitoring team findings did not support these evaluations. Other Actions Steps reported in compliance included doing skin assessment prior to transfer to hospital and documentation of actual and potential medical problems in the Quarterly Nursing Assessment.</td></tr>
<tr><td>Summary of Monitor's Assessment:
There was a great deal of variability across disciplines and areas of support needed as to whether assessments were performed regularly at an acceptable frequency, whether assessments were triggered by changes in an individual's status, and whether assessments included all necessary components.</td></tr>
</table>

	There were numerous examples in which changes in an individual's health status did not trigger timely and effective change in treatments and interventions. Collaborative review between psychology and psychiatry occurred, including presentation of behavioral data. While this was useful, clinical data related to the diagnoses was lacking. The Quarterly Nursing Assessments have shown improvement. Policies are in process of revision.

#	Provision	Assessment of Status	Compliance
H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	BSSLC did not comply with this provision. There was a great deal of variability across disciplines and areas of support needed as to whether assessments were performed regularly at an acceptable frequency, whether assessments were triggered by changes in an individual's status, and whether assessments included all necessary components. • Psychiatry (re)assessments were done via Psychiatry Treatment Reviews (as needed, often monthly, and at least quarterly) and Annual Psychiatric Medication Reviews. • Intellectual assessments are not conducted at the Facility and adaptive assessments results include only the provision of scores without interpretation or identification of strengths and limitations. Furthermore, standardized assessment of intellectual functioning, adaptive ability, undesired operant behavior and psychopathology lacked the sophistication and timeliness to produce meaningful information about the individual. As a result, reported results consist of scores and levels without presenting information in a way that compliments the overall assessment process. • Ten of ten (100%) individuals' records reviewed for Quarterly Nursing Assessments were completed according to the Personal Support Plan schedule. The Quarterly Nursing Assessments contained more comprehensive information than the baseline review regarding the individuals' heath risks and/or potential health risk factors during the quarter but failed to consistently describe effectiveness of the Health Maintenance Plans and/or Acute Care Plans established to meet identified risk or potential risk factors. • The PNM (NMT and HST) Team did not meet regularly to address change in status, assessment, clinical data and monitoring results. Additionally, no assessments were conducted in response to identified issues. The HST and NMT minutes reviewed did not show evidence of active discussion or problem solving and provided only a summary of the events and does not provide adequate detail. • Documentation of assessment with Reiss Screens was not found for several	N

#	Provision	Assessment of Status	Compliance
		individuals. • There were numerous examples in which changes in an individual's health status did not trigger timely and effective change in treatments and interventions.	
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.	Refer to Provision J2 and J6 for discussion of psychiatric diagnostics. Effort will be needed to provide (when possible) more specific diagnoses, In particular, review should be done of people who have psychiatric disorders Not Otherwise Specified (NOS).	N
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.	There were numerous examples in which change of status did not trigger timely assessment and intervention. This was true for medical care, Refer to Provision V4 for an example in which data on a program objective for Individual #4 clearly could not identify a change of status. Refer to provision O2 to note examples in which change of status did not result in change in identified risk level or appropriate intervention for Individuals #30, #59, #69, #413, and #554.	N
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.	This was variable across disciplines. There were, generally, no measurable goals established for interventions provided. Documentation was more anecdotal in nature, making it difficult to track progress and compare data to determine progress over time. Refer to Provision V4 for an example in which data on a program objective for Individual #4 clearly could not identify a change of status. Collaborative review between psychology and psychiatry occurred, including presentation of behavioral data. While this was useful, clinical data related to the diagnoses was lacking.	N
H5	Commencing within six months of the Effective Date hereof and with full implementation within two	Although no overall system to monitor health status is in place, the Quarterly Nursing Assessments have shown improvement and provide one approach to monitoring health status. Changes in health status, monitored and noted or not, did not always result in	N

#	Provision	Assessment of Status	Compliance
	years, a system shall be established and maintained to effectively monitor the health status of individuals.	changes in treatment and intervention.	
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.	There was no system in place to ensure clinical indicators were reviewed and used to trigger changes in treatments and interventions. Except for the use of behavioral data in Psychiatric Treatment Reviews (PTRs), the monitoring team noted few examples in which clinical indicators and other data were referred to in discussions. At PSP planning meetings, such data were inconsistently reported and never used during discussion of changes in the PSPs.	N
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility reported that these policies are in process of revision.	N

Recommendations:

1. The Facility should complete revision of policies regarding implementation of integrated services and follow these revisions with staff training on the policies and on how to carry out integrated planning.
2. Each discipline should review national standards to identify clinical indicators that could be selected.
3. Treatment plans and PSPs should include information on the clinical indicators to be monitored for specific treatments and interventions.
4. At PSP planning meetings and other treatment review meetings, the discussion of clinical indicators should be routine, and documentation of decisions should reflect how those decisions were affected by this discussion.

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Health Status Team Review and Recommendations 5/5/10 (Bowie A) 2. Health Status Team Quarterly Review Meeting minutes 4/20/10 (Fannin C), 5/13/10 (Bowie B), 6/8/10 (Cottage B), 4/29/10 (Driscoll D), 5/11/10 (Childress B), 6/3/10 (Cottage A and C) 3. Hospital ER Visit Log January-May, 2010 4. Hospital Admission Log January-June, 2010 5. List of individuals who have had pneumonia January-May, 2010 6. List of individuals with four or more displays of Pica, SIB, and/or Physical Aggression within the past six months 7. DADS Nursing Services Policy 010, dated 1/31/10 8. DADS Nutrition Management Team Policy 013, dated 1/31/10 9. DADS Physical Nutrition Management Policy dated 1/31/10 10. Medication Error Committee minutes 5/26/10 and 6/29/10 11. Medication Error Report, June, 2010 12. PSP's and related documents for Individuals #3, #31, #52, #61, #70, #122, #139, #173, # 181, #377, #390, #399, #400, #417, and #598 13. BSSLC Plan of Improvement (POI), dated 5/17/10 **People Interviewed:** 1. J. Bret Hood, M. D., Medical Director 2. Kim Littleton, QA Director 3. Susie Johnson, Settlement Agreement Coordinator 4. Jill Quimby, QE Nurse 5. Terry Hancock, Chief Psychologist 6. Debbie Williams, Chief Nurse Executive 7. Sarah Colvin, Nursing Operations Officer 8. Caitlin Connor, Program Compliance Auditor 9. Shawn Cureton, M.S., Psychology Manager 10. Kathleen Williamson, M.Ed., Psychology Manager **Meeting Attended/Observations:** 1. Facility Incident Management Team 7/26/10 and 7/29/10 2. Program Improvement Council 7/26/10 3. Facility wide Interdisciplinary meeting regarding dental processes, especially pre-treatment sedation practices 4. PSP Meeting for Individuals #390, 181, 5. PSPA Meetings for Individuals #4, #31, #52 and #61

	Facility Self-Assessment: The Facility reported it is not in compliance with any of the provisions of this Section. The Facility reported that most components of a risk screening and management system are in compliance; the monitoring team findings did not confirm this was the case. The Facility accurately reported that not all Personal Support Teams (PSTs) routinely screen for risk, and the Facility reported they are being trained to do so. The Facility reported that each individual identified as at risk has a plan in place that is integrated into the PSP; the monitoring team found that PSPs do reference risk, but the identification of risk level is flawed, and increased risk levels do not necessarily lead to integrated planning. The State is in the process of revising the POI template to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for the BSSLC did not include such a description it identified many Actions Steps of the provisions in Section I as being in substantial compliance. The monitoring team did not find the Facility to be in substantial compliance because of the inherent deficits of the risk identification process described in the baseline report. At this review's entrance meeting the Medical Director reported "not a whole lot has changed, still waiting on State office."
	Summary of Monitor's Assessment: The monitoring team made the following observation in the baseline report: "The system for identifying individuals who are at risk and why, and to plan, implement, and monitor measures to put in place to reduce risk for these individuals, is rudimentary. This item was difficult to assess due to the way individuals are assessed for risk. State policy identifies people whose risk is being managed effectively as medium risk, even if significant resources are needed on a consistent basis; even so, many of these people are rated as low risk due to a perception that the expectation is to have fewer people at higher risk levels. For example, if an individual had a choking episode, the immediate risk level would be elevated to high. However, once the acute phase is resolve, according to this method, BSSLC then lowers their risk to medium or low. It seems that this is a matter of facility/staffing convenience because if the individual remained classified as high risk (as is the usual practice), the individual would require weekly monitoring. This type of risk classification system is not functional or useful to the clinicians or the individuals living at BSSLC. DADS should review and revise the risk management policy. Brenham SSLC will then need to develop facility policy to operationalize state policy. Staff will then need training and support so that appropriate risk levels and actions to address risk are appropriately identified." The monitoring team believes these comments are equally appropriate with respect to this compliance review. Finally, the monitoring team did not attend a Health Status Team meeting during the week of the review so it was impossible to gauge any improvement in the quality of interdisciplinary discussion on risk

	assessment levels and safeguards to be put in place.

#	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.	A system is in place; however, it lacks objective criteria and relies too heavily on "clinical judgment." From document review and interview this results in too few people being identified as high risk. The "At Risk" policy has two main issues. One is that the Facility incorrectly follows the policy as BSSLC is placing the majority of individuals as being at "low risk" when they should have been placed as at "medium risk". Second, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline, injuries due to behavior problems, or other areas of risk. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. For people with dysphagia, following the policy as written would result in BSSLC having their entire population with a few exceptions listed as "Medium Risk" since the remaining individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at BSSLC. Similar concerns are found related to polypharmacy, behavior problems, and other issues.	N
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.	Because the identification of risk level is so problematic and does not adequately respond to changes in an at-risk individual's condition, review of the assessment process was not done. Refer to I1 and O1. Furthermore, as documented in Provision O2, there changes in at-risk condition often do not trigger interdisciplinary assessment.	N
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	Although there were many actions taken to address risks for individuals, including preventive interventions, these were not addressed through a systematic risk assessment and management process. Because the identification of risk level is so problematic and does not adequately respond to changes in an at-risk individual's condition, review plan implementation did not occur this review.	N

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	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.		

Recommendations:

1. The Risk Policy should be reviewed and revised by DADS and implemented with appropriate training at the BSSLC.
2. BSSLC should review all risk levels and identify risks as dictated in policy until the policy is revised.
3. The State and Facility should consider using nationally recognized standardized risk assessment tools and standards.
4. After the Risk Policy is revised, an audit system should be put into place to monitor appropriateness of risk levels and of the actions taken to address higher levels of risk.

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Response to request for any policies, procedures and/or other documents addressing the use of pre-treatment sedation medication. Response received: Facility policy is currently under revision. 2. Response to request for a list of individuals who have received pre-treatment sedation medication for medical or dental procedures that includes: date the pre-sedation was administered, and the name dosage, and route of the medication, and an indication of whether a plan is in place to minimize the need for the use of pre-treatment sedation medication. Response received: Explanation that the AVATAR system has just been initiated to track medical and dental pre-treatment sedation but the system is not set up to report medication dose and route. 3. Response to request for any auditing monitoring data and/or reports addressing the use of pre-treatment sedation medication. Response: No evidence available. 4. Response to request for a description of any current process by which individuals receiving pre-treatment sedation are evaluated for any needed mental health services beyond sensitization protocols. Response received: No evidence available 5. Listing provided in response to document request of individuals prescribed psychotropic/psychiatric medication and, for each individual: (a) Name of individual; (b) Residence/home; (c) Diagnoses; and (d) Medication regimen (including psychotropics, nonpsychotropics, and PRNs, including dosage of each medication and times of administration). Response received: partial list consisting of name, diagnosis and residence and medication, but not dose of medication 6. List of individuals prescribed benzodiazepines, including the name of medication(s) prescribed and duration of use 7. A list of individuals prescribed anticholinergic medications, including the name of medication(s) prescribed and duration of use 8. A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date 9. Facility-wide data regarding polypharmacy, including intra-class polypharmacy. 10. A list of individuals being monitored for tardive dyskinesia 11. A list of individuals with tardive dyskinesia 12. Request for a list of new admissions since January 1, 2010, and whether a Reiss scale was used. Facility response: List of seven individuals with no indication regarding Reiss Screen 13. Request for five (5) individuals most recently admitted, and for the seven (7) individuals for whom information is provided pursuant to section VIII.13 of this document request (i.e., a total of 10 individuals),

	(a) Their most recent psychiatric assessment; (b) Last three (3) psychiatric progress review notes, including data provided to the psychiatrist by the psychologist and/or other Team members; and (c) For the past year, i. Dates of all Psychiatric Treatment Reviews, ii. Health Services Team notes, iii. Moses and Discus exams, iv. Neurology consults (if any); and v. The most recent Medical, Pharmacy, and Nursing summaries. Facility Response: " I do not know what documentation that monitors are looking for as it pertains to recent medical, nursing, pharmacy summaries." 14. Request for a list of families/LARs who refuse to authorize psychiatric treatments and/or medication recommendations. Facility response: "There are no families/LARs who refuse to authorize psychiatric treatments and or medication recommendations." 15. Request for description of availability of genetic screening for individuals. Facility response: "No evidence found" 16. List of all meetings and rounds that are typically attended by the psychiatrist, and which categories of staff always attend or might attend 17. List and copy of all forms used by the psychiatrists 18. Examples of forms used to document side effects. 19. Response to request for all policies, protocols, procedures, and guidance that relate to the role of psychiatrists. Facility response: "We are awaiting State Office Psychiatry Policy." 20. Job description of psychiatrists 21. List of all psychiatrists, including board status (i.e., board-certified, board-eligible), status of (a) if employee or contracted; and (b) number of hours working per week. 22. Response to request for example of contract with contracted psychiatrists. No facility response. 23. CVs of all psychiatrists, including any special training such as forensics, disabilities, etc. 24. Psychiatrists' weekly schedule. 25. Response to request for description of relationship with Columbus as relates to providing physician and psychiatrist staffing. No Facility Response 26. Response to request for description of administrative support offered to the psychiatrists (e.g., secretarial, administrative scheduling of psychiatric consultation, etc.). Facility Response: No evidence available. 27. Response to request for a list since January 1, 2010, a list/summary of complaints about psychiatric and medical care made by any party to the facility. Facility Response: No evidence available. 28. Request for the past six months, minutes from the committee that addresses polypharmacy. Facility Response: No Evidence Available. 29. Request for the last 10 newly prescribed psychotropic medications, provide (a) Psychiatric Treatment Review/progress notes documenting the rationale for choosing that medication,

	(b) signed consent form, (c) PBSP, and (d) HRC documentation. Facility Response: None 30. List of individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). 31. Document prepared by BSSLC Psychology Department titled "Psychology Section (C&K) initiatives since 01/2010 DOJ visit." 32. Draft Dental Policy (revised 04-28-2010). 33. Listing of the number of dental patients receiving psychoactive drugs for treatment during 2010. 34. Dental Visit Report – Form for documenting behavioral difficulties reported by dental staff during clinical examination appointment. 35. Brenham SSLC P Nursing Pre Procedure Sedation tracking form. 36. List of individuals provided a dental desensitization program via dental service. 37. List of individuals living at BSSLC who receive medication for both seizures and for psychiatric indications. 38. List of all individuals treated at BSSLC who are prescribed anticonvulsant medications for both epilepsy and psychiatry 39. Active records for individuals #007, #009, #019, #020, #026, #051, # 52, #61, #065, #076, #085, #122, #139, #159, #163, #173 #205, #231, #273, #286, #298, #316, #377, #399, #417, #450, #493, #502, and #543. 40. BSSLC Plan of Improvement (POI), dated 5/17/10 **People Interviewed:** **1.** Victoria Morgan, M.D. (July 28 and July 29, 2010) 2. Gary Johnson , D.D.S. (July 29, 2010) **Meeting Attended/Observations:** 1. PSP Meeting #52, July 29, 2010 2. Unusual Incident Review meeting, July 27, 2010 3. Meeting to discuss dental clinic procedures, for pre-treatment sedation and for desensitization procedures, July 27, 2010.
	Facility Self-Assessment: The Facility reported psychiatry staff are appropriately trained and qualified, which was supported by the findings of the monitoring team. The Facility reported compliance with requirements for participation by psychiatrists in interdisciplinary process; the monitoring team found improvements in interdisciplinary discussion and planning but that these improvements were in early stages. The Facility also reported compliance with requirements for positive behavior support plan development; the monitoring team noted that the process of integration of psychological and psychiatric data was in early stages and that the Facility's proposal for an integrated process existed only in draft form.

	The Facility reported that many other actions were in process. The monitoring team finding agreed with this report. **Based on interviews with staff and review of documents:** The Facility's self-report referred to several ongoing initiatives that will make compliance with the SA possible. Some of these initiatives, for example the examination of the flow of clinical information through the IDT process, were broad evaluations of the manner in which clinical information is obtained and organized. Others were at the stage of development of specific policies and procedures that were in draft form at the time of the visit. The self assessment report helped the monitoring team decide that a broad exploratory meeting with many BSSLC staff members who interact with the dental clinic was needed. That meeting took place on 07/27/10. The meeting helped the monitoring team better understand the less formal procedures that are in place and which provide, for example, some treatments to reduce the need for pre-treatment dental sedation. In several instances, the clarity of the self assessment report facilitated informal discussions between the monitoring team and key BSSLC staff who are leading the initiative toward change. These contacts helped establish that the ongoing work toward change in the area of psychiatry at BSSLC is on track.
	Summary of Monitor's Assessment: The BSSLC Psychiatry Department was staffed with two experienced psychiatrists. The combined caseload of the two psychiatrists was 168 individuals, and their combined level of effort was 1 Full Time Equivalent (FTE). The Facility is actively recruiting for an additional psychiatrist. Reviews of clinical records showed that each individual who had been assigned to a psychiatrist and who was treated with psychotropic medication had undergone a psychiatric assessment. These invariably led to credible psychiatric diagnoses. However, the number of individuals who received non-specific diagnoses from the "not otherwise specified" (NOS) category was high. Problems noted by the monitoring team included the fact that clinicians often did not designate the particular psychiatric symptoms or behavioral characteristics that were the targets of medication treatments. Additionally, there was no formal collection of psychiatric data, with which to track an individual's response to medications. As a result, it was often not possible to determine whether or not particular medication treatments were appropriate. The lack of objective psychiatric data also meant that even though many interdisciplinary meetings took place, meaningful integration of information from the key disciplines was not possible. This adversely effected the functioning of the interdisciplinary team process. Review of clinical records also showed that required clinical elements, such as PST considerations of treatment options and alternatives, risk/benefit analyses of treatment options, and outlines of plans for the use of medication, were either poorly documented or absent. In the area of dental pre-treatment sedation, informal procedures were described for the monitoring team, but these procedures were not formalized. Several evaluations that had been mandated by the SA, such as the use of the REISS Screen, and the mandated format for psychiatric evaluations, had either been postponed or were only partially in place. Facility-wide monitoring of psychiatric data, which were required under provisions J11, J12, J14, and

	which would be wise to do under provision J15, were not in place. At the time of the monitoring team's visit, the Psychology and Psychiatry Departments were evaluating several possible improvements in both work flow and documentation. Documents reviewed included a memo which provided a broad outline for the establishment of medication treatment plans, and proposed procedures for the future integration of pharmacological and behavioral treatments. One of the proposed procedures would direct the manner in which PSTs organized and documented consideration of various treatment options and their relative risks and benefits. At the time of the visit of the monitoring team, the Facility had already modified and improved the template used by professional staff as they prepared for and then documented the results of PTR meetings. The staff psychiatrist had joined meetings of the PBSC committee and began to attend neurology clinic appointments for individuals jointly supported by herself and the neurologist. These steps helped to integrate psychiatric, psychological and neurological care. These and related undertakings were positive steps toward the meeting the requirements of the Settlement Agreement.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	There were no changes in the psychiatric staff at BSSLC since the baseline visit of the monitoring team in January 2010. The two psychiatrists for the Facility remained Victoria Morgan, MD, and Reeba Chacko, MD. The credentials of the two psychiatrists were reviewed, and both psychiatrists remain fully qualified for the positions at BSSLC. Dr. Morgan was employed by the Facility as a staff psychiatrist on an 80% basis. Dr. Chacko was employed by the Facility as a contract psychiatrist on a 20% basis. The combined psychiatric staffing for BSSLC was 1.0 FTE psychiatrist. However, the Facility is approved for a staffing level of 2.0 FTE psychiatrists. The Facility reported that it had a posting for a full time psychiatrist, but it reported it had received no inquiries about the position, from qualified applicants. Nevertheless, although psychiatrists currently in place are qualified, the monitoring team would like to point out actions the psychiatrists should take. First, as reported in Provision J5, additional psychiatric resource is needed. Second, as documented in Provision J8 below, psychiatry participation in the PSP process needs to improve to ensure the qualified psychiatric staff participate in and provide their expertise for integrated decision-making. Finally, pPsychiatric contributions toward facility wide monitoring of psychiatric issues was reviewed. Psychiatrists did not participate in either facility wide monitoring of psychopharmacology/polypharmacy practices, or facility wide response to findings on side effects monitoring tools such as DISCUS. This was acknowledged by the Facility, in the self assessment for the POI. The absence could be understood to be a consequence of	C

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		the psychiatric staffing shortage, and the need to prioritize psychiatric direct care services for the individuals who live at BSSLC. See also assessment of status for provisions J11 and J12, J13 and J14.	
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.	In order to assess compliance with the various provisions of the psychiatry section of the SA, a core reference group of 25 individuals was selected. Membership in the group was determined as follows: Seven of the individuals were those identified by Facility, in response to document request item VIII 13. This group of individuals was selected, so that in addition to the current analysis, an additional in-depth analysis of clinical integration between psychology and psychiatry could also be undertaken. The individuals in question were #019, #065, #076, #085, #159, #205, and #316. Four additional clinical records were individuals who had been recently admitted to the Facility. The inclusion of those individuals allowed the monitoring team an opportunity to track current practices at BSSLC. The individuals in question were #417, #139, #399, and #377. Fourteen additional records were selected randomly, in the following manner: The monitoring team had requested a list of individuals who lived at BSSLC, which included the psychotropic medication the individuals were given. The printout that was received provided a separate alphabetical list for each of the Facility's seven main housing areas. The first two names on each of the seven lists were selected for the core reference group. These were individuals #007, #009, #020, #026, #051, #163, #173, #231, #273. #286, #298, #450, #502, and #543. In addition to the core reference group, a number of additional records were also examined in detail. These were selected during the visit of the monitoring team, according to particular circumstances. For example, several clinical records were reviewed due to the fact that the individual's PSP meeting took place during the visit of the monitoring team, and members of the monitoring team had attended the PSP. Individuals reviewed were #52, #61, #122, #173, and #493. These individuals were not added to the core reference group, To examine the status of the Facility's compliance with provision J2, the clinical records of the 25 individuals in the core reference group were first reviewed for evidence that each individual had undergone a clinical psychiatric evaluation, and that the resulting psychiatric diagnoses were credible. The clinical records of each individual met the two criteria. The clinical records were then reviewed to examine the particular clinical diagnoses assigned to those individuals. Those clinical diagnoses obviously varied. As a general matter, however, the group included a large number of individuals who were diagnosed with DSM IV Axis I diagnoses that fell in the cluster of "not otherwise specified" (NOS) disorders. This was deemed important, since these are diagnoses for which very little diagnostic specificity is required: Individuals are typically diagnosed with NOS disorders when there is some evidence of a broad area of clinical concern, but when the individual does not meet the requirements to for related but more specific DSM	N

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		IV codified disorders. Assignment of NOS codes is sometime necessary, but the lack of diagnostic specificity of these disorders means that the diagnosis alone says relatively little about the individual. Many individuals had more than one Axis I clinical diagnosis. In typical clinical practice, the most important diagnosis is listed first, and is referred to as the primary diagnosis. Even after pervasive developmental disorder (PDD) was excluded from the count, eight of individuals in the core reference group, were diagnosed with an NOS disorder, and for seven of the eight individuals, that disorder was the primary clinical diagnosis. PDD was excluded from the second counting, since its use may have been unavoidable. To provide a broader perspective on the use of NOS disorders, the frequency with which such diagnoses were used throughout the Facility was examined. Facility software did not allow a printout of either the names or the numbers of individuals diagnosed with specific disorders. However, a printout was available, that provided the names of all individuals living at BSSLC, and where applicable, that list also contained the individual's psychiatric diagnoses. The facility-wide list was examined and NOS disorders were counted manually. There were 220 individuals who lived at BSSLC who were diagnosed with DSM Axis 1 disorders. 37 individuals were diagnosed with PDD NOS; 12 individuals were diagnosed with a Psychotic Disorder NOS; 18 individuals were diagnosed with Bipolar Disorder NOS; 11 individuals were diagnosed with Disruptive Behavior NOS; 11 individuals were diagnosed with Anxiety Disorder NOS; 11 individuals were diagnosed with Mood Disorder or Depression NOS; 6 individuals were diagnosed with impulse Disorder NOS; and 4 individuals were diagnosed with Attention Deficit NOS. Additionally, 10 individuals were diagnosed with Intermittent Explosive Disorder, also a relative non-specific diagnosis. A rough measure of the use of non specific disorders at BSSLC is the fact that for 45 individuals diagnosed with an Axis I disorder (20% of the total number of individuals diagnosed with psychiatric disorders), the primary clinical diagnosis was a non specific disorder, even after the exclusion of PDD, The monitoring team acknowledges that manual counts are always subject to the possibility of counting errors. Future data entry of information of individuals psychiatric data, including diagnosis, in a database form that would allow flexible printout, would likely be useful not only for the monitors, but more importantly, for facility wide monitoring of psychiatric information that is required by the Settlement Agreement (see assessment of status reports for provisions J1, J11, and J12) BSSLC has not yet implemented the examination required by Appendix B. When that is done, any diagnostic reevaluations that will be done will also be opportunities to establish the particular symptoms or behavioral characteristic of an individual that could be the best focus for psychiatric treatment monitoring. Whenever possible, "NOS" diagnoses should be replaced with more specific diagnoses. If the individual does not	

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		meet relevant criteria for any appropriate specific diagnoses which properly describe the behaviors of concern, the specific reason that an "NOS" diagnosis was retained should be made explicit. Such clarifications would also help establish exactly which clinical symptoms/ behavioral characteristic should be tracked, for treatment response .. In addition, tools from psychology such as the Diagnostic Assessment for Severely Handicapped individuals (DASH II) and the Assessment for Dual Diagnosis (ADD), amongst others, can be used for both evaluation and treatment monitoring. Additionally, diagnostic reevaluations could present an opportunity for colleagues from psychology to both contribute to the evaluation process and to provide opinions as to whether or not particular subscales or items of such tools are likely to be sensitive measures of an individual's clinical state, and thus suitable for treatment monitoring purposes (see related discussion in other sections, including J3). There are, of course competing priorities for early use of detailed evaluation procedures. Initial deployment should be with individuals being admitted to the Facility. Other priorities, however, could include individuals newly prescribed with medications, and individuals with non specific diagnoses.	
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.	The records of all 25 individuals in the core reference group were reviewed, in order to ascertain compliance with provision J3. First, there was a need to ascertain that psychotropic medications were being used appropriately, and not being used for prohibited purposes – in the absence of a treatment program, for the convenience of staff, or as punishment. Review of the clinical records demonstrated that all 25 individuals had treatment programs. Routine monitoring of medications was present per Health Care Guidelines. Labs were reviewed in PTRs and APTRs, and QDRRs reviewed use of benzodiazapines, anticholinergics and polypharmacy, with a focus on risk. Side effects were also monitored with side effect rating scales, per provision J12. Several additional charts were reviewed, for individuals who were administered psychotropic medications on an emergency basis (chemical restraints). Individuals reviewed were #173 (regarding events of 05/17/10), #61 (regarding events of 05/25/10), #493 (regarding events of 06/13/10) and individual # 205 (regarding events of 12/12/09). Documentation reviewed included restraint checklists, face-to-fact assessments, debriefing forms and the review forms used for crisis intervention. Nurses provided physical assessments for safety, and documented individual's vital signs, as required. All four individuals had treatment programs. In the cases of individuals #61, #173 and #493, the medication administered was lorazepam, a benzodiazepine sedative with a short half-life. In the case of individual #205, the medication used was meperidine, an agent not commonly used for acute agitation. In none of the combined group of four individuals was there evidence that medications were used as punishment or for convenience. The choice of medications used for chemical restraints will be reviewed with Facility physicians during the next visit of the	N

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		monitoring team. Second, there was a need to establish that each individual had a psychiatric evaluation and diagnosis, and that the choice of medication met generally accepted indications for use of the medication, in the setting of the particular diagnosis and symptoms. At the time of the monitoring team's visit, the Facility did not have the kind of medication plan that was described by SA provision 13 that prospectively identified why the medicine was selected and what was expected from it Each clinical record was examined and available clinical information reviewed, to compare the linkage between prescribed medications and diagnoses. In two cases, those of individuals #019 and individual #020, there clearly was such a linkage In the case of individual #019 the diagnosis of dementia was anticipated on the basis of his treatment with the cholinesterase inhibitors memantine and donepezil. This was the case, since these medications are used exclusively for individuals with dementia. Individual # 020 was treated with atomoxetine. Here again, that fact that atomexetine is used only for attention deficit made the linkage straightforward, and individual # 020 was diagnosed with a disorder of attention. But even with these two individuals, there were other medications and diagnoses, and those could not be easily linked. Additional efforts to link medications with diagnoses were less successful. For example, Lithium is often used to treat bipolar disorder. But it also can be used for other indications, such as mood lability. In the case of individual #139 it was used in symptoms of autism, not a mood disorder. The sample also contained individuals who were diagnosed with Bipolar I disorder – for example individual #205, and that individual was not treated with lithium. Similarly, SSRI medications are commonly associated with treatment of mood disorders. Individuals #316 and #399 were diagnosed with mood disorders and were treated with SSRIs. But individual # 273 was treated with sertraline and the individual's diagnosis was disruptive behavior disorder. Individual #076 was treated with escitalopram, and that individual's diagnosis was autism. In other examples, individuals #399 and #051 were treated with naltrexone. Naltrexone is used in the setting of individuals with dual diagnoses of intellectual disabilities and mental health almost exclusively for self injury – elsewhere it could have been in the setting of opioid addiction – and indeed both individuals had self injury. But with a single exception (movement disorder with self injury) self injury is treated by the DSM IV as a symptom, not a diagnosis. Indeed, the diagnosis of individual #399 was mood disorder and oppositional defiant disorder, and the diagnosis of individual #051 was disruptive behavior disorder and autism. Neither diagnosis could have been predicted on the basis of the medication, or vice versa. In short, the fact that an individual had a credible psychiatric diagnosis was not sufficient to provide a meaningful understanding of the manner in which the medication was used. To understand the use of the medication, the	

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		specific psychiatric symptoms/behavioral characteristics that are targeted by the medication must be specified. To further examine the use of the psychotropic medication, clinical records were examined to see whether a clear rationale was provided which explained the use of the medication, and whether the decisions related to the medications were data-based. In general, clinical charting notes by the psychiatrist and psychologists gave suggestions as to the intended use of medicines. But this information was often at variance with information provided in documents such as informed consent forms provided to families and other legally authorized representatives or with information reviewed by the Behavior Review and Human Rights Committees. For example, individual #205 was diagnosed with bipolar disorder. Medication consent forms for divalproex and quetiapine, dated 10/13/09, state that he took those medicines "to reduce/eliminate challenging behaviors of "physical aggression, self injurious behavior, verbal aggression, and inappropriate touch" related to bipolar disorder. Per the consent forms zolpidem was prescribed for sleep disturbance related to primary insomnia (a diagnosis not mentioned elsewhere), and lorazepam was prescribed for sleep disturbance related to bipolar disorder. Hydroxyzine was described as a treatment for self injurious behavior and the itching associated with agitation related to bipolar disorder. The Human Rights Committee (HRC) review form (undated, but together with other forms from 10/29/2009) joined divalproex, quetiapine, zolpidem, lorazepam and hydroxyzine together as "medications for bipolar disorder." But elsewhere in a PTR notation from 05/19/2010, the psychiatrist stated that lorazepam and hydroxyzine were prescribed for anxiety A separate but related question was whether continued use of a medicine was warranted. Obviously, one could have a reasonable reason/hypotheses upon which a medicine might be started, but it might not be reasonable to continue the medicine if it was ineffective. The reason/rationale for continued use could come only from response data. Individual # 205 did have some behavioral tracking, for aggression, self injury, inappropriate sexuality and sleep disturbance (these were listed in the Behavior Master Report and elsewhere). These were indeed very challenging behaviors, but they were very indirect measures for his manic depressive illness. Elsewhere in his chart, there was an excellent description of his psychiatric symptoms: "When he is experiencing a manic phase the following symptoms can be seen. Hyperactivity, loud, rapid speech, distractibility, inability to focus on activities, euphoria, excessive masturbation, intrusive behavior, urinating on self, rubbing or scratching self	

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		(often resulting in increased injuries) and lack of sleep. During the depression cycles these symptoms are seen: Difficulty in getting up and down, difficulty walking, lethargy, difficulty in waking him, seldom talking, drooling, difficulty sitting up straight, fatigue, decreased verbalizations and an appearance of being generally depressed. (Annual Behavioral Services Review, 10/13/2009)." The above detailed descriptions were consistent with the psychiatry notes. For example, in the PTR note of 03/02/10 the psychiatrist noted "the bipolar disorder is brittle, and he swings from mania to depression." It is reasonable, of course, to ask whether one could assess the status of the bipolar disorder from the behavioral data that <u>was</u> reported. The answer to that is that to some extent one could have learned something from that data: For example, one could reasonably deduce from his sleep data whether he is manic or depressed. However, sleep is only one symptom, and it could not alone substitute for the many other symptoms of depression and mania. Individual #065 was diagnosed with autism and bipolar disorder. That individual was treated with buspirone and alprazolam, for behaviors of self injurious behavior, problematic departure, and emotional outbursts. The connection between the symptoms and diagnoses was plausible, but not obvious. In a PTR note from 3/30/2010, the psychiatrist was clear that the reason the medicines were used was to treat anxiety. But there was no data collection for anxiety. In another case, individual #076 was treated with escitalopram. In the case of that individual, the consent form dated 11-20-09 directed that the use of the medicine was "to eliminate challenging behaviors of sleep (sic)." But in the PTR document from 02/17/10 the target behavioral symptom for escitalopram was listed as aggression, and in the PTR document of 04/20/10 the target behavioral symptom was listed as both aggression and self injurious behavior. On the basis the charts reviewed, the monitoring team could often not determine whether or not (continued) psychotropic medication use was appropriate. As outlined in other sections of the report, an effort will be needed to provide (when possible) more specific diagnoses, clearer prospective delineation of psychiatric symptoms/behavioral characteristics which will be the targets of treatment , and medication plans that will outline the specifics for the use and assessment of the medications (see also sections J2, J8, J9and J13).	
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	<u>1. Desensitization procedure for individuals who experience behavioral difficulty in the dental clinic</u> The procedure in place for initiating a desensitization procedure for individuals who experience behavioral difficulty in the dental clinic was reviewed by staff from the dental clinic. The first step was that the dental staff filled out a form labeled "Dental Clinic	N

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	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.	Report" whenever an individual experienced difficulties in the clinic. This form had three sections. The first is "Behaviors Exhibited" which listed a variety of difficulties ranging from refusal to come into the clinic, to holding lips and teeth tight, to verbal abuse and various forms of physical aggression. A second section described the behavior sequence, and the third documented whether or not the difficulty subsided. If the dental staff assessed that an intervention was needed, they then contacted the QMRP for the individual, who scheduled a special meeting of the PST to discuss next steps. The result of that meeting could result in a determination by the QMRP and PST that the individual should have informal visit to the clinic to allow the individual to become more familiar with the clinic. Alternatively, the QMRP and IDT could make a referral to one of the health care professionals. Dental clinic and other staff explained that the details of the arrangements made were included in the PSP for the individual. The procedures that were presented were said to be informal, but known to BSSLC staff. The plans of several individuals who were referred for desensitization protocols were forwarded to the monitoring team and were reviewed: For individual #465, a PSP addendum dated 4/15/10 identified the individual's difficulty tolerate touch, and presented that the individual had needed sedation for several recent appointments as a result. The PSP Addendum outlined a plan to desensitize touch, with the hope that the need for sedation would be lessened. The program consisted of efforts by direct care staff to encourage the individual to tolerate washcloth touch, for time periods as short as 5 seconds. The program started on 4-22-10, and documentation was provided of daily efforts, and the level of assistance needed, to assist the individual to accept touch, for April, May and June, 2010. For individual #49, a PSP dated 02/09/10 was reviewed. The PSP included a plan for the individual to be able remain in the dental chair for familiarization, in order to lessen the individual's difficulty attending dental visits. The objective was for the individual to be able to remain seated in the dental chair for 20 seconds, for 3 sessions weekly, for 2 consecutive months. Tracking forms for May and July 2010 were provided and reviewed. These documented his response to the treatments For individual #259, a plan for dental desensitization dated 04/30/10 was reviewed. The plan stated that a dental hygienist would visit the individual at the program services location, and that the hygienist would talk with the individual about going to the dental office. Documentation from May and June was reviewed. This documented the gentle encouragement provided by the hygienist. For individual #065, details of the desensitization plan were located in the PSP. The PSP	

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		described steps to be taken by the dental hygienist. For example in step (1) (the individual would remain in the company of the dental hygienist for 10 seconds for three sessions a month, for two consecutive months. In step 2, the individual would remain in the company of the dental hygienist for 15 seconds, for three sessions a month, for two consecutive months. In step 3, the individual would remain in the company of the hygienist for 20 seconds, for three sessions per month for two consecutive months. Per the POI/self assessment, a Facility Policy and Procedure for strategies to minimize or eliminate the need for pre-treatment sedation, and those are in process and awaiting approval from the PPC. I sum the monitoring team appreciated the information provided above, but will need either a copy of the relevant procedure or a written description outlined the steps of the evaluation process and the manner in which they are documented This will enable substantive future reviews of the process of development and utilization of desensitization programs. <u>2. Dental pre-treatment sedation</u> As per the POI/self assessment, the facility acknowledged that medical and pharmacy supports for pre-treatment sedation were not in place. A Draft Dental Policy (revised 04-28-2010) was provided by dental staff, during the visit Operating procedures that were in place were reviewed. In particular the monitoring team was interested in provisions for the assurance of for safety during dental procedures, when pretreatment sedation was deemed necessary. During the meeting held on 07/27/09, monitors were informed that once a determination was made that a pretreatment sedation was, needed, the dental staff and the QMRP arranged for consent to be obtained from the individual's guardian/LAR. No medication was administered before that consent was obtained. Once consent was obtained and an appointment was scheduled, the primary care physician was consulted and appropriate medication orders were written. Medications chosen were selected by the PCP. Lorazepam was commonly used for oral medication, and when necessary intramuscular meperedine was used. When intramuscular medications were given, they were typically administered two hours prior to the scheduled procedure, and they were given on the residential unit. A nurse remained with the client and provided q 15 minute checks. The administration of the medication and post administration medical monitoring were guided by the nursing pre and post procedure sedation forms which consisted of monitoring for vital signs and documentation of the level of sedation/arousal. The individual was transported to the clinic close to the time of the planned procedure. If the individual was too sedated to walk safely, he/she was transported in a wheelchair. There was no nurse in the dental clinic, but the dental clinic was located in the general health building and nurses were	

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		available to assist if needed. Dental clinic staff provided information on the frequency with which pre-treatment sedation was used during the first six months of 2010. This information was as follows:	

	# of clinic appts:	% receiving pre-treatment sedation	# of individuals receiving TIVA
01/10	191	3	0
02/10	195	1	8
03/10	215	6	3
04/10	177	5	6
05/10	127	2	5
06/10	201	9	7

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J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	Per the POI and self assessment of the Facility, approved staffing was for two FTE psychiatrists. That level of staffing would allow clinical caseload of 60 individuals per FTE, which consistent with staffing at other DADS facilities. The current staffing provides one FTE for 116 individuals. The facility reported that it had posted the position for a full time psychiatrist.	N
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	Provision J6 required BSSLC to provide individuals with psychiatric assessments that were based on current, accurate and complete clinical data. All available psychiatric assessments were examined, for each of the 25 individuals in the core reference group. All individuals had at least one psychiatric examination. The format of the exam varied considerably, and was found under various names. These included "*Psychiatric Consultation"* (for example individual # 502, on 06/03/09) and "*Behavior Therapy Review and Psychiatric Consultation*" (for example, Individual #009 on 03/04/09). The monitoring team found that the quality of psychiatric practices reflected in the documents was consistently sound. This was the case even for examinations done at a time when psychiatric staffing for the facility was 0.2 FTE for the entire facility. For example, individual # 163 was admitted to BSSLC in 2002. The individual's initial Psychiatric Assessment ("Behavior Therapy Review and Psychiatric Consultation") was done within weeks of admission, on 07-31-02. It consisted of two pages of detailed	N

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		information. The document included a paragraph of the history of present illness. It reviewed (then) recent events. It briefly reviewed the individual's childhood history and circumstances of his admission to the State Hospital System some 20 years earlier. The document reviewed past psychiatric history, it reviewed the individual's medical history and allergies, and it contained a paragraph long mental status exam, and it provided a credible diagnosis. The psychiatrist outlined a careful plan regarding the continuation of the five psychotropic medications with which the individual was treated at the time of his transfer from another facility to BSSLC. Overall, examination of the records revealed that competent clinical practices regarding psychiatric evaluations have been in place for many years at BSSLC. This not withstanding, the evaluations that were reviewed do not answer to the level of detail that is outlined in Appendix B of the SA The Facility clarified that as of 07/01/10, the Appendix B format was not in use as the Facility was awaiting SO release of the psychiatry policy. The Facility is encouraged to begin implementation as soon as possible.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	Review of the records of the 25 individuals in the core review group showed the in each case there was a psychiatric assessment and clinical diagnosis. Findings of the monitoring team on the psychiatric assessments in place at the Facility are detailed in the preceding sections for provisions J2 and J6. In the self assessment, the Facility reported that the Reiss screen was in use for all new admissions. Reiss screen results for four new admissions were requested. These were for individuals 139, #377, #399, and # 417. The Reiss Screen on these individuals could not be located. Per the POI, the Facility has not yet completed Reiss Screens for of individuals who lived at BSSLC and who did not have a psychiatric assessment.	N

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J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Psychiatry participation in the interdisciplinary (PST) process was reviewed. BSSLC psychiatrists participated in IDT processes via participation in Personal Support Team (PST) and Psychotropic Treatment Reviews (PTR) and by participation in Medical Staff Debriefings. Psychiatrists also prepared Annual Psychiatric Medication Reviews (APMR), and text from that summary was used by colleagues from other disciplines, for example in Personal Support Plans (PSP). Contributions from psychiatry to the PSP process were reviewed for two individuals, #52 and #122. These two individuals had their annual PSP meeting during the visit of the monitoring team. Documents reviewed for each individual included the 2009 PSP, PTRs, psychiatric notes, APMRs, various PST records, and general pharmacy and health records. Individual #52 was treated with the psychotropic medications guanfacine, olanzapine, carbamazepine and lisdexamfetamine. PTRs for the individual contained descriptions of both pharmacological and non-pharmacological psychiatric interventions. Examples of non pharmacological interventions included recommendations for a communication book (mentioned in the psychiatrist report of 06/16/10), discussions of efforts to encourage behavioral redirection (mentioned in the PTR of 12/2/09), and rating scale monitoring for hyperactive behavior (mentioned in a psychiatric report of 06/16/10). However, psychiatric information in the 2009 PSP was limited to general instructions, for example a statement that the individual should continue to have monthly reviews with the psychiatrist, and a statement that the individual would need to be provided with psychiatric consultations at least quarterly, due to his use of psychotropic medications. Discussion on the role of the individual's medications in the pharmacy section of the PSP was limited to a list of the names of the medications and the listed Diagnostic and Statistical Manual IV (DSM IV) diagnoses. Review of updates to the 2009 PSP that contained psychiatric information demonstrated only a PSP addendum dated 03/05/10, which mentioned the addition of carbamazepine, to decrease the number of episodes of aggression. Members of the monitoring team attended the annual PSP meeting for the individual on 07/29/10, and the psychiatric issues identified above received no attention. Individual#122 was treated with olanzapine. The clinical chart for the individual described details of the behavioral characteristics of the individual's psychiatric disorder, for example that she might accuse the empty chair next to her of taking things. Her behavioral tracking was for verbal aggression and delusional statements. In the case of that individual as well, PSP references were general and uninformative. Overall, in the opinion of the monitoring team, both individuals had psychiatric disorders which significantly impaired the day to day functioning of the individual, and for which more specific comments about habilitation would have been helpful. In neither case were	N

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		such comments present in the PSP. Clinical records of individual from the core review group were reviewed, in order to determine whether or not there was evidence of integrated pharmacological and behavioral care, through combined assessment and case formulation. The records showed that there is a close working relationship between the Psychiatry and Psychology Departments at BSSLC. The collaboration between the two departments was most evident in the structure of the PTR. At that meeting the psychologist provided the psychiatrist with behavioral tracking data, including graphs of behavioral data for the preceding period. Additional information was provided, including information regarding whether or not any form of restraint had been used. More general descriptions were also provided by the psychologist, regarding additional events in the individual's life that had occurred during the preceding period. Presentations were also made by the QMRP and RN, who reviewed information on side effects and general medical issues. Quarterly Drug Regimen Review (QDRR) information review provided information from the pharmacy, and general discussion followed. The psychiatrist then dictated a note which documented her understanding of the individual's status at that time, and the psychiatrist then outlined the psychiatric treatment decisions for the period to follow. Additional chart documentation also showed that the psychiatrist interacted at other times with colleagues from the medical staff. The process outlined above was compared to the requirements of provision J8 regarding needed integrate of pharmacological treatments with behavioral and other interventions, through combined case analysis and case formulation. The chart reviews, supplemented by the interview with the staff psychiatrist demonstrated that there was evidence of collaboration across disciplines, that behavioral data was considered in decisions regarding pharmacological treatments, and that nurses participated in the process of collaboration. In short, it was clear that considerable amounts of information were brought to the PTR meetings, by member of different disciplines. However, the resulting discussion did not always provide coordinated care. This was particularly true when psychiatric illness occurred in conjunction with maladaptive behaviors. The reason for this was that the data presented to the psychiatrist, most notably in the graphs of behavioral data, typically consisted solely of information on target behaviors that had already been established by the psychology group, and for the purposes of their behavioral interventions. This data did not include information relevant to the psychiatric illness at hand. The net result of this situation was that the psychiatrists were placed in an impossible situation: Since data relevant to psychiatry had not been collected, if the psychiatrist wanted to rely on documented data to support treatment, she necessarily had to rely on the data that	

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		was collected as part of the behavioral treatment plan. More often than not, that data related to aggression: 18 of the 25 individuals had either verbal or physical aggression identified as targets of their behavioral treatment programs (the individuals who did not have aggression as behavioral targets were individuals #007, #231, #51, #20, #159, and #065. Individual #37 was newly admitted and his target behaviors were yet not included in the master list. Under those constraints, it was impossible to demonstrate that the medications were used for legitimate psychiatric purposes, and not merely for behavioral control. Of course, irritability and its consequences can be the result of psychopathology, too: In a series of classic papers and presentations, the late Robert Sovner highlighted this matter, by pointing out that there are 15 DSM IV defined disorders in which irritability is either a diagnostic or associated feature. But each of these disorders also had has other features that made more focused psychiatric monitoring possible. Tracking for features associated with the psychiatric diagnosis and symptoms is needed at BSSLC, in order to establish that medications are being provided for the treatment of specified psychiatric disorders. There were of course cases when the psychiatrist did go beyond the psychologist's target behavior and designated different symptoms as the proper targets for medication treatment. But these new targets were not accompanied by collection of relevant data. In addition, no effort were made to correct or update prior – and sometime ongoing – documents describing the individual's treatment, and the result was inconsistent and sometimes contradicting chart notations. An example of the resulting difficulties was evident in the case of individual #009, who was diagnosed with bipolar disorder. According to the consent forms signed on 03/24/2010, the individual was prescribed ziprasidone, topiramate, olazapine and divalproex, for the behaviors of self injury and aggression. However, the PTR of 05/12/10 indicated that the client was prescribed ziprasidone for depression, for which there was no data collection. During the same PTR, olanzapine was linked to aggression, but not to self injury. Also at the same PTR, divalproex and topiramate were no longer associated with the diagnosis of bipolar disorder. Instead, those medications were linked to the diagnosis of post traumatic stress, and the psychiatrist suggested that medications could be assessed via measures of irritability, anger and regression (baby talk). But information on irritability and anger could be at best estimated from measures of aggression, and there was simply no data collection related to regression/baby talk. Another example was that of individual #085, diagnosed with bipolar disorder and treated with various medications including alprazolam (xanax). The consent form for the individual indicated that alprazolam was used for self injurious behavior, agitation and aggression. In the PTR note of 01/07/10, however, the psychiatrist stated that most of	

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		the individual's behaviors were driven either by pain, (to be addressed by the individual's PCP), or by anxiety. Similar references to the use of alprazolam for anxiety were made in the PTR of 02-04-10. However, there was no data collection for measures of anxiety. During the Monitoring Team's visit, issues related to the needed integration between psychology and psychiatry were discussed with the Staff Psychiatrist. The conversation was very productive, and it included the need for psychology to participate more fully in case formulations and the need for psychology and psychiatry to collaborate to assure collection of behavioral data needed for psychiatry. In the meeting, the Staff Psychiatrist reviewed newly proposed procedures, developed by the Psychology Department for the purpose of for integrating Behavior Support Plans and Psychotropic Drug Reviews. In particular, the draft defined the role of psychologist in the process. According to the proposed procedure, "(*The) psychologist leads the discussion and is the person who is to ensure that the Team operationally defines the symptoms/problem and approved clinical methods of observing and collecting behavioral baseline data (including the Reiss Screen)."* The proposed procedures also defined the role of other PST member as follows: "The physician and/or nurse medically examines the consumer and documents the results to determine or rule out medical causes of the symptoms/problem behaviors (e.g. constipation, ear nose, throat or other common illnesses or medical or dental problems known to contribute to self injury or aggression, possible side-effects.)" Further, "The social worker and psychologist assess for any negative environmental and social conditions such as crowding, excessive noise, roommate changes, family visits/changes, job losses loss of a friend, etc." In summary, while the Monitoring team was not able to state that at the time of the visit that pharmacological treatments were integrated with behavioral and other interventions. It did appear that the Psychology and Psychiatry Departments were working closely together, to develop procedures needed to achieve the integration and combined case analysis that was required by provision J8.	
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,	Review of the clinical records of the core reference group demonstrated that all 25 individuals reviewed had Behavior Support Plans. Review of PTRs and other documents demonstrated that there was PST discussion in which the psychiatrist participated. The process by which the PST determined the least intrusive and the most positive interventions to treat the behavioral or psychiatric condition could not be identified in many of the records; Similarly, the determination of whether the individual was best	N

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	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.	served primarily through behavioral pharmacological or other interventions, in combination or alone, could not be located in many charts. However, it did appear that the newly proposed procedures intended to address many of these issues, as follows: "*Once the assessments (described in J8 above) have occurred, the QDDP calls the Person Centered Team to reconvene to review the medical and environmental causes that have been ruled out (and) to review the results of the Reiss Screen and behavioral baselines of symptoms/problem behavior that have been collected. At this time the PCT (PST?), including the psychiatrist, reviews all assessments and decides if positive behavior support alone or in combination with psychotropic medication treatment is warranted. The QDDP documents the decision. The psychiatrist makes the decision on medication changes, but only after a full collaborative Teams discussion takes place*. Overall, the Monitoring team found that many of the requirements of provision J9 were not in place at the time of the visit. Nonetheless, it appeared to the Monitoring team that the Psychology and Psychiatry Departments were aware of these process deficiencies and were in the process of considering way to address the requirements outlined by provision J9.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	The clinical charts for the 25 individuals in the core reference group were examined, to determine compliance with provision J10. Since the required discussions of risk vs. benefit and possible alternative treatments rests of knowledge of what the risks and benefits are, the charts were first examined to see what information was listed for risks and benefits or the medication treatments that had been selected for each individual. Information on side effects was found in the charts in several places. It was listed in the informed consent forms that were signed by guardians/LARs. Information on side effects was also included in the deliberations of the treatment team at the PTRs and in the APMR's of the psychiatrists. Side effect information was also reviewed during the deliberations of the PBSC and HRC reviews, and also pharmacy's QDRR notes. All the charts that were reviewed contained side effect information. However the information presented in each chart location varied somewhat. The most detailed listing of side effects came from the informed consent section of the record. The form itself referred to WORx, a detailed pharmacy reference. Along with the references on the form, guardians/LARs were sent a copy of the relevant pages from the text. In contrast, presentations to the committees regarding side effects were more selective. The psychiatrist's notes typically presented the information that was most tailored to the individual's particular circumstances.	N

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		For example, individual #298 was medicated with olanzapine and lorazepam. Possible lorazepam side effects were listed with the consent form that was signed by the guardian, on 7/20/10. The pharmacy printout listed drowsiness, dizziness, loss of coordination, headache, nausea, blurred vision, change in sexual interest/ability, hair loss, constipation, heartburn, and change in appetite. The committee forms listed drowsiness, lack of coordination and dry mouth. In the APMR of 07/19/10, the psychiatrist listed sedation, dizziness, ataxia, and depression. The committee listed the risks of not taking the medicine as "continued agitation and hyperactivity, leading to increased challenging behaviors, quality of life, and programming." The psychiatrist mentioned the benefit of reduced anxiety, but does not mention hyperactivity. For olanzapine, the committee listed possible side effects as including stomach pain, dizziness and dry mouth. The psychiatrist listed somnolesence, urinary incontinence, constipation, weight gain, elevated blood sugars, abnormal lipids, elevated prolactin levels, muscle stiffness and abnormal involuntary movements including tardive dyskinesia. The WORx list of side effects for olanzapine was not provided. The risks of not taking olanzapine were listed by the committees as "increasing challenging behaviors, interference with (the individual's) day programming, sleep disturbance, and symptoms of (the) bipolar disorder." The psychiatrist states that the treatment would likely improve quality of life and reduce the risk of aggression and self injury. All the information presented was correct, but it varied, as it did in most charts. At times, the fact that different information was presented by the different sources led to different presentation of risk and benefit. For example individual #1099 was diagnosed with Disruptive Behavior Disorder, and was treated with the antipsychotic medication Risperdal. At the time of PTR review on 11-25-09, the individual's psychiatrist wrote a detailed clinical note in which she discussed the risks and benefits that were most pertinent to this individual, and she conducted a careful review of how this applied to the individual. The psychiatrist named risks of dyskinesia as a reason for future careful downward titration of the medication dose should be considered, in order to reduce the long term risk. However, side effect information presented to the HRC Committee listed only dizziness, drowsiness and dry mouth, but not dyskinesia This of could have skewed deliberations of risk vs. benefit. The requirement of provision J10 is that the interdisciplinary team conduct a risk/benefit analysis on the basis of the information provided about the medicine and the individual's particular circumstances, and that treatment alternatives should be considered. Discussion of risks and benefits was and alternative was typically included in the psychiatrist's notes for PTR and the APMR, and there was also discussion during PBSC /HRC meetings. However, key members of the interdisciplinary team did not attend the committee meetings, and the PCPs did not attend either the PTRs or the committee	

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		meetings. In the POI for provision J10, the Facility mentioned that an interdisciplinary review process was being developed. It was not clear whether or not this was a reference to the procedures that have been proposed by the Psychology Department for integrating behavior support plans and psychotropic drug therapy (discussed under provision J8), whether it was a reference to proposals for the development of medication treatment plans, (discussed under provision J13), a reference to a newly proposed weekly meeting for key PST team members and the PCP, or something else In summary, several configurations for clinical information flow are possible. Any configuration should place the key documentation regarding issues such as side effect information, risk/benefit analyses, and discussions of treatment alternatives close to the clinical meeting at which those decisions are considered. Success in doing so will increase the quality of the documents, and will allow others to reference that key source without the need for translation and duplication, and will increase the likelihood that the same basic information will be considered in all settings.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The key requirement for this provision was that the facility needed to ensure that the use of polypharmacy was clinically justified, and that medications that were not clinically justified were eliminated. In the POI, the Facility referred to the monthly PTRs and QDRRs as venues for such determinations. The QDRR format included questions that addressed whether or not the individual met agreed-upon criteria for the presence of polypharmacy. These questions were 1. Does this person take 2 or more psychoactive medication with the same drug class? 2. Does this person take 3 or more psychoactive medications? Records for all 25 individuals in the core reference group were examined. These demonstrated that PTRs – and Annual Psychotropic Medication Reviews as well - contained information on the clinical need for polypharmacy. QDRRs contained very useful pharmacy oversight reviews for considerations such as pharmacodynamics and pharmacokinetics, for issues related to drug/drug interactions, for general checks about whether or not side effect screens such as the MOSES and DISCUS, and whether or not critical labs had been drawn, and what the results had been. However, the QDRRs did not, and could not; fulfill the key requirement of this provision – that the polypharmacy in question was justified. The information regarding the need/justification for polypharmacy could ultimately come only from the treating/consulting psychiatrist. The QDRR did track the presence or absence of polypharmacy, as defined by the SA.	N

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		The Facility acknowledged that it did not have the required system to monitor at least monthly prescribing practices that constituted psychiatric polypharmacy. However, the information already contained in the chart could be tapped to yield such reports. When the Facility develops a data based system to determine treatment efficacy, it will be much easier to know when medications are no longer needed or are simply ineffective, so that those medications can be eliminated.	
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.	Clinical records of all 25 individuals in the core review group were reviewed and they showed consistent use of the MOSES and DISCUS, as presented in the Facility self assessment. MOSES and DISCUS form were completed by nurses, and substantive reviews took place during PTRs, which were attended by the nurse who completed the screenings, and the psychiatrist. The format for the psychiatrists' PTR notes included a section of comment on DISCUS and MOSES screenings. Per the self assessment, the facility does not yet have a facility level system for responding to side effects of psychotropic medications.	N
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 psychiatric treatment identified in the treatment plan, as often as	The clinical records of all 25 records of individuals in the core reference group were examined, in order to determine whether or not the Facility was in compliance with the requirements of provision J13 for medication treatment plans. In all cases some elements required by the provision were present. Each of the individuals had an overall behavioral treatment plan, each had a working psychiatric diagnosis, and each was assessed on an ongoing basis by the psychiatrist, at the PTR meetings These took place at least quarterly and also as the need arose. Laboratory monitoring per requirement of the health care guidelines (HCG) was found to be timely and consistent with the requirements. However, many elements required by provision J13were not in place. As discussed elsewhere in this report, a specific rationale for treatment was not always identified, there was no prospective identification of the psychiatric symptoms/behavioral characteristic that would be the targets of medication treatment, and objective psychiatric data to guide the treatment was not collected. The requirement to provide details about the mechanics of treatment monitoring could not be met, since the monitoring system itself was not in place. In order to understand more fully the Facility's current use of psychotropic medications, an informal examination was made to determine how many individuals took psychotropic medications, what percentage of the overall number of individuals living at BSSLC those individuals represented, and what were the medications with which that were treated. In the POI/self assessment, the Facility indicated that Dr. Morgan was	N

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	necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	assigned to provide psychiatric services to 94 individuals and Dr. Chacko was assigned to provide services to 74 individuals. The combined number of individuals receiving psychiatric services was 168. The number of individuals receiving psychotropic medications was initially assessed via examination of the Facility's response to Document Request VII 5, which asked for a list of individuals prescribed psychotropic medications: 112 individuals were named on that list. In response to Document Request VIII 6, the Facility also provided a list of all individuals who had any type of behavioral support list. That list contained the names of 161 individuals who were prescribed psychotropic medications. The longer list contained the names of all 112 individuals on the shorter list, and it included all individuals whose charts were examined/referenced in the psychiatry section of this report. The longer list was used for the various tabulations that follow; it appeared that 43% of individuals living at BSSLC were prescribed with psychotropic medications, and that the psychiatrists' caseload consisted almost entirely of individuals who took psychotropics. The list of 161 individuals receiving psychotropic medications was examined, to determine the relative frequency with which particular medications were used. The printout indicated that 128 individuals, (80% of the total) were prescribed one or more antipsychotic medications. All the medications on the list were from the class of atypical antipsychotics. 68 individuals (42% of the total) were prescribed one or more sedative hypnotics. The combined grouping of sedative and hypnotics included buspirone, benzodiazepines, gaba receptor drugs, clonidine, guanfacine, antihistamines (when prescribed for listed purposes), mirtazapine and trazadone. Hypnotics and sedatives were combined, since benzodiazepines and related gaba receptor agents such as zolpidem and clonazepam were prescribed variably for both sleep and for daytime anxiolysis and efforts to separate about the uses was not successful. .Mirtazapine was included as a hypnotic and not antidepressant, to reflect the charting documentation of its use as a hypnotic. 53 individuals (31% of the total) were prescribed with one or more of the mood stabilizing medications. These medications were lithium and the anticonvulsants valproic acid/divalproex carbamazepine, gabapentin, pregabalin, oxcarbazepine and topiramate, when these were used for behavioral purposes. The monitoring team requested and received a list of individuals for who were treated with anticonvulsants for both epilepsy and for psychiatric indications. There were 12 such individuals. 48 individuals (29% of the total) were prescribed one or antidepressant medications Since no printout was possible for this class of medicines, bupropion and tricyclic, selective serotonin uptake inhibitors (SSRI), serotonin and norepinephrine uptake blockers (SNRI) and tricyclic (except clomipranine)classes of medicine were manually. Other psychotropic medications prescribed for smaller numbers of individuals. These included medications for attention (stimulants, atomoxetine, clonidine and guanficine) and the opiate antagonist naltrexone for self injurious behavior.	

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		In the POI, the Facility acknowledged the need for treatment plans for psychotropic medications. It indicated that such a treatment plan did not yet exist, and that a formal treatment plan was in development. A document prepared by BSSLC Psychology Department titled "Psychology *Section (C&K) initiatives since 01/2010 DOJ visit*" included a copy of a June 18, 2010 memo from Dr. Don Williams, of the Psychology Department. This described plans of the Psychology and Psychiatry Departments, to provide the needed medication treatment plan. The memo indicated that future documentation would include *"...psychiatric symptoms or behavioral definition that will be monitored to assess drug effect (marker behaviors), how and when the monitoring will occur and who will monitor...Current data to support the need for each medication: proposed medication/dosage/rationale; potentially risk of not receiving medications mostly likely risks of not taking the medications , most likely side effect of the medication plan with criteria for changes in the medication if the targets decrease, increase or remain the same."* A few of the requirements listed under provision J13- or example for a time-line for expected treatment effects - is not included in the memo. It was also not clear from the memo whether the medication plan discussed in the memo cited above was, to be part of larger proposal by the Psychology Department, to better integrate function of psychology and psychiatry. That document was described under provision J8. While the development of medication treatment plans appeared to be at an early stage of development, it appeared that the Psychology and Psychiatry Departments were meaningfully engaged in discussion of how to best provide the requirements information. The monitoring team encourages the Facility to choose a format that will consolidate related information items in one document, that can be referenced and updated as needed.	
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	Medication consent forms were obtained annually. The consent form signed by guardian or legally authorized representative contained a section on associated risks. Per the Facility POI/self-assessment, no department specific plans exist to assure that there were no unnecessary delays in treatment resulting from the requirement to obtain consent. No departmental processes were in place to show that proper authorization is obtained in a timely manner in the case of an emergency.	N

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	limitations on the use of the medications or restrictive procedures and shall identify associated risks.		
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.	The staff psychiatrist is now attending scheduled clinics of the consulting neurologist This alone has improved coordination between psychiatry and neurology greatly. However, the contract psychiatrist cannot be expected to do the same, and there is no assurance that future psychiatrists will be able to physically attend the neurology clinic either. For that reason, there remains a need to develop a facility system that will assure coordination of care, and such a system should include more than maintenance of routine consultation notes. For example, the Facility provided the monitoring team with a list of individuals who were treated with anticonvulsant medications for both seizures and for psychiatric symptoms, at the time of the monitoring team's visit. The facility should consider tracking such information on an ongoing basis, perhaps via the database needed for mandated facility wide tracking of psychiatric data. Coordination of neurological and psychiatric care will be reviewed in more depth during coming visits of the monitoring team.	N

Recommendations:

1. The Facility should provide written a description of procedures used, to minimize or eliminate the need for pretreatment sedation (provision J4).
2. The Facility should provide a written description of procedures used, to monitor individuals who receive pre-treatment sedation, for side effects, and for overall safety (provision J4).
3. The Facility should continue to recruit for a qualified FTE psychiatrist to fill the vacant position (provision J5).
4. The Facility should implement the psychiatric assessment format outlined in SA Appendix B, as soon as possible (provision J6). Initial use should be with priority groups such as new admissions (see assessment of status, for provision J2).
5. The Facility should continue development of the proposed (draft) procedures for integrating Behavior Support Plans and Psychotropic Drug Therapy (provision J8).
6. The Facility should continue development of the proposed (draft) procedures for IDT determination of appropriate modalities for the treatment of behavioral difficulties (provision J9), for risk/benefits analyses, and for considerations of alternative treatments (provision J10).
7. The Facility should develop a system for required facility-level reviews for polypharmacy, for side effect screens, for consent (J11 and J12, J14).
8. The Facility should consider the development of a database that could support Facility-wide tracking of psychiatric information per item #7, above. More electively, the database could also include information on individuals' diagnoses, psychotropic medications, and medication plan treatment .objectives.
9. The Facility should continue to develop plans for Psychotropic Medication Plans, (provision J13).
10. The Facility should outline its plans to facilitate communication between the Contract Psychiatrist and the Neurologist, for individuals supported by both professionals (provision J15).

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Documents that were reviewed included the annual PSP, PSP updates, SPOs, PBSPs, treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #3, #4, #7, #9, #9, #11, #12, #12, #15, #19, #35, #38, #41, #51, #53, #55, #75, #83, #95, #185, #206, #281, #321, #327, #358, #390, #403, #427, #467, #471, #474, #514, #539 and #556. 2. Counseling/psychotherapy plans for individuals #3, #9, #11, #38, #206 and #467 3. Examples of "Best Work" by Behavior Services staff were requested. Examples of "Best Work" were reviewed for individuals #4, #12, #15, #281, #321, #358, #403 and #539. 4. BSSLC Plan of Improvement (POI), dated 5/17/10 **People Interviewed:** 1. Terry Hancock, Ph.D. – Chief Psychologist 2. Shawn Cureton, MS – Psychology Manager 3. Kathleen Williamson, MEd – Psychology Manager 4. Mellisa Waters, MBS, BCBA 5. Direct Care Professionals (Bowie - A, Bowie - B, Bowie - C, Childress - A, Childress - B, Cottage - A, Cottage - B, Cottage - C, Cottage - D, Cottage - F, Cottage - G, Driscoll - C, Driscoll - D, Fannin - B, Fannin - C, Fannin – D, on-campus vocational sites, off-campus workshop and Blue Bell Ice Cream worksite) **Meeting Attended/Observations:** 1. Meeting with multiple Facility staff to discuss the use of sedation for dental procedures 2. Observed in campus residences (Bowie - A, Bowie - B, Bowie - C, Childress - A, Childress - B, Cottage - A, Cottage - B, Cottage - C, Cottage - D, Cottage - F, Cottage - G, Driscoll - C, Driscoll - D, Fannin - B, Fannin - C, Fannin – D) 3. On-site vocational programs 4. Off-site vocational programs (off-campus workshop and Blue Bell Ice Cream worksite) 5. Program Services classrooms 6. Classrooms located in residences (Driscoll - C, Driscoll - D, Fannin - B, Fannin - C, Fannin - D)
	Facility Self-Assessment: The Facility indicated that almost all provisions of the SA were not yet in compliance, although a number of actions had been taken toward compliance. The areas for which the Facility reported compliance involved peer review and psychological assessment. The findings of the monitoring team did not support compliance by the Facility in completing psychological assessments that were current and complete. Peer review processes have been implemented, but peer review did not identify and correct deficiencies in psychological assessment that can affect the appropriateness of behavioral interventions.

	The Facility reported implementation of a plan to increase the number of BCBA-certified and to provide training to increase the skills of psychology staff; the monitoring team found the plan and training to be in place and agreed with the Facility's assessment that these were not yet complete.
	Summary of Monitor's Assessment: **For Provision K.1, t**his provision was determined to be not in compliance. A Chief Psychologist has been hired, but the person has not yet completed the BCBA credential. As only a single BCBA is employed by BSSLC, it was not possible to demonstrate that PBSPs were developed by qualified staff.. Four additional Behavior Services staff are receiving supervision by a BCBA in order to fulfill requirements for Board Certification. **For Provision K.2, t**his provision was determined to be not in compliance. BSSLC successfully recruited and hired Dr. Terry Hancock for the position of Chief Psychologist. Dr. Hancock will sit for the BCBA exam later this year. Additional time will be needed to determine if this Provision is in compliance. **For Provision K.3, t**his provision was determined to be not in compliance. BSSLC has made progress in meeting the expectations of both internal and external peer review. Additional time will be needed to determine if BSSLC is in compliance with this Provision. **For Provision K.4, t**his provision was determined to be not in compliance. Data collection continues to lack demonstrable reliability and validity. It is also unclear that existing data are used to make data-based treatment decisions. **For Provision K.5,** this provision was determined to be not in compliance. Intellectual assessments are not completed at BSSLC and adaptive assessments are not consistently completed on an annual basis. Some improvement has been made in functional assessment, but these efforts were preliminary at the time of the site visit. **For Provision K.6, t**his provision was determined to be not in compliance. Issues discussed in Provision K5 indicate that BSSLC does not provide psychological assessments that are current, accurate and based upon complete clinical and behavioral data. **For Provision K.7, t**his provision was determined to be not in compliance. Psychological evaluations completed at the time of admission reflect the same substantial limitations as those evaluations completed for other individuals living at the Facility. **For Provision K.8, t**his provision was determined to be not in compliance. For the majority of individuals participating in counseling or psychotherapy, the treatment plans did not reflect an evidence-based approach to treatment and lacked clear, objective and measurable goals.

	For Provision K.9, this provision was determined to be not in compliance. Although the Facility typically provided some form of consent and approval for restrictive interventions, the quality of the assessments and interventions reviewed did not meet acceptable practice under applied behavior analysis. **For Provision K.10, t**his provision was determined to be not in compliance. Data collection continues to lack demonstrable reliability and validity. It is also unclear that existing data are used to make data-based treatment decisions. **For Provision K.11, t**his provision was not in compliance. Very few PBSPs had been revised since the Baseline Visit to BSSLC, indicating that baseline conditions continue to exist. **For Provision K.12, t**his provision was determined to be not in compliance. Plans are underway to provide training, but this has not been implemented yet. **For Provision K.13, t**his provision was determined to be not in compliance. Progress has been made toward increasing the number of staff with the BCBA credential, but the numbers do not currently meet the criteria reflected in this Provision.

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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 site visit, BSSLC employed a single individual – Mellisa Waters -- credentialed as a Board Certified Behavior Analyst. The Facility has a PBSP in place for each individual identified as requiring behavior intervention. At the time of the site visit, fewer than five PBSPs had been developed by staff with board certification in applied behavior analysis. Without the demonstrable competence of BCBA credentialing, the facility cannot be said to have achieved compliance in Section K1. The facility has demonstrated effort in increasing the number of staff competent in applied behavior analysis. Terry Hancock, recently employed by BSSLC as the Chief Psychologist, is scheduled to sit for the BCBA examination later this year. Four additional Behavior Services staff are receiving supervision by a BCBA in order to fulfill requirements for Board Certification. In addition, documentation was provided indicating several individuals, each of whom was credentialed as a BCBA, had been interviewed for vacant positions in the Behavior Services department. Several Behavior Services staff also indicated that DADS had revised the requirement for obtaining funding for employees planning to take classes required for BCBA	N

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		credentialing. According to the staff who were interviewed, funding will now be provided prior to taking the class rather than requiring employees to seek reimbursement for tuition after completing the class. If correct, this is a positive step toward making training and credentialing more affordable, and has the potential to substantially enhance the competence and expertise of Behavior Services staff. Prior to the site visit, the Behavior Services department had implemented a variety of internal staff training efforts. Individual mentoring from a BCBA was being conducted with all Behavior Services staff with an emphasis upon functional assessment and behavioral intervention. In June, a full week was dedicated to instruction and hand-on application of applied behavior analysis and data collection. Due to the proximity between the implementation of these strategies and the site visit, it was not possible to determine the degree of benefit achieved form the additional training. As described in K4 and K9, PBSPs did not consistently demonstrate completion of functional assessment adequate to guide choice of interventions. Furthermore, data collected were not sufficient to monitor progress and determine effectiveness.	
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.	BSSLC successfully recruited and hired Dr. Terry Hancock for the position of Chief Psychologist. Dr. Hancock is scheduled to sit for the BCBA examination later in 2010. Her vita includes extensive experience in working with individuals who have intellectual and developmental disabilities, with much of this experience involving applied behavior analysis. When interviewed, Dr. Hancock presented a well-grounded approach to meeting the requirements of the Settlement Agreement over the next several years. Of those Behavior Services staff interviewed, there was acceptance and enthusiasm for the plans presented by Dr. Hancock. Sufficient time has not elapsed to allow for the determination of whether Dr. Hancock's plans will be successfully implemented. These steps reflect admirable progress toward meeting the requirements of section K2. Additional time will be needed to review the effects of these changes before this section could be determined to be in compliance with Section K2.	N
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	At the time of the site visit, Policies regarding internal and external peer review for Behavior Services were under development. Based upon observations and record reviews, BSSLC has revised the internal peer review process and initiated an external peer review process.	N

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	of PBSPs.	• 42 of 42 internal Peer Review Minutes documented discussion of and steps for revising PBSPs that specifically addressed behavioral issues. • 37 of 42 internal Peer Review Minutes reflected additional external review by Dr. Don Williams, a BCBA. At the time of the site visit, external peer review consisted primarily of Dr. Williams reviewing the documents and materials previously reviewed by the internal Peer Review Committee. This external review is likely to produce benefit by ensuring the quality of the internal review of behavior assessments and interventions. In a clinical setting, however, it is more common for peer review, whether internal or external, to involve a more open forum where reviewers and staff can discuss the various facets of clinical care, exchange ideas and jointly reach consensus on the most appropriate revisions and corrections. Without such an interactive forum, an obstacle exists in the ability of BSSLC to provide full external peer review. One measure of the efficacy of peer review is the quality of assessments, interventions and other clinical efforts developed and implemented by the professionals included in the discipline being reviewed. Based upon observations and record reviews at the time of the site visit, the assessments and interventions produced by the Behavior Services department at BSSLC did not conform to accepted practice in applied behavior analysis. For example, data collection practices did not ensure valid and reliable data, functional assessments did not identify specific functions for undesired behavior and the assessment and intervention process did not employ sufficient empirical rigor. Until such time as progress is noted in comporting with acceptable practice in applied behavior analysis, it cannot be stated that the Facility is in compliance with Section K3.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility	Based upon observations and record reviews, substantial limitations remain evident in data collection practices and treatment monitoring in relation to PBSPs. • In 20 of 20 records reviewed (100%), data collection consisted primarily of narrative reporting initiated upon the display of an overt behavior. • In seven of eight "best work" examples provided by the Behavior Services staff (88%), data collection consisted primarily of narrative reporting initiated upon the display of an overt behavior. A narrative recording of behavior displays can under certain circumstances provide insight into the characteristics of a behavior and the environment in which it is displayed. Once an intervention plan has been developed, however, sufficient information should be known about the behavior so that additional narrative descriptions are not warranted. Furthermore, once an intervention plan has been	N

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	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.	implemented, there is a requirement that data be collected under formal and specific conditions that eliminate subjective interpretation of behavior displays. Narrative statements do not provide objective data and often obfuscate changes in behavior that would be apparent under objective conditions. • In 20 of 20 records reviewed (100%), intervention targets were presented and monitored congregately regardless of differing function, topography or other characteristics. • In eight of eight "best work" examples provided by the Behavior Services staff (100%), intervention targets were presented and monitored congregately regardless of differing function, topography or other characteristics. One of the key features of applied behavior analysis is the use of an empirical or scientific process to ensure that interventions produce observable and measurable changes in the targeted behavior. This requires that the target of the intervention consist of a single behavior or a group of behaviors, called a functional class, that have been proven to serve the same purpose under the same conditions. In order to determine the success of the intervention, measurements and treatment decisions must focus only upon the specific behavior or functional class. Frequently at BSSLC, data and progress notes did not focus upon the specific behavior or functional class, instead presenting a more general review of a variety of behaviors. It also remains unclear, based upon provided information, that available data are used to identify the need for enhanced assessment or revised PBSPs. Records reflect that behavior data graphs are reviewed on a monthly basis in some context. It is not clear, however, that the interdisciplinary team is involved in this review process, or that the review produces meaningful changes in intervention strategies or behavior. This lack of a data-based process for treatment decisions is reflected in the examples below. • In nine of 20 records reviewed (45%), substantial increases in targeted behaviors did not result in revised behavioral intervention plans. • In three of eight "best work" examples provided by the Behavior Services staff (38%), substantial increases in targeted behaviors did not result in revised behavioral intervention plans. • Individual #12 was admitted on 5/2008. No functional assessment or formal assessment of psychopathology completed since admission was available in the chart. The individual remained on four psychotropic medications: Pexeva, Seroquel, Risperdal and Tenex. Without formal assessment, effective intervention planning is limited and the current treatment cannot be justified.	

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		Current limitations in data collection, interpretation and use in formulating treatment decisions do not allow for compliance with Section K4.
		• The PBSP for Individual #390 was reviewed by the BCBA on 7/12/2010.
		    o Statements in the PBSP about risk, progress, etc. were global rather than specific, as in "has improved substantially this year" in regard to all behaviors listed.
		    o Drug changes were noted on the graph table but not marked with a condition change line.
		    o The specific elements of the PBSP involved talking and interacting with the individual following displays of pica, aggression and refusal. The PBSP stated that the functions of these behaviors for the individual are "attention and escape" under the Fundamental Outcomes, but as only "escape" under Functional and Structural Assessment. Therefore, the plan could reinforce the undesired behaviors according to the assessment findings.
		• Individual #556 was admitted 9/2009.
		    o No functional assessment completed since admission.
		    o No diagnostic assessment.
		    o Individual prescribed low-dose antipsychotic for unclear targets.
		    o Data collection emphasized narrative logs rather than reliable and specific measure of behavior.
		    o Verbal aggression spiked from 12/2009 through 1/2010. No change to the PBSP was implemented and no additional assessment was conducted.
		• Individual #9
		    o Problem behaviors increased in 11/2009 and remained above previous levels through 5/2010. Restraint also increased during this time.
		    o Progress notes did not reflect a revision to PBSP or a review of assessment results.
		    o No data graph included with progress notes.	

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	Standardized assessment of intellectual functioning, adaptive ability, undesired operant behavior and psychopathology lacked the sophistication and timeliness to produce meaningful information about the individual. As a result, reported results consist of scores and levels without presenting information in a way that complements the overall assessment process. The assessment of intellectual ability and adaptive skills should complement this process by adding to the overall understanding of the individual as a person. The reiteration of scores and categories does not inform the members of the IDT as to what specific skills or limitations the individual displays. It is therefore important	N

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	other reasons for target behaviors, and of other psychological needs that may require intervention.	that intellectual and adaptive assessments clearly and specifically indicate strengths and limitations, such as "identifies six basic safety signs when asked," "cannot point to colors when named," or "experiences difficulty in processing abstract rather than concrete concepts." This information can then be used to develop the appropriate training programs for the individual. Behavior Service staff report that BSSLC does not employ a person or persons with experience in intellectual and adaptive assessment. As a result, intellectual assessments are not conducted at the Facility and adaptive assessments results include only the provision of scores without interpretation or identification of strengths and limitations. • None of 20 records reviewed (0%) included results from an intellectual assessment conducted within the previous five years. • None of eight "best work" examples provided by the Behavior Services staff (0%) included results from an intellectual assessment conducted within the previous five years. • None of 20 records reviewed (0%) included interpretive findings from an adaptive behavior assessment conducted within the previous 12 months. • None of eight "best work" examples provided by the Behavior Services staff (0%) included interpretive findings from an adaptive behavior assessment conducted within the previous 12 months. Facilities serving people with intellectual and developmental disabilities must emphasize the use of applied behavior analysis and employ personnel with experience in applied behavior analysis. This does not preclude the employment of staff with different yet essential training, experience or credentials. Knowledge of current intellectual ability and adaptive skills can often be instrumental in formulating PBSPs or skill acquisition programs. At the time of the site visit, BSSLC reported that it did not possess the ability to conduct intellectual and adaptive assessments. Numerous documents included in records make reference to functional or behavioral assessment. Observations and record reviews did not indicate, at the time of the site visit, that the Behavior Services staff routinely employed strategies of assessing behavior that comport with acceptable practice within applied behavior analysis. • Two of 20 records reviewed (10%) included results obtained from a process or instrument recognized as being able to identify potential functions of a behavior. • One of eight "best work" examples provided by the Behavior Services staff (13%) included results obtained from a process or instrument recognized as	

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		being able to identify potential functions of a behavior.
		• None of 20 records reviewed (0%) reflected the use of more rigorous or empirical procedures, such as functional analysis/analog functional analysis, scatter plots, or preference assessments, necessary to clarify potential functions and address limitations inherent to indirect functional assessments.
		• None of eight "best work" examples provided by the Behavior Services staff (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address limitations inherent to indirect functional assessments.
		
		As indicated above, various documents in the record make reference to functional or behavior assessment. Reviews and observations revealed that 100% of all records sampled, both quasi-random and "best work" examples, presented discussion of setting events, antecedents, consequences and functions. Without the requisite assessments, these findings possess limited validity and are unlikely to lead to successful intervention strategies.
		
		Example: Individual #390
		• No psychological assessment in the chart.
		• The Annual psychiatric assessment (7/22/2010) included
		  o No identified need for diagnostic review with psychologist to clarify targets
		  o No use of objective assessment for psychopathology.
		• The Functional assessment did not address issues of psychopathology or behavioral correlates.
		• The PBSP lacked integration with the functional assessment.
		• The assessment report did not address antecedents, setting events or motivating operations.
		• No indication was included to indicate that replacement behaviors were derived from the functional assessment process.
		• The Preference Assessment was listed on the PBSP "to be completed"
		• Treatment expectations were included but lack measurable outcomes	

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	Based upon the information presented in K5, minimal documentation in the record reflects assessment findings that can be demonstrated to be current, accurate or complete.	N

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	complete clinical and behavioral data.		
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Records reflect that individuals newly admitted to the Facility have a psychological assessment completed within 30 days of admission. Records do not reflect that individuals admitted to the facility routinely receive an intellectual or adaptive assessment at the time of admission regardless of the amount of time since the most recent assessment. Acceptable practice dictates that an intellectual assessment should be conducted at a minimum of every five years with adaptive assessments to be conducted annually. BSSLC does not possess the ability to conduct intellectual assessments, preventing the Facility from meeting this element of acceptable practice. Assessments of adaptive skills are conducted at BSSLC, although records do not reflect that an annual schedule for adaptive assessment is used. Reporting of adaptive assessments typically consists of only a presentation of scores and levels without additional interpretation of personal strengths and limitations in relation to programmatic needs.	N
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.	At the time of the site visit, BSSLC had identified 6 individuals who were involved in counseling or psychotherapy. A review of counseling/psychotherapy plans for individuals #3, #9, #11, #38, #206, #467 submitted by the facility did not reveal the use of evidence-based practices in relation to counseling/psychotherapy services. • One of six Counseling Treatment Plans reviewed (17%) included clearly defined and measurable goals. • One of six Counseling Treatment Plans reviewed (17%) provided no statement defining the goals of counseling. For the other five plans, goals were included, but they were not observable and measurable. Instead, they included goals to be measured by the narrative behavior data collection process, subjective opinion of the interdisciplinary team or other anecdotal evidence. • None of six Counseling Treatment Plans reviewed (0%) included evidence-based strategies to measure the acquisition of skills rather than reductions in undesired behavior. Examples of treatment goals definitions that are subjective and lack the ability to be measured are provided below. • "The progress towards this goal will be reflected first in [the individual's] ability to have positive interactions with peers and staff in [the] present living environment. As well as [the] ability to process feelings about [the individual's]	N

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		mother in the therapeutic environment.” • “[The individual] exhibits appropriate grief of the loss of [the individual’s] mother via healthy understanding of death of a loved one and emotions surrounding [the individual’s mother’s] death.”	
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.	The Facility has a PBSP in place for each individual identified as requiring behavior intervention. At the time of the site visit, fewer than five PBSPs had been developed by staff with board certification in applied behavior analysis. The remainder of intervention plans had not been revised since the Baseline Visit to BSSLC. Based upon record reviews and interviews, this latter group of PBSPs typically possessed a variety of weaknesses in assessment, implementation and documentation and did not reflect acceptable practices in applied behavior analysis. Consents and approvals are routinely obtained for PBSPs, restrictive procedures and the use of psychotropic medication. Due to pervasive weaknesses in the assessment process, it is likely that limited understanding of the individual’s treatment targets is gained and only minimal support for intervention strategies can be provided. The committees and employees tasked with ensuring the individuals living at BSSLC were not subjected to inappropriate or unnecessary risks failed to perform the essential components of the task. These individuals and committees routinely approved or submitted for consent, interventions that could not be demonstrated to be necessary, safe or effective. As such, the processes of approval and consent used at BSSLC, although timely, did not fulfill the inherent obligation of protecting the individual in question or providing the information necessary to formulate informed decisions to the individual or designated representatives • Two of 20 records reviewed (10%) included results obtained from a process or instrument recognized as being able to identify potential functions of a behavior. • One of eight “best work” examples provided by the Behavior Services staff (13%) included results obtained from a process or instrument recognized as being able to identify potential functions of a behavior. • None of 20 records reviewed (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address limitations inherent to indirect functional assessments. • None of eight “best work” examples provided by the Behavior Services staff (0%) reflected the use of more rigorous or empirical procedures necessary to clarify potential functions and address limitations inherent to indirect functional assessments. • In 20 of 20 records reviewed (100%), data collection consisted primarily of	N

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		narrative reporting initiated upon the display of an overt behavior. • In seven of eight "best work" examples provided by the Behavior Services staff (88%), data collection consisted primarily of narrative reporting initiated upon the display of an overt behavior. • In none of 20 records reviewed (0%), intervention targets were presented and monitored congregately regardless of differing function, topography or other characteristics. • In none of eight "best work" examples provided by the Behavior Services staff (0%), intervention targets were presented and monitored congregately regardless of differing function, topography or other characteristics. Without comprehensive assessment, and the resulting poor support for provided interventions, it is unlikely that the information contained in the consent and approval documents is valid, that treatments for which consent and approval have been requested can be supported, and that the those who have been requested to provide consent have been provided with adequate information upon which to base a decision. Record reviews revealed circumstances in which the Facility did not act in regard to a known risk to an individual. • Individual #12 was admitted to BSSLC in May of 2008. The individual has been on four psychotropic medications since admission. The provided record does not indicate any formal assessment of behavior or psychopathology since admission. No data are available regarding treatment for the 2010 calendar year. • Individual #41 was prescribed Risperdal until December of 2006 at which time the medication was discontinued due to very low prolactin levels. No alternative behavioral strategies were implemented and undesired behaviors increased. The Risperdal was reinstated in December of 2008, when it was determined that the risks were outweighed by the potential benefits of the drug. The individual's prolactin level was not measured at the time of the Risperdal reintroduction, and no prolactin level measures have been ordered or obtained in the 19 months since reinitiating the Risperdal.	
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	The Facility reported progress only in regard to monthly graphing of behavior treatment data. Information regarding data collection and graphs is provided in section K4.	N

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	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.		
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.	BSSLC reported no substantial progress in this area. Very few PBSPs had been revised since the Baseline Visit to BSSLC, indicating that baseline conditions continue to exist. Behavior Services staff at BSSLC reported during the site visit that no comprehensive training for staff regarding the content or implementation of PBSPs had been conducted since the baseline site visit. Direct care staff in Driscoll and Fannin residences could not answer specific questions about PBSPs, but indicated that the programs were available in the individual notebooks. Interviews with Behavior Service staff revealed that other than isolated test cases no attempt had been made to establish a system for assessing or ensuring treatment integrity.	N
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.	BSSLC reported no substantial progress in this area. During interviews, Behavior Services staff presented preliminary plans to offer direct care staff training in residences. In addition, there are efforts underway to utilize a portion of the Program Services classrooms to conduct intensive training on both intervention plans and applied behavior analysis skills in a hands-on environment. As these plans had not been implemented at the time of the site visit, it was not possible to assess progress in this area beyond that obtained during the baseline visit.	N
K13	Commencing within six months of the Effective Date hereof and with full implementation within three	Progress in relation to increasing the number of BCBA credentialed staff is presented in the assessment of Provision K1.	N

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	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.	Due to BSSLC employing a single BCBA at the time of the site visit, this section does not reflect compliance with the Settlement Agreement. Certification for all qualifying positions in Behavior Services would allow for a ration of 1:27. If all staff in qualifying positions were credentialed with BCBA, there would exist one psychology assistant for every two BCBAs.	

Recommendations:

1. Training for Behavior Service staff should be expanded to include the scientific method and an empirical approach to treatment. The application of applied behavior analytic interventions relies upon knowledge of scientific principles. Staff should be fully familiar with the basics of scientific investigation, such as the need for objective and reliable data, the use of consistent and controlled implementation of interventions and the manner in which data from interventions should be interpreted.
2. External peer review should be expanded to include multiple external participants in a fully interactive process.
3. The current data collection process should be revised so that data collection efforts are driven by the parameters of the behavior rather than the convenience of an existing system. Different forms of behavior, such as episodes of crying versus quick displays of hand-biting, require different forms of data collection. A data collection system should be devised that helps the Behavior Services staff to select a data collection method that best suits the behavior rather than using the same data collection strategy for all behaviors.
4. Training with the interdisciplinary teams should be implemented to increase their understanding of evidence-based practices and the need for clear and measurable treatment goals. Training should include tools for facilitating the interdisciplinary teams in monitoring response to treatment.
5. A review of non-behavioral intervention procedures, such as counseling and psychotherapy, should be conducted with the goal of establishing clear guidelines for evidence-based practice.
6. Specific policies for graphic presentation of behavioral data should be established. These policies should address the presentation of psychotropic drug treatment, documentation of condition changes, and the selection of colors and symbols for use in graphs to minimize confusion.
7. The current process of including all undesired behaviors in a single PBSP should be reviewed. The universal use of single PBSPs can reduce the ability to focus upon specific functional classes.
8. A comprehensive review of the consent and approval process should be conducted. An emphasis should be placed upon determining if data collection and assessment weakness mean that individuals and LARs do not have adequate information to provide truly informed consent..

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Medical records of Individuals #3,#5,#9,#23,#26,#50, #51, #54, #59, #66,#68,#70,#77,#79,#84,#99, #109, #111,#165,#190,#192,#195, #209, #231,#237,#250,#253, #275, #305,#311, #386,#392, #473, #557, #594 including: • Seizure log and graph • Laboratory assessment • Physician order • Physical examination and assessment • Consultation report • Team meeting report • Medication consent forms for antiepileptic drugs • Human rights report • Annual examinations • IPN • QDRR report • Medication list • Problem list • Nursing assessment • Health management plan • Annual medical summary • Preventive care flow sheet • Immunization records • Specific diagnostics including mammograms, hemocults, PSAs, EEGs, MRI's, CTs and EKGs • Hospital discharge summary • Transfer sheet • Moses • Discus • Preventive care flow sheet 2. BSSLC Plan of Improvement **People Interviewed:** 1. Robert Ham, Facility Director 2. Brett Hood, M.D, Medical Director 3. Joseph Willams, Director of Pharmacy 4. Gary Johnson, D.D.S 5. Trey Knittel, Pharm. D, R. Ph. (RN) 6. Julie Moy, M.D, Coordinator of Medical Services

	Meeting Attended/Observations: 1. Unusual Incident Review Meeting, July 27, 2010 2. Meeting to discuss dental clinical procdures, for pre-treatment sedation, July 27, 2010 3. Introductory meeting with Dr. Julie Moy, Coordinator of Medical Services, State Office, July 29, 2010 4. Meeting to discuss review of recent death with Dr. John Hood, and Robert Ham, July 28, 2010 5. Medication Error Meeting, July 27, 2010 **6.** Meeting to discuss pharmacy reviews, July 30, 2010 To complement the review of clinical documentation the monitoring team conducted general observational assessment for positioning and gait assessments at all homes and conducted specific observational assessments of six individuals #50, #51, #209, #237, #353, and #594, for movement disorders.
	Facility Self-Assessment: The Facility reported it was in compliance with all aspects of provision of routine, preventive, and emergency health care except for those action steps related to hospitalization, on-campus transfers, PSP documentation of discussion of seizure disorder diagnosis and treatment, and discharge documentation. Compliance was reported for provision of health care, including evaluation of seizures. This was not congruent with the findings of the monitoring team, which discovered numerous instances in which changes in health care status were not aggressively evaluated, clinical practice was not integrated into the team process, and follow-up to resolution of clinical issues was not routinely observed. The Facility accurately reported that it had not yet come into compliance with development of policies and procedures governing the provision of medical care that includes all requirements of State Office policy, as those policies are in development. The Facility reported accurately that it does not yet have a medical quality improvement process. In the POI, the Facility indicated that the evidence of compliance would be "Policy." This would be a serious error. The evidence would be that appropriate information is collected, reviewed regularly and analyzed to identify actions needed, and documentation that actions are taken and are effective.
	Summary of Monitor's Assessment: No Provisions of this Section have been found in substantial compliance yet. Five major obstacles were identified as problematic and resulted in significant limitation to the monitoring team's ability to assess compliance. First, the center continues to work on developing appropriate policies and procedure for health care purposes and during the monitoring team's on-site assessment updated policies, and procedures were not available for review. Secondly, revisions to the Health Care Guidelines are in process, and the medical leadership at the Facility and the monitoring team have concerns with some of the current guidelines. Third, and of particular issue, is the overt lack of appropriate qualitative and quantitative documentation in all areas reviewed for health care compliance. Throughout the monitoring team's on and off site review, documentation was either lacking, or inadequate to assess compliance. Fourth, the lack of integration of clinical practice into the team process is significant, and limits delivery of

	quality health care. Fifth, follow-up to resolution of clinical issues and incorporation of new medical conditions are not routinely observed by review of the clinical record. BSSLC has made significant improvements in their emergency response system. Mock Medical Emergency Drills were conducted quarterly according to procedure. One drill failed out 158 conducted. However, only one unit's nursing staff consistently checked emergency equipment on a daily bases and were consistently reviewed monthly by the Nurse Manager according to policy. The Nursing Department needs to continually improve performance with regard to checking emergency equipment daily; with nurse managers reviewing the Emergency Checklist monthly. Administrative and Clinical Death Review Records for onsite review were not available for review and in the future needs to be made available in time for the Monitoring Team Members to complete an adequate review.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team's assessment of seizure management demonstrates a systemic lack of continuity of care specific to appropriately identifying, and documenting seizure type, and seizure activity, as well as clinical management of seizure disorder by medical staff. 1. Direct care professionals lack basic understanding of seizure disorder as related to individuals served by them and in general context. This is evident by documentation review of seizure records, observational assessment of an individual experiencing seizure activity, and response by nursing staff, and direct care professionals. The nurse educator for the center corroborates that training efforts, although improved, remain inadequate in the area of seizure disorder. This issue can results in misdiagnosis, under treatment of seizure disorder and other adverse outcomes. 2. It is evident by document review and interview with the centers Clinical Pharmacist, that Physician follow-up on seizure management does not meet standard of care practice. This is evident by document review of abnormal drug levels that remain abnormal for a prolonged period, and physician orders and notes that demonstrate inadequate or no physical assessment by the physician of individuals for side effects to antiepileptic drugs, especially when noted to be in toxic range. 3. A review of seizure records, seizure logs and neurology consultation reports demonstrate individuals with diagnosed seizure disorder, albeit prolonged seizure free periods, are not assertively assessed for medication reduction or alternate therapy regimen. Individuals known to be free for more then two years remain on either polypharmacy or more toxic medications, such as	N

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		Phenobarbital and Dilantin, with minimal documentation supporting continued treatment. At most, documentation states, "in my opinion" the individual should remain on current medications. It is a standard of care that persons with prolonged seizure free periods should receive a comprehensive clinical review that includes a physical assessment, detailed review of seizure records to assess accuracy, review of all prior treatments and diagnostics that include an EEG, when possible. Although the Health Care Guidelines currently in place require review only after five seizure-free years, the current medication regimens in use dictate more careful review. Importantly, a full complement of team members, including the guardian, nursing staff, direct care professionals, clinical pharmacist and the primary care physician should review current seizure management and explore the use of less toxic treatment and associated risks and benefits. All individuals receiving anticonvulsant medications should undergo a comprehensive review of their condition and management at least annually, and whenever there is a significant change in condition. 4. Review of neurology consultation reports indicated a lack of completeness that is necessary to provide clinical information in a team setting. Reports should include a physical assessment of the individual, review of clinical history during interim of visits, comprehensive review of seizure record and log, specific diagnosis of seizure disorder and a plan that provides supporting clinical evidence to either continue current therapy or changes therapy. Historic review of neurology consultation reports suggests more completeness in the past. A review of monitoring for medication side effects was conducted through chart reviews, and observations of associated individuals at their homes and by documentation review of MOSES, and DISCUS assessment forms. Physician progress notes were also assessed. 1. Direct observation of five individuals at their homes indicated excellent corroboration with DISCUS assessments completed by nursing professionals. Unfortunately, in three of the reviews, the physician component of the DISCUS was not appropriately completed by the physician. The physician either failed to sign the DISCUS form or failed to complete the prescriber's portion of the assessment. In a document review of MOSES and DISCUS assessments, the evaluation component was adequately completed, signed and dated by the assessing nurse but was without signature, date and comments by the prescribing physician. 2. As important as the MOSES and DISCUS assessments, independent physician assessment of drug side effects, especially when an acute and unexplained medical issue develops, and when drug levels are known to be toxic, should be	

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		sought. This issue was specifically attended to by the monitoring team while conducting chart reviews during the review period and when reviewing clinical documents off site. In no circumstance were identified toxic drugs levels documented by the physician, nor were physical assessments conducted by the prescribing physician. Neurology consultation reports minimally documented side effect issues in some cases by simply stating "no side effects" without documenting positive and negative findings of an exam. A review of recent hospitalization and emergency room admissions and discharges was conducted on six individuals. The monitoring team recognized that assessment and documentation by nursing professionals has significantly improved. Also noted was daily follow-up of hospitalized individuals with the admitting hospital. Several areas of concern were noted. 1. Post discharge follow-up by the physician, in general, was not adequately documented. For example, the monitoring team could not consistently find a physical examination and comprehensive review on the part of the physician, regarding the reason for hospitalization, current condition of the individual, and the discharge plan. This issue is evident by the lack of physician documentation, and lack of physician understanding of the individual's condition when it resulted in multiple hospital admissions. Neither the physician nor the PST adequately explored an example of Individual #77 who was hospitalized on four occasions over a three-month period, for the same diagnosis. 2. A review of hospitalizations clearly delineates the lack of "integrated team involvement in the process of health care delivery. The PST" remained a passive component of clinical care and for the most part focused on human rights issues and participated minimally in root cause analysis of significant health care issues or identifying support needs to address clinical issues. Active team involvement can serve as a valuable resource for physicians. With rare exception, primary care physicians rarely participated at team meetings and in most cases participation was limited to a "physician report." 3. Lack of specific documentation indicated that the physician did not adequately review the course of hospitalization, nor was important clinical information conveyed to the team for review and integration into the individual's service plan. This situation can be clearly delineated by review of an individual who was evaluated in the emergency department for abnormal gait, which was noted to be deteriorating over a short period of time. The emergency room assessment was minimal and vague and nowhere in the differential diagnosis was the potential for drug toxicity caused by Phenobarbital or other causes such as	

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		spinal cord involvement mentioned. Findings of an old, healed rib fracture were identified on a hospitalized individual and the team to determine its cause did not review this information. The diagnosis of dementia was made on an individual with no discussion or work up of its etiology, nor was a specific type of dementia determined or entertained. Because of time constraints only a limited review of preventive health care issues were conducted by the monitor team during this site visit and comments of compliance cannot be made. A review was conducted on a recent death at the center of Individual #77. The monitoring team clearly recognizes the complexity of clinical issues involved in this case and recommends that clinical leadership at the State level develop a meaningful mechanism to conduct comprehensive mortality reviews that will enable a better understanding of the clinical practice of individuals served at the center. During the interim, it may be advantageous to develop a clinical team from alternate centers within the system to review deaths, including this most recent case. Document and observational reviews of specific individuals revealed the need to enhance clinicians'understanding of common co-morbid conditions associated with developmental disabilities. The monitoring team has identified areas of concerns specific to aspiration pneumonia, and degenerative spine and other orthopedic conditions. Appropriate diagnosis and ongoing assessments to monitor for progression and treatment options aimed at resolving the condition, preventing worsening, or for palliative purposes must be afforded to all persons with known or suspected neuromotor and orthopedic conditions. Importantly, there does not seem to be a meaningful process in place for clinicians to receive general and developmental disability specific continuing medical education. The review of dental practice at the center included interviews with the centers Dentist, Dental hygienist, Medical Director, and a comprehensive meeting with all parties involved in the dental consultation process. The review focused on one area of immediate concern, related to sedation of individuals served at the center. The use of polypharmacy and use of powerful hypnotics was identified as a high-risk practice that must only be provided under well-controlled circumstances and in accordance of practice standards and State regulations. The Facility's primary care physicians are currently responsible for determining and prescribing the medication needs of individuals for pretreatment sedation. In the comprehensive meeting to discuss dental practices, it was commented that the use of sedating medications was also to be explored for other on-site treatments, including podiatry. If the Physician prescribes any	

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		medication that alters consciousness, there must be practice standards in place, appropriate staff and technology to ensure the safety of individuals served, which at this point such practice standards are not evident. Throughout the monitoring team's clinical review Physician documentation and maintaining of health care records remains problematic. The Facility has developed a new strategy that enhances record keeping but the process is too novel to assess effectiveness. Physician documentation remains less than adequate. While reviewing clinical records (the individuals chart), in no case was the monitoring team able to fully understand the individual's entire clinical need. Physician notes were incomplete, problem lists did not adequately reflect the individuals current medical condition, follow-up on acute and chronic health care issues were lacking, clinical issues were not adequately reflected in team meeting notes and it was lack of consistency with regards to physician documentation and method of documentation BSSLC had made significant improvements in their emergency response system since the baseline visit. Emergency Kits were purchased and put in place for ready access. Monitoring team member toured Driscoll Gardens, Fannin Villa, Bowie Springs, Childress Terrace, Cottage Estates Homes C and D, and the Health Center Building. All units and cottages C and D had emergency kits and other related emergency equipment located in close proximity for ready access. Emergency equipment for Cottage Estate Homes A and B was located in Cottage Estates Home C. Emergency equipment for Cottage Estate Homes E, F, and G was located in Cottage Estates Home D. All units, cottages, and Health Center had yellow signs written in black lettering with arrows pointing to the location of the emergency equipment posted at eyelevel throughout the hallways and in other related areas to ensure that staff would be able to readily locate and access the equipment. There was evidence that notification for nursing personnel for Cardiac Pulmonary Resuscitation (CPR) and Automatic Defibrillator (AED) assistance had been sent to non-residential areas, e.g., Administration Building, Competency Training and Development (CTD) Building, Food Services Building, Maintenance Building, and Recreation Center. The information included telephone numbers to contact nurses in the CTD Building during hours of operation, after hours and on the weekend.	
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	As with all clinical practice, performance assessments are essential in helping to ensure quality practice of medicine. During the monitoring team's review of the peer review process, discussion with the Facility's Medical Director revealed that this issue has yet to be fully developed. Of primary concern is the centers lack of external experts who could provide regular "peer and clinical reviews". BSSLC Emergency Checklists were reviewed to verify that emergency equipment was	N

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	assistance to facilitate the quality of medical care and performance improvement.	checked daily for presence of equipment and working order. Review findings included. • Bowie Springs A: Emergency Checklists for April, May, and June, 2010 were not recorded on the standardized Emergency Checklist. The information contained on the form (not titled) for items to be checked only included a space for dates, nurses' initials, emergency kit and refrigerator temperature. One of three months (33%) was checked daily. • Bowie Springs B and D: Emergency Checklists May, and June, 2010 were not recorded on the standardized Emergency Checklist. The information contained on the form (not titled) for items to be checked only included a space for dates, nurses' initials, emergency kit and refrigerator temperature. One of two months (50%) was checked daily. • Bowie Springs C: Emergency Checklists for April, May, and June, 2010 were not recorded on the standardized Emergency Checklist. The information contained on the form (not titled) for items to be checked only included a space for dates, nurses' initials, emergency kit and refrigerator temperature. Three of three months (0%) were **not** checked daily. • Cottage Estates Home C: Emergency Checklists for May, June, through July 26, 2010 were recorded on the standardized Emergency Checklist. Nurses' signatures and initials were included on one of the monthly checklists. None of the checklists were reviewed monthly by the nurse manager. Three of three months (0%) were **not** checked daily. • Cottage Estates Home D: Emergency Checklists for May, June, through July 26, 2010 were recorded on the standardized Emergency Checklist. Nurses' signatures and initials were included on all of the monthly checklists. None of the checklists were reviewed monthly by the nurse manager. Three of three (0%) were **not** checked daily. • Childress Terrace: Emergency Checklists for March, April, May, and June, 2010 were recorded on the standardized Emergency Checklist. Nurses' signatures and initials were included on one of the monthly checklists. None of the checklists were reviewed monthly by the nurse manager. One of three months (33%) was checked daily. On 04/17/10 the nurse noted the oxygen take to be low, e.g., 600 oxygen pounds per square inch (psi) and needs to be refilled. According to the May, 2010 checklist the tank was not refilled until 05/13/10. This represented a 30 day delay in refilling the oxygen tank. The purpose of checking the oxygen tank daily was to ensure an adequate supply of oxygen was available at all times. • Driscoll Gardens: Emergency Checklists for March, April, May, and June, 2010 were recorded on the standardized Emergency Checklist. Nurses' signatures and initials were included on one of the monthly checklists. All checklists were reviewed monthly by the nurse manager. Four of four months (100%) were checked daily.	

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		• Fannin Villa: Emergency Checklists for March, April, May, and June, 2010 were recorded on the standardized Emergency Checklist. Nurses' signatures and initials were included on all of the monthly checklists. None of the checklists were reviewed monthly by the nurse manager. Four of four months (0%) were **not** checked daily. Review of eight units' and/or cottages' Emergency Equipment Checklists revealed that only one unit (Driscoll Gardens) or 12.5% of the units and cottages were checking emergency equipment daily as required. Only one unit's (Driscoll Gardens) Nurse Manager reviewed the checklist monthly. This demonstrated the need for monthly reviews of the Emergency Checklist by the Nurse Managers. Nurse' signatures and initials were not consistently documented on the Emergency Checklists. The Nursing Department needs to ensure that the Emergency Checklists are completed daily, that nurses' sign and initials checklists, and checklists are reviewed monthly by Nurse Managers. The Nursing Department needs to establish guidelines that specify at what psi oxygen tanks need refilled. The guidelines needs to include who is responsible for ensuring when oxygen tank psi's are identified as needing refilled that the order is turned in timely and refilled promptly. Nurses responsible for checking the oxygen tanks needs to be trained to calculate the remaining time left in the oxygen tank based on the liter flow per minute used. Mock Medical Emergency Drill Sheets were reviewed for January through July, 21, 2010. Drills were completed as scheduled except for two that were carried over and completed the following month. Review of the 158 completed Mock Medical Emergency Drill Sheets indicated significant improvement from the baseline review. One of 158 (0.6%) drills was identified as failing. In that situation, there was documentation on the Plan of Action Section that staff who did not respond to the drill were identified and referred to CDT for retraining. There was also documentation in the Plan of Action Section when staff did not perform the drill correctly that they were retrained on the spot. If staff were not successful with on the spot retraining they were referred to CDT for further retraining. Documentation was not available for review validating retraining by CTD. Further review of the Mock Emergency Drills Sheets reveal missing documentation for two items: • First nurse on scene ensured that: a) EMS has been activated, b) The AED was obtained, c) All necessary persons were notified, and d) ABC's of CPR." This item was missing on 19 of 158 (12%) of the drill sheets. • Was all equipment in good working order? This item was missing on 6 of 158 (4%) drill sheets. Although, these two items were not consistently documented the drill sheets, the drills were marked as passing. It is necessary that all items on the drill sheets are completed to validate drills as passing. The Mock Emergency Drill Form, revised 02/02/10, was not	

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		consistently used. The Facility needs to ensure that all items included on the Mock Medical Drill Sheets are completed in order to consider drills as passing. The Facility's staff conducting the Mock Emergency Drills needs to purge the old drill forms and replace them with the revised form. The Facility needs to develop and implement an internal procedure specifying the communication flow of the completed Mock Medical Emergency Drill Sheets, e.g., how is CTD notified of staff who need retraining on CPR and how is the retraining validated? An impromptu Mock Medical Emergency Drill was called in the Dental Office of the Health Center Building. Dental staff responded immediately as did other staff in the Health Center, including three physicians. The drill was successfully passed. The Health Center Building was not included on the schedule requiring quarterly Mock Emergency Drills. Although the building was staff with health related professional staff; it is equally necessary for them to participate in drills to ensure that they maintain their emergency response skill, emergency equipment is readily available, and in good working order. The Facility needs to include the Health Center Building's staff on the Mock Emergency Drill Schedule. The Facility's Nursing Department needs to ensure that Emergency Equipment Checklists are completed for the Health Center Building's emergency equipment. According to the Mock Medical Emergency Drill Procedure the Facility was required to perform a trend analysis that included the following information: The number of required drills per quarter, the number of drills conducted for the quarter, the number of passed drills for the quarter, and the number of failed drills for the quarter. A breakdown by the three months in the quarter with number conducted, passed, and failed. Noting any trends or observations. The trend analysis report was not available for review as requested. This item will be reviewed on the next tour. Review of the Facility's CTD Employees Delinquent in CPR report as of July 01, 2010, indicated that 22 personnel were delinquent in CPR basic and one for Basic Life Support (BLS) for Healthcare. The Facility's CTD staff needs to ensure that all delinquent staff in CPR basic and BLS for Healthcare are promptly retained.	
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;	The center has made significant strides with data collection in many domains, primarily in pharmacy services, and specific to medication variances. The monitoring team attended the medication error committee meeting, which is developing a method to offer meaningful review of medication variances. During the monitoring team's review it was evident that data collection is less then adequate to enable a full review of medication variance. For instance, all aspects of medication storage, prescribing, delivering, documentation practices and administration must be included as part of a medication variance review. At this point, the center has focused on medication omissions. Critical,	N

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	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	is the fact that data are being collected and presented but there not is yet a formal process to integrate data in the clinical process. Data are presented but not analyzed nor integrated into health care process.	
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.	DADS is in the process of reviewing the Health Care Guidelines (HCGs) to identify updates to be proposed. Policies and procedures do not yet ensure that all current HCGs are followed.	N

Recommendations:

1. Noted improvement with regards to clinical records and documentation practices must continue. A comprehensive, accessible, well maintained clinical record, along with a robust documentation practice, is one of the essential and rate-limiting factors that will result in the delivery of quality clinical care to persons served. An efficient and robust clinical record will not only enhance the care of individuals served but will ultimately enhance human and financial resources for the center and State. The great quantity of data and significant access issues suggests that an electronic clinical record system be incorporated at the center. If an electronic record system is entertained, the system should ensure that a modern, electronic "health care record" system be considered specific for the delivery of health care issues. Alternate electronic systems can be utilized to address the many other components of service delivery.

2. Physician documentation must be enhanced. There is evidence that documentation practice at the center is improving and that some physicians are beginning to rely more on dictation systems. It is essential that continuity of care be easily followed throughout delivery of care of individuals served. Physicians must clearly document all direct and indirect contact with individuals served. Documentation must be clear, concise and comprehensive enough to provide a meaningful understanding of the clinical approach. The term "if it was not documented, it was not done" continues to hold true in all clinical settings.

3. Physician integration with the team process must continue to be enhanced. Physicians must take a more active role in the team process and participate in interim meetings that address clinical issues and all annual reviews. Conversely, non-clinical participants of the team must better understand the role of the physician in the context of the team process. The physician is a resource for the team to better understand the individuals' clinical needs. Whenever there is a disagreement among physician team members and non-physician team members, the issue should

be reviewed by escalating professional authority and when necessary, external consultation should be obtained to resolve continued disagreement.

4. To address serious and common clinical issues, such as recurrent aspiration pneumonia, neuromotor and orthopedic conditions , osteoporosis, bowel issues (chronic constipation, obstruction and perforation), and seizure disorder, the Facility or DADS should consider developing clinical teams that could involve experts in the field of developmental disabilities, as well as physicians and other health care professionals from other State facilities to enhance current practice standards for these conditions. It is essential that the diagnosis, monitoring and treatment of seizure disorder, aspiration pneumonia, musculoskeletal, and neuromotor conditions be assertively addressed by the center.
5. It is paramount that the center, statewide clinical leadership, and the Monitoring team address concerns related to the Health Care Guidelines. The current guideline is considerably dated and although there are qualifying statements indicating that guideline should only be used in context of current practice standards, there must be updated clinical guidelines for physicians to refer to when providing clinical care to individuals served.
6. The physicians' role in providing pretreatment sedation warrants significant review. If the Facility is to offer on-site sedation or any other medication's that alters the level of consciousness, a comprehensive approach which utilizes all necessary standard of care practices for sedation, such as those used in community based out-patient surgical and dental centers.
7. Clinical staff must be afford robust and regular opportunities for continuing medical education for general practice purposes and for purposes specific to developmental disabilities. Enabling educational leave, conference development and use of telemedicine should be explored.
8. Physician documentation standards must be developed. For example, specific documentation requirements to ensure completeness for history and physicals, follow-up to acute, and chronic problems, follow-up to consultation and diagnostic studies should be standardized. In-service training and regular competency based training should offered to physicians to ensure their understanding and compliance. Importantly, documentation must be inclusive and enable continuity of care. Documentation must also be legible, hence, a modern method, such as dictation or user dependent word processor should be considered as a standard method for documentation. The incorporation of an electronic health care record (EHR) would help mitigate documentation and record keeping issues.
9. As the center continues to explore mechanisms to provide external reviews, an emphasis on the development of a true peer review process should be considered. Only "like peers" should evaluate the clinical performance of professionals. Specific to physicians, only physicians with equal or greater qualifications should evaluate the performance of a physician's clinical performance. An administrative review of adherence to Facility policies and procedures can be accomplished by Facility administrators.
10. When developing a method for a mortality review process, the system should take into consideration the need for a legally protected method that would enable physicians to review their own practice in a professional group setting, such as in the context of a physician morbidity and mortality review committee. Some States have developed laws to protect information shared within such contact (ie. Medical Studies Act). Such a committee would not take the place of the Facilities mortality review, which should include an external clinical review.
11. Regular clinical conferences, such as a monthly physician meeting, should be considered at the State level, to provide physicians an opportunity to share clinical experiences and learn from each other. External "experts" in the field can be brought in periodically to help explain current trends in the clinical aspects of developmental disabilities.
12. To address the lack of availability of "external" resources to provide peer review and assist in evaluating complex cases, the center should consider developing a comprehensive telehealth venue that could serve all centers throughout the State for such purposes, as well as to enable hard to

obtain consultation services and regular educational venues. Such a program, if developed properly, could also provide a mechanism to reduce overall cost related to travel for administrative purposes. A well supported telehealth venue will help mitigate professional resource issues, enhance educational experiences for health care and other professionals and reduce costs secondary to travel related issues – the cost of taking individuals to consultants many miles away can be significantly reduced by the use of a well supported telehealth system.

13. The center should ensure that all data collection systems developed are statistically relevant for the purpose of data collection and outcome studies. This may necessitate persons who have some experience with statistics and data analysis be involved in the development of quality assurance measures that require data analysis. One example is the importance on relying on "rates" rather than on "percentages".

14. It maybe relevant for certain data-intense processes to be developed at a central level and incorporated universally among all centers.

15. When reviewing data, staff involved in the review must always use the data and analysis to enhance clinical processes.

16. Appropriate technology should be utilized for data collection and analysis. For example, when developing a method to regularly assess large data fields, an Access data base or software of equivalent or great ability should be considered.

17. The Facility should reconsider the name of the Medication Error Committee to Medication Variance Committee.

18. Meaningful practice standards are essential for the delivery of quality health care. Standards enable the basis for peer review process and enable important outcome studies to be developed, that in turn result in enhanced practice and improved outcomes for individuals served. The system should consider developing a central committee structure that involves clinical staff from all centers to help develop and implement updated practice standards. When necessary, external resources could be sought to help develop standards for more challenging issues. Clinical members of the monitoring team should be considered integral in the process.

19. The Facility's The Nursing Department needs to ensure:

    a. Emergency Checklists are completed daily, that nurses' sign and initials checklists, and checklists are reviewed monthly by Nurse Managers.
    b. The Nursing Department needs to establish guidelines that specify at what psi oxygen tanks need refilled. The guidelines needs to include who is responsible for ensuring when oxygen tank pounds per square inch are identified as needing refilled that the order is turned in timely and refilled promptly.
    c. Nurses responsible for checking the oxygen tanks needs to be trained to calculate the remaining time left in the oxygen tank based on the liter flow per minute used.
20. The Facility needs to ensure that all items included on the Mock Medical Drill Sheets are completed in order to consider drills as passing.
21. The Facility needs to develop and implement an internal procedure specifying the communication flow of the completed Mock Medical Emergency Drill Sheets, e.g., how is CTD notified of staff who need retraining on CPR and how is the retraining validated?
22. The Facility's staff conducting the Mock Emergency Drills needs to purge the old drill forms and replace them with the revised form.
23. The Facility's CTD staff needs to ensure that all delinquent staff in CPR basic and BLS for Healthcare are promptly retrained.
24. The Facility's needs to include the Health Center Building's staff on the Mock Emergency Drill Schedule.
25. The Facility's Nursing Department needs to ensure that Emergency Equipment Checklists are completed for the Health Center Building's emergency equipment.
26. In future monitoring visits the Facility needs to make Administrative and Clinical Death Reviews available, in a "red folder", to allow Monitoring

Team Members adequate time for review.

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. Reviewed Records for Individuals: #8, #26, #31, #34, #43, #70, #26, #78, #84, #89, #153, #158, #186, #190, #192, #223, #269, #311, #323, #331, #343, #344, #386, #392, #395, #403, #411, #422, #428, #436, #450, #453, #577, and #597 2. BSSLC Hospital Admissions and Emergency Room Visits, January through July 26, 2010 3. BSSLC Sutures List, January through July 9, 2010 4. Fracture List, January through July 9, 2010 5. BSSLC Personal Support Plan Due List for Quarterlies and Annual 6. BSSLC Weight Change Report and Individuals Out of Ideal Weight Range for May 20, 2010 7. BSSLC Nursing Peer Review Process Instructions, Schedule, and Audit Tools 8. Texas Department of Aging and Disability Services, Comprehensive Nursing Assessment Blank Form 9. Texas Department of Aging and Disability Services, State Supported Centers Policy/Procedure Index 10. BSSLC Nursing Department's Competency-based Training Materials and Training Records 11. BSSLC Nursing Department's Continuous Medical Record (Kardex) Sample for individuals: #8, #43, #84, #89, #269, #311, #323, #331, #343, #392, #395, #422, #453, and #597 12. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Post Anesthesia Care, Date June 2010 13. BSSLC Nursing Department's Cross Communication Sheet and General Follow-up Daily Until Resolved (for shift reports) Blank Form 14. BSSLC Nursing Department's Nursing Call-in Reports, January through June, 2010 15. BSSLX Nursing Department's Direct Nursing Care Ratios and Nurse Case Manager Ratios and Nursing Staffing Minimums 16. BSSLC Seizure Records for Individuals: #12, #70, #87, #230, and #304 17. BSSLC Safety Committee Minutes February through June, 2010 18. BSSLC Medical Service/Infection Control: Employee Infection Control Program Policy, Date Approved April 1, 2009, Next Review Date: March, 2010 19. BSSLC Infection Control Policies and Procedures, Training Materials, and Training Records 20. BSSLC Infection Control: Monitoring of Handwashing on Campus Reports, March through June, 2010 21. BSSLC Infection Control: Walk through Environmental Check List Reports March through May, 2010 22. BSSLC Infection Control Meeting Minutes, March 31, 2010 and June 30, 2010 23. BSSLC Infection Control Spread Sheet 24. BSSLC Reportable Infection Rate Reports, January through May, 2010 25. BSSLC Current list of Individuals with Decubitus Ulcers, July 27, 2010 26. BSSLC Skin Care Committee Meeting Minutes, March 31, 2010 and June 30, 2010 27. BSSLC Nurse Case Managers Meeting Minutes, January 28, 2010, March 5, 2010, April 9, 2010, June 10, 2010 28. BSSLC Nurse Managers Meeting Minutes June 9, 2010 29. BSSLC Registered Nurses and Licensed Vocational Nurses Meeting Minutes, January 28, 2010

	30. BSSLC Medication Error Committee Meeting Minutes, January 27, 2010, March 31,2010, April 29, 2010, and May 26, 2010 31. BSSLC Drug Utilization Report – Antibiotics, July 19, 2010 through July 23, 2010 32. BSSLC List of Individuals with Mothercare/Maroon Spoons 33. BSSLC Medication Errors – Root Cause Analysis, Reported June, 16, 2010 34. BSSLC Trending Report for Medication Errors on Campus, January through June, 2010 35. 2010 – Medication Error Trend Reports for Bowie Springs, Childress Terrace, Driscoll Gardens, Fannin Villa, and Cottages 36. BSSLC Pharmacy and Therapeutics Committee Meeting Minutes, January 29, 2010 and April 29, 2010 37. BSSLC Nutritional Management Curriculum for Professional Staff and Direct Care Professionals 38. BSSLC Department of Aging and Disability, Texas (DADS) Active Employee Course Participation for Nutritional Management, January 1, 2010 through July 26, 2010 39. DADS Staff Delinquent Nutritional Management List, July 26, 2010 40. BSSLC Plan of Improvement (POI), dated 5/17/10 **People Interviewed:** 1. Debra Williams, RN, Chief Nurse Executive 2. Sara Colvin, RN, Nursing Operations Officer 3. Johanna Schroeder, RN, Nurse Educator 4. Cynthia Clay, RN, Nurse Recruiter 5. Jill Quimby, RN Quality Assurance Nurse 6. Wendy Smith, RN Hospital Liaison 7. Janette Wawarosky, RN, Nurse Manager, Bowie Springs 8. Jim Cloud, RN, Nurse Manager, Cottages 9. Connie L. Gordon, RN, Nurse Manager, Fannin Villa and Childress 10. Joanne Guard, RN, Infection Control Nurse 11. Leona Sian, RN, Shift Manager 12. Barbara Baronowski, RN, Self-Administration of Medication (SAM) Coordinator 13. Brandy Todd, LVN Manager **Meeting Attended/Observations:** 1. Nursing Administrative and Management Staff, July 27, 2010 2. Medication Error Committee Meeting, July 27, 2010 3. Dental Sedation Meeting, July 27, 2010 4. Toured Driscoll Gardens, Childress Terrace, Bowie Springs, Childress Terrace, Cottage Estates Homes C and D, July 29, 2010 5. Medication Pass Observations in Bowie Springs, Driscoll Gardens, a d fannin Villa July 29, 2010
	Facility Self-Assessment: The Facility stated it is not yet in compliance with any of the provisions of this Section but has implemented a number of actions to lead toward compliance. The Facility reported several actions related to annual and quarterly nursing assessments to be in compliance. Although not finding compliance with every identified action, the monitoring team noted

	progress in all these areas. o The Facility stated the records reviewed showed that there was documentation that Annual Nursing Reviews (Assessments) were: scheduled, with documented reviews that assessed an individual's health status; and were. completed by the RN. o The Facility stated the records reviewed showed that the Annual Nursing Assessment was recorded on a standardized form, according to policy. o The Facility stated the records reviewed showed that the Annual Nursing Assessment included the date and name of the RN completing the assessment. The Facility reported, and the monitoring team confirmed, a Skin Integrity Assessment had been completed annually using Braden Scale or similar evaluation tool, as part of the nursing assessment, and reviewed quarterly or as clinically indicated. The Facility reported the records reviewed showed that there was documentation that general preventative health services were established collaboratively between the RN, PST, and relevant professional staff, including at minimum: Each individual will be weighed once a month and records kept indicating monthly variations in weight.. The monitors found progress in these areas and also in adoption of nationally recognized protocols..
	Summary of Monitor's Assessment: At this review none of the Provisions were found in compliance. There were elements of progress found in all of of the Provisions. A finding of progress does not imply that compliance was met. Furthermore, many newly implemented procedures are too new to demonstrate compliance yet. **For Provision M.1**, progress has been made with regard to completing the Braden Scale for skin integrity assessments as part of the Annual and Quarterly Nursing Assessment. There were five open RN II positions the Facility was actively recruiting to fill. The development and implementation of the Peer Review Process and audit assignments for the various monitoring tools was a positive step forward in self-monitoring but needs continued refinement. **For Provision M.2**, progress has been made with regard to Annual and Quarterly Nursing Assessments quarter but failed to consistently describe effectiveness of the Health Maintenance Plans and/or Acute Care Plans established to meet identified risk or potential risk factors. Therapeutic responses to medications, particularly psychoactive and antiepileptic medications were rarely described. Only Registered Nurses completed the assessments. Assessments were documented on a standardized form. **For Provision M.3**, progress has been made with regard to annually developing and implementing interventions to address individual's health care needs. Nurses were completing the MOSES and DISCUS assessments and were participating in the quarterly psych med reviews. Chronic conditions need ongoing monitoring.

	For Provision M.4, progress was being made by the adoption of the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses for the development of chronic and acute care plans. Improvements were beginning to increase collaboration between the RN, PCP and interdisciplinary team. Monthly, or as ordered, weights were maintained in a computerized database, accessible to all Personal Support Team members to review. Nursing protocols were implemented for assessing and reporting urgent care/emergency room visits, hospitalizations, transfers, and readmissions. The Facility Nursing Department needs to ensure that nurses also receive training in Physical Management due to the potential risk many medically fragile individuals have for developing skin breakdown. **For Provision M.5**, progress was being made with regard to developing a system for assessing and documenting clinical indicators of risk for each individual including infection control. Progress was also made in training as competency-based training regarding Infection Control issues was included in new employee orientation and as needed. Data collected regarding infections and communicable diseases needs improvement. Records reviewed showed that there was documentation indicating that all individuals have had their immunization status evaluated within thirty days of admission. **For Provision M.6**, the Nursing Department continues to strive to make improvements in medication administration practices by increased monitoring of records, direct observations, and training. During several Medication Administration observations, the staff nurses failed to follow correct medication administration procedures. The Facility's Nursing Department adopted and are in the process of implementing the Settlement Agreement's Monitoring Tools to use for Nursing's Peer Review Process. The Nursing Department adopted, implemented and provided training for the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses for care plan development. The Annual and Quarterly Nursing Assessment Tool was replaced by the Comprehensive Nursing Assessment tool. The Nursing Case Managers were trained in the proper use of the new Comprehensive Nursing Assessment tool which should improve the quality of nursing assessments, identification of risk factors or potential risk factors for the development of quality Health Maintenance Plans. The Facility's Nursing Department needs to continue to refine the Peer Review Process toward the American Nurses Association (ANA) definition. Since the baseline review the Facility's Nursing Department has made improvements in nursing staffing ratios. Coverage across campus on the 10-6 shift has improved; there was at least one RN available on campus each night in addition to the other staff nurses. The Facility's Nursing Department has improved their nursing shift to shift reporting and communication systems. The Nursing Assessment section of the Personal Support Plans contained more substantive information relating to individuals' health status during the quarter, current status, status of response to health care plans, and any need for change. Therapeutic responses to medications, particularly psychoactive and antiepileptic medications were rarely described. The Facility's Nursing Department needs to continue to

	strengthen the quality of the Annual and Quarterly Nursing Assessments. Medication administration observations documented problems with privacy, infection control, and delivery. The improper administering medications without the MARs present to perform the required three medication checks during medication administration could lead to medication errors. The Infection Control Program needs continued improvement. The Nursing Department needs to develop and implement a formal procedure for reporting infections to the Infection Control Nurse. The Quality Assurance Nurse was developing a computerized program and using data generated from the Medication Error Report forms to perform a "root cause analysis". Once this system becomes operational the quality of the trend analysis should provide more comprehensive information to apply toward developing and implementing corrective action plans.

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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.	Since the baseline review the Facility's Nursing Department has made improvements in nursing staffing ratios. Coverage across campus on the 10-6 shift has improved; there was at least one RN available on campus each night in addition to the other staff nurses. Presently, all three of the 10-6 shift managers' positions were filled. There was one RN II on each unit serving medically fragile individuals for a total of two. They also had one RN II assigned to cover two units serving people with behavior problems. The Cottages are the next units to receive a 10-6 RN II. There were five open RN II positions the Facility was actively recruiting to fill. The Nursing Department continued to hire agency nurses to supplement vacant positions until they can be filled with full-time BSSLC positions. According to the CEN usage of agency nurses consists of nurses who have been working at BSSLC for one to three years and know the individuals. Review of nursing staffing ratios during the last six months indicated that the Facility had not fallen below the minimum staffing requirements. Direct nursing care staffing ratios for the Facility indicated Monday through Friday 6-2 and 2-10 shifts projected ratios of 1:12-15 on units serving medically fragile individuals. On Saturday and Sunday projected ratios were 1:14-19. The 10-6 shifts, for every day's projected ratios were 1:20-30. On the units serving people with behavior problems, Monday through Sunday on the 6 to 2 and 2-10 shifts, projected ratios were 1:22-23. Reportedly when nursing services were needed on the 10-6 shifts, they were covered by the Nursing Shift Managers and/or pulled nursing staff. Nurse Case Managers for the on units serving medically fragile individuals had projected ratios of 1:12-18; units serving people with behavior problems had projected ratios of 1:18-31. Due to the potential for declining health status of individuals in the medically fragile units, and the complex polypharmacy	N

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		of psychoactive medications and potential for maladaptive behavioral issues in the behavioral units, compounded by the implementation of the revised Comprehensive Nursing Assessment for Annual and Quarterly Nursing Assessments, use of the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses for care plan development, and Peer Review Process, the Facility's Nursing Department needs to evaluate Nurse Case Managers caseload ratios. Without a reasonable caseload, no matter how motivated, dedicated, and well intended the Nurse Case manager are they will not be able to meet their weight of responsibility with too high caseloads. The Nursing Department continues to precept nursing students from Blinn School of Nursing for LVNs and RNs, an Associate Degree Program and Prairie View College of Nursing for Bachelor of Science in Nursing (BSN) Program. According to the Chief Executive Nurse (CEN) affiliating with these schools of nursing provides an excellent source for recruitment. According to the CEN, Facility Nursing Policies have been reduced down from 44 to three. If there was a State Policy referring to any of BSSLC's policies the State Policy replaced the Facility policy. Any of BSSLC's policies that could be found in the Lippincott Manual of Nursing Practice were used for procedures. The Nursing Department was also following the Health Care Guidelines with exception of a few Facility procedures they previously followed. Since the baseline review the Facility's Nursing Department had purchased and put in place: Two to three cell phones per unit /cottage, one to two additional computers for each unit, needed professional quality diagnostic equipment, current drug reference guides for each unit, Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses to use as guides for developing nursing care plans, and current Lippincott Manual of Nursing Practice for each unit. Since the baseline review the Facility's Nursing Department has improved their nursing shift to shift reporting and communication systems. Two taskforces were formed consisting of at least one Nurse Case Manager and one LVN from each unit in order to develop more efficient readable reports written and verbalized from shift to shift. It was commendable that the taskforces were a self initiated effort by the staff RNs and LVN after identifying the need to improved communication for shift to shift reporting. They designed and created a Continuous Medical Record (like a Kardex) with vital information such as name, allergies, diagnosis, guardian contact information, that was kept in front of the Medication Administration Records (MARs) and copied as needed for transport to the hospital, and/or other outside facilities. It was also a way for agency or pulled staff to become familiar with the individuals. The Continuous Medical Records were observed to	

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		be placed in the MAR and contained substantive information that could serve as a quick reference for nursing staff. This was validated through review of Continuous Medical Records for individuals: # 392, #395, #311, #323, #8, #453, #89, #331, #422, #343, #43, #269, #597, and #84. In an effort to further improve shift to shift communication the taskforce developed and implemented Cross Communication Sheets that included the individual's name and indicated Health Maintenance and/or Acute Care Plan items to be monitored shift to shift, including, bowel monitoring and blood pressure monitoring, among other health care conditions.
		
		The next task for the Documentation Taskforce was focused on assigning a lead nurse on each unit to ensure follow-up documentation was completed. Additionally, the lead nurse will ensure per necessary (PRN) medications and therapeutic responses were documented on the MARs and integrated progress notes. The taskforce will also assist in implementing the DAP charting system, e.g., D – Data includes the subjective and objective information such as symptoms, concerns, and problems;. A – Assessment/Analysis addresses the response and findings from the nursing assessment; P – Plan is what the nurses' actions and/or interventions are for follow-up.
		
		Since the baseline review the State Office and BSSLC Nursing Department had adopted the Settlement Agreement and Health Care Guideline Monitoring Tools to use for their Peer Review Process. Instructions and assignments were developed and implemented, June 20, 2010, for the Peer Review Process. The process includes:
		• Every month the Quality Assurance Nurse (QAN) will select individual records for audit. If applicable, two charts will be chosen from Driscoll, Bowie, Fannin, and Childress and three from the Cottages. The selected group will be forwarded to the nursing CEN and Nursing Operations Officer (NOO) for distribution to the Nurse Case Managers.
		• The Nurse Case Manager will audit the selected records on different units following a monthly rotation schedule.
		• All completed audits are due to the NOO by the 28th of each month for review. After review, audits will be forwarded to the QAN. The QAN will develop a tracking and trending system and share information results with the NOO.
		• The NOO will share results with Nurse Managers and appropriate training/corrective action plans will be implemented.
		Monitoring Tool Items for audits were assigned to specific nursing management staff:
		• Nurse Manager will audit:
		    o Medication Administration
		    o Quarterly Nursing Assessments
		• Nurse Case Managers will audit:	

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		o Seizure Management o Respiratory Distress o Pain Management o Diabetes o Aging o GERD o Hypertension (HTI) o Urinary Tract Infections (UTI) o Bowel Management (Constipation) • Nurse Shift Managers will audit: o Acute Illnesses and Injuries • Infection Control Nurse will audit: o Infection Control o Skin Integrity • Quality Assurance Nurse will audit: o Nursing Care Plans (Health Maintenance and Acute Care Plans) o Restraints o Annual Nursing Assessments • Hospital Liaison Nurse will audit: o Urgent Care • Nursing Shift Managers will audit: o Documentation No one was assigned to audit Prevention The development and implementation of the Peer Review Process and audit assignments for the various monitoring tools was a positive step forward in self-monitoring. The QAN was in the process of developing and implementing a computer program to enter auditing findings, track and trend data, and identify areas for corrective action. It was too soon after implementation of the Peer Review Process to evaluate for compliance. This item will be reviewed for compliance on the next tour. The Facility's Nursing Department needs to continue to refine the Peer Review Process toward the American Nurses Association (ANA) definition: Peer Review is an organized effort whereby practicing professional nurses review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. The Facility in conjunction with the State Office needs to develop instructions for each monitoring tool to ensure that all auditors are using the documentation and criteria to determine item compliance. This will assist in establishing inter-rater reliability. In order to effectively monitor medical records the monitor must	

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		exercise critical thinking. As the Peer Review Process matures, the audit sample size needs to be increased with the goal of auditing 20% of the records each month in order to provide confidence that the findings of the audits can be applied to all of the records. Refer to Section L.1 and 2 for information related to the Facility's emergency response system.	
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 records for individuals: #78, #70, #26, #436, #411, #31, #192, #190, #422, and #223 with focus on their current Personal Support Plans, last four Quarterly Nursing Assessments, last six months' Health Maintenance Plans, and Acute Care Plans for compliance purposes showed that Integrated Progress Notes for those records demonstrated some progress since the baseline visit. The Nursing Assessment section of the Personal Support Plans contained more substantive information relating to individuals' health status during the quarter, current status, status of response to health care plans, and any need for change. Ten of ten (100%) individuals' records reviewed for Quarterly Nursing Assessments were completed according to the Personal Support Plan schedule. The Quarterly Nursing Assessments were signed by the Nurse Case Manager but failed to contain a date by the signature validating the actual date the review was completed. The Quarterly Nursing Assessments contained more comprehensive information than the baseline review regarding the individuals' heath risks and/or potential health risk factors during the quarter but failed to consistently describe effectiveness of the Health Maintenance Plans and/or Acute Care Plans established to meet identified risk or potential risk factors. Therapeutic responses to medications, particularly psychoactive and antiepileptic medications were rarely described. In reviewing integrated progress notes and/or Annual and/or Quarterly Nursing Assessment Summaries, it was noted that psychotropic and/or antiepileptic medication doses where changed or new medications were ordered but failed to have corresponding Acute Care Plans. According to the Health Care Guidelines changes in psychoactive medications or newly prescribed such medications require an Acute Care Plan during the period of adjustment. There was not proper documentation indicating the Qualified Mental Retardation Professional was notified that the Quarterly Assessment was completed and sent. The Facility's Nursing Department needs to ensure that when there is a change in the dose of psychoactive medications or when new such medications are prescribed that Acute Care Plans are developed, implemented and the Home Leaders and direct care staff are trained in the plan. The Facility's Nursing Department needs to add a line for date on the form to validate the day the review was actually completed. The Facility's Nursing Department needs to continue to strengthen the quality of the Quarterly Nursing Assessments.	N

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M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Ten of ten (100%) individuals' records reviewed for Annual Nursing Assessments were completed according to the Personal Support Plan schedule. The Annual Nursing Assessments were signed by the Nurse Case Manager but failed to contain a date by the signature validating the actual date the review was completed. The Annual Nursing Assessments contained more comprehensive information regarding the individuals' health risk and/or potential health risk factors during the past year but they failed to consistently describe effectiveness of the Health Maintenance Plans and/or Acute Care Plans established to meet identified risk or potential risk actors. Therapeutic responses to medications, particularly psychoactive and antiepileptic medications were rarely described. The Facility's Nursing Department needs to date the Annual Nursing Assessments when signed. The Annual Nursing Assessments, particularly the ones completed since June 2010, were beginning to demonstrate improvement in identifying health risk and/or potential health risk factors Records reviewed for individuals with chronic conditions did not always have Health Maintenance Plans for chronic conditions if their conditions had been stable for the past year or had a Health Risk screening score that was low.. Just because individuals are stabilized on medication does not mean that the chronic condition cannot become unstable. The low risk score or past years' relatively stable condition does not absolve the nurse from exercising good clinical judgment and developing a Health Maintenance Plans for individuals receiving one or more medications to treat the chronic condition, who also may require ongoing diagnostic monitoring to ensure stability, including periodic laboratories as appropriate . For example, Individual #78 had an active medical problem for osteoporosis with a history of fractures to both hips with open reduction internal fixation, fractures of fingers, severe contractures, immobility, and frequent seizures, yet the Health Risk Screening score for osteoporosis was low. Further, this individual does not take any preventative medication for osteoporosis except multivitamins. Individual #78 also had an active medical problem for hypertension and was receiving three different medications for control with blood pressure assessment daily on each shift.. Within the past year individual #78 was sent to the emergency for an extremely high blood pressure. Individual #78 did not have a Health Maintenance Plan to address either osteoporosis or hypertension. The Facility's Nursing Department needs to evaluate their practice regarding establishing Health Maintenance Plans for individuals with chronic conditions who were considered stable for the past year or who have a low Health Risk Screening score. The Nursing Department's Health Maintenance Plans and Acute Care Plans reviewed demonstrated steady improvement since June, 2010, with the adoption of the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses and increased training of the nursing staff on care plan development. They were more applicable for	N

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		individuals with intellectual and developmental disabilities and were improving in quality. Other improvements noted were Home Leaders and direct care staff receiving training on the care plans, as documented through use of accompanying training rosters validating training. A concern identified was the date for Health Maintenance Plan review which was typically six months after implementation. The Facility's Nursing Department needs to ensure that Health Maintenance Plans are reviewed at the time of the Quarterly Nursing Assessment as well as when health status changes. The Care Plan form includes a line for the date care plans were reviewed and/or resolved. The form needs to include both the date reviewed and resolved. Additionally, the Care plan form needs to include a line for the Home Leader's name and date to validate training occurred. The Facility's Nursing Department needs to ensure Health Maintenance Plans are continued at the time of the Annual Nursing Assessment, the Home Leaders and direct care staff are retrained, or are retrained anytime there are changes in the Home Leader and or direct care staff. Review of the records demonstrated that acute injuries and illness were better assessed, physicians were notified more promptly and follow-up assessments and interventions were more consistently documented in the integrated progress notes. Still missing consistently were resolution notes when the Acute Care Plans were discontinued. Pre and post emergency room visits and hospital assessments were improved. The Hospital Liaison consistently contacted the hospital regarding individual's health status and provided comprehensive documentation. Hospital Liaison Nurse's notes were typed and placed chronologically in the integrated progress notes. This was validated through review of individuals #78, #436, #422, and #223's multiple hospital and emergency room visits and admission. Review of individuals #223, #411, #78, and #192's multiple issues with skin integrity demonstrated the need for continued improvement in charting the size and appearance of the wounds. Often documentation in the integrated progress notes described the wounds as "getting smaller" or was "wound healing" as opposed to describing the size and stage of healing. The Facility's Nursing Department needs to provide staff nurses with additional training on how to assess and document wounds.	
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.	Beginning March 29, 2010, one section of the charting guidelines (Health Care Guidelines) and one section from Nursing Management of Chronic Conditions (Health Care Guidelines) were sent to nurses via e-mail each week. At the end of the weekly period, the entire two sections were sent again for review. After each nurse was given the opportunity to review, competency test were administered. This item will be followed up on the next tour to ensure that all nurses received training.	N

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		There was evidence that training on the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses began June 21, 2010. As of July 27, 2010, 36 of 56 (65%) RNs had completed the training. The Nursing Department needs to ensure that all RNs receive training as soon as possible. Training on the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses needs to be included as part of orientation for all RNs as well as included in the annual competency-based training. As was recommended at the baseline review, all nursing staff had received four hours of competency-based training on Nutritional Management. In addition, nurses received competency-based in-service training provided by the Nestle Nutrition Institute, "From Intensive Care to Long Term Care: Nutritional Management of Pressure Ulcers." These trainings should strengthen the nurses' skills and knowledge when monitoring dining and assessing individuals with swallowing difficulties as well as administering enteral nourishment and medications. The Facility Nursing Department needs to ensure that nurses also receive training in Physical Management due to the potential risk many medically fragile individuals have for developing skin breakdown. Since the baseline visit, the Nursing Department had implemented the Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Post Anesthesia Care, Date June, 2010. This was evidenced by review of individuals # 8 and #223 Pre Sedation Procedure and Post Sedation Procedure and follow-up records.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Facility maintains weight measurements on Weight Change Reports and Individual Out of Ideal Weight Reports in a database. Review of these weight records found weight measurements were entered into the database at the frequency they were ordered. Hand written notes were recorded on the printed copy along with the printed weights describing pertinent information, follow-up actions, and recommendations. The notes were not dated or signed by the author. Nurse Case Managers and Physicians signed-off of at the end of the reports but they were not consistently dated. In the comment sections some of the reports stated that information pertaining to all individuals was reviewed at the Medical Quarterly Meeting, June 2010. The procedure for how these weight reports were used and/or communicated was not available for review. Consequently, it was not possible to determine how the information was communicated, or to whom it went, how the information and follow-up actions were carried out and recorded in the individuals' medical record. Therefore, information about risk was not available to be used to make treatment decisions or to evaluate effectiveness of follow up. Review of individual #8's integrated progress notes for May 2010; found that the information written on the printed weight record was not documented in the medical record. Failure to document pertinent information written informally on the printed weight records into the individuals' medical record and/or integrated progress notes	N

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		interferes with continuity of care. The Facility needs to develop and implement a procedure that clarifies the communication flow of documentation noted on the printed weight records into the individuals medical and/or integrated progress notes. The Infection Control Committee Meeting Minutes for March 31, 2010 and June 30, 2010, the current Infection Control Spreadsheet, and the Rate of Infections Reports, January through June, 2010, were reviewed. Interview with the Infection Control Nurse indicated that there were no infection control trends identified in the past six months. The Infection Control Nurse related that receiving reports of infections was often difficult because different Nurse Managers handle the communication differently. Often infections were identified by going to the Pharmacy and obtaining a copy of antibiotic usage. An example of failing to report a communicable disease to the Infection Control Nurse was identified in review of individual #78's, Physician's Order, March 18, 2010, where Vancomycin-Resistant Enterococcus (VRE) urinary tract infection was diagnosed. Individual #78 was treated with Doxycyline 100 mg per tube at 7:00 am and 7:00 pm for 14 days. There were no orders for isolation. Nor was the VRE reported on the Infection Control Spreadsheet. According to Texas Department of Health of State Health Department Services this was a reportable condition. The Infection Control Nurse also needs to receive copies of culture and sensitivity reports. There was no formalized procedure in place for reporting infections to the Infection Control Nurse. Lack of standard procedures to ensure communication of infectious diseases puts individuals served at the Facility at risk because the Infection Control Nurse does not know to conduct surveillance to ensure that proper infection control measures are in place to prevent the spread of the infectious processes. The Nursing Department needs to develop and implement a formal procedure for reporting infections to the Infection Control Nurse. The Facility did not use Antibiograms to prescribe antibiotics. The Clinical and Laboratory Standards Institute defines an antibiogram as an overall profile of antimicrobial susceptibility results of a microbial species to a battery of antimicrobial agents, which should reflect health care needs along with the Facility's formulary. Antibiograms are an important resource for physicians in deciding and prescribing empiric antibiotic therapy. Appropriate empiric data is essential in attempting to treat infections correctly and quickly in an effort to decrease morbidity and mortality. The uses of antibiograms are also helpful in identifying trends in antibiotic resistance. Basic components of an antibiogram include: Antibiotic tested, organisms tested, number of isolates for each organism, percentage susceptibility data for each drug/pathogen combination, specimen sites notations (e.g., blood, urine catheters) and area or unit being tested. It is important to tailor antibiotics as soon as sensitivities are known. This is the best way to avoid drug resistance and new/emerging organisms that are resistant.	

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		The goal to minimizing infection is to proscribe broad-spectrum antibiotics based on unit specific antibiograms. The Facility needs to develop and implement the use of antibiogram to improve appropriate antibiotic therapy. Review of immunization records for individuals #78, # 436, #70, #26, 411, #428, #31, #192, and #190 showed that eight of nine (89%) of the individuals' immunizations were up to date. Individual #411's last Tetanus Diphtheria (TD) Booster was January 6, 2000. TD Boosters are due every 10 years. The Facility's Infection Control Nurse did not maintain a centralized-computerized database for tracking immunizations or for flagging when individuals were due for periodic immunization updates. The Facility needs to develop and implement a centralized-computerized database to track and flag when immunizations are due for periodic updates. When infections were diagnosed it was the responsibility of the Nurse Case Managers to develop and implement Acute Nursing Care Plans and train the house managers and direct care staff as indicated. Review of the Infection Control Spreadsheet January through June, 2010, indicated the following number of reportable communicable diseases: • 6 Cases of Methicillin-Resistant Staphylococcus aureus (MRSA) • 1 Case of Clostridium Difficile (c-diff) • 2 case of Vancomycin-Resistant Enterococcus (VRE) Review of sample records for infection control measures and follow-up care for individuals #78, #26, #436, #411, and #70 revealed the following findings: • Individual #78 was reported on the Infection Control Spreadsheet with a diagnosis of MRSA on January 08, 2010. Review of Physicians Order's and integrated progress notes did not document a diagnosis of MRSA on or around that date. The accuracy of the diagnosis entered on the Infection Control Spreadsheet was questionable. • Individual #436 was sent to the emergency room on June 18, 2010 for evaluation of an infected left knee and fever. #436 was started on antibiotic therapy, but condition worsened and the individual was sent to back to the emergency room on June 19, 2010 for further evaluation and treatment for cellulitis, fever and low blood pressure. The blood culture of June 18, 2010 was positive. The wound was treated with antibiotic therapy. An Acute Care Plan for MRSA was developed and implemented on June 18, 2010 and extended to July 5, 2010 and again on July 30, 2010. There was verification on June 18, 2010 and June 30, 2010 that the Home Leader and direct care staff were trained on the Acute Care Plan for MRSA. The date of resolution was not documented on the Acute Care plan. • Individual #26 was sent to the emergency room on February 22, 2010 with an evaluation temperature of 102.4° and decubitus on right buttock secondary to	

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		cellulitis. Individual #26 was admitted to the hospital with a diagnosis of peri-rectal abscess as opposed to a decubitus ulcer. The abscess culture showed MRSA. The abscess was incised and drained. Antibiotic therapy was initiated. The wound was left open to heal. Individual #26 was discharged from the hospital on February 25, 2010. An Acute Care Plan for decubitus ulcer secondary to abscess/cellulitis was initiated on February 22, 2010, revised on February 25, 2010 for impaired skin integrity. It was revised again on May 20, 2010, and resolved on June 4, 2010. Acute Care Plans included contact isolation and standard precaution. There was documentation on the Acute Care Plans that the Home Leader and direct care staff were trained as a means to prevent spread of MRSA to other individuals and staff.. • Individual #70 was diagnosed with c-diff, treated and resolved while in the hospital February 2, 2010 through March 11, 2010. • Individual # 78 was diagnosed with VRE on March 19, 2010. There were no Physician's Orders for isolation precaution, nor was it reported on the Infection Control Spreadsheet. On July 10, 2010, individual #78 was diagnosed again with VRE and the Physician ordered full isolation precautions. On July 15, 2010, the physician changed full isolation precautions to contact isolation because there was no treatment for VRE colonization. Nursing's integrated progress notes, July 10, 2010, indicated that isolation precautions were implemented and on July 15, 2010, progress notes indicated isolation precautions were changed to contact. There was an Acute Care Plan for Urinary tract infection – VRE which was implemented July 12, 2010 with evidence that direct care staff were trained. This case involved careful review of risk and involvement of the PST. • Individual #411 was diagnosed with VRE while in the hospital (January 3, 2010 through February 2, 2010) with diagnoses of pneumonia and urinary tract infection. Upon discharge Acute Care Plans for pneumonia and urinary tract infection were developed and implemented. The physician ordered contact isolation for approximately one week. There was no Acute Care Plan for VRE; since VRE is a communicable disease, a plan to train staff specific to VRE should have been in place. Review of sample records for individuals #78, #26, #436, #411, and #70 revealed that over the past six months the BRADEN Scale assessments for skin integrity were consistently completed on the Annual and Quarterly Nursing Assessments. This provides a means to screen for risk of skin breakdown. There was documented evidence that the Infection Control Nurse provided two hours of competency-based training to all new employees and refresher training on topics covering all aspects of Infection Control, including good hand washing techniques and standard precaution. There was documented evidence that the Infection control nurse performed periodic training when there was an identified need. For example, on June 16,	

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		2010, there was documented evidence that all shifts in Driscoll Gardens C received training on Herpes Simplex Virus I and II. There was documented evidence that Shift Managers routinely performed handwashing and standard precaution audits, environmental surveillance, and took corrective action when needed. During the baseline review a concern was raised over performing routine annual chest x-rays on individuals with past tuberculin-positive Mantoux tests. Since the baseline visit the Facility has stopped routine annual chest x-rays on these individuals. Now chest x-rays for individuals with past tuberculin-positive Mantoux tests are at the discretion of the individual's physician. The Facility's Medical and Nursing Department needs to regularly contact their local Health Department's Epidemiology Program regarding the current Centers for Disease Control (CDC) requirements for performing chest x-rays on individuals with past tuberculin-positive Mantoux tests as well as management of other reportable contagious diseases. Information regarding the status of tuberculin testing was not available for review as requested in the document request. This issue will be followed-up on the next tour. At the baseline review a concern was identified regarding a seeming increase in oral infections. The monitoring team member recommended that the Infection Control Nurse conduct infection control inspections of Dental Services' clinical equipment and environmental conditions. The Infection Control Nurse had observed the dental services equipment and environmental conditions and discussed infection control measures with the dental clinic staff. An action plan was written and will be implemented by July 31, 2010. The Infection Control Nurse will begin unannounced infection control observations in the Dental clinic to reduce risk of infection. This issue will be followed-up on the next tour. The Infection Control Nurse had begun using the Monitoring Tools for Infection Control and was working with the Quality Assurance Nurse to develop a computerized program to enter data and perform trend analyses from which issues for corrective action can be identified, developed, and implemented. Infection Control Policies are in the process of revision by the State Office. In the meantime the Facility was using Lippincott Manual of Nursing Practice procedures and CDC guidelines. This issue will be followed-up on the next tour. Infectious diseases whether acute or chronic and/or communicable require a great deal of expertise in Infection Control Management for many clinical complex variables. The Infection Control program performs an integral role in ensuring the health and safety of individuals and staff. The Facility needs to consider securing the services of an expert in the area of infection control to provide consultation and onsite technical assistance in order to strengthen the infection control program.	

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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.	As was recommended at the baseline tour, the nursing staff had worked collaboratively with the Physical and Nutritional Management Team to identify individuals who required the use of Mothercare or Maroon spoons for safe oral intake and for use when mixing medication with food stuffs for administration. Individuals #450, #403, #158, #186, and #395 were identified. Medication Administration Records (MARs) reviewed in Bowie Springs, Driscoll Gardens, Childress Terrace, and Cottages. revealed that Physical and Nutritional Management Plans (PNMPs) were placed in individuals MARs with the exception of Cottage C. One cottage was missing seven of 16 PNMPs in the MARs. The Nurse Manager explained that Cottage had very recently changed to house young male individuals and were in the process of updating records. The Nurse Manager assured the monitoring team member that the missing PMNPs would be promptly located and placed in the MARs. Medication Administration Observations were conducted in Bowie Springs C, Childress Terrace D, and Driscoll Gardens A, B, and C. Five staff nurses were observed administering medication to six individuals. In four of six (67%) individuals observed receiving medications, administered by four of five (80%) staff nurses; the staff nurses failed to follow correct medication administration procedures. Incorrect procedures observed included: • Staff nurse administering medication via enteral route to individual #344 failed to follow proper infection control measures by improperly disposing the used washcloth on top of the med cart after administering medication. This action contaminated the med cart. • Staff nurse administering medication via enteral route to individual #577 failed to tell the individual the name and purpose of the medications administered. • Staff nurse administering medication via oral route to individual #153 failed to check the PNMP. Individual #153's PNMP called for the use of a Mothercare or Maroon spoon. Medication mixed with pudding was administered with a plastic picnic style spoon. The Motherspoon or Maroon spoon was not available on the med cart. • Staff nurse administering medication via oral route to individual #34 failed to provide privacy during medication administration. Although the individual # 34 was taken to area in the day room away from the general population, it was still in a public area. After receiving medication mixed in pudding the staff nurse failed to provide fluids to assist in washing down the medications. The practice of giving medication in Bowie Springs C was to hand carry prepared medications in a cup, without the MARs, to individuals. The rationale for this practice as described by the staff nurse was: Individuals who reside in this home were elderly with mobility problems and it was easier for them if the medications were taken to them. The need to create privacy for individuals during medication administration was discussed	N

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		with the Bowie Springs' Nurse Manager. The Nurse Manager agreed to create a privacy space for individuals to received medications. Additionally, discussed with the Nurse Manager and staff nurse was the improper method of administering medications without the MARs present to perform the required three medication checks during medication administration. None of the individuals observed had Self-Administration of Medication Programs. The Facility's Nursing Department needs to ensure: • Med carts are stocked with an adequate supply of Mothercare or Maroon spoons for individuals whose PNMPs requires their use and that these spoons are properly sanitized after use. • Arrangements for privacy are provided in all areas where medications are administered. • Medication Error data are reviewed to identify nurses who frequently commit medication errors and for those nurses perform more frequent Medication Administration Observations than quarterly until the frequency is reduced or eliminated. Per Nursing Department policy, each staff nurse responsible for administering medications received a quarterly Medication Administration Observation. This was validated through a review of Bowie Springs, Childress Terrace, and Fannin Villa completed Medication Administration Observation Checklists for March, April, and May, 2010. Completed Medication Administration Observation Checklists were cross-checked with the units' quarterly schedules. Of the nurses scheduled for quarterly observations: Eight of eight (100%) were completed in Bowie Springs. Eight of eight (100%) were completed in Childress Terrace. Seven of eight (86%) were completed in Fannin Villa. There was evidence documented on the Medication Administration Observation Checklists for corrective action when a nurses were observed failing to follow correct medication administration procedures. Completed Quarterly Medication Administration Observation Checklists were requested for all units but were not received for Driscoll Gardens and the Cottages. The Medication Administration Observation Checklist was recently revised to provide more comprehensive information. The revised form failed to include observations for Physical and Nutritional Management Plan (PNMP) instructions, e.g., liquid consistency, consistency, positions, and adaptive equipment. Nor was observation for privacy included. The revised Medication Administration Observation Checklist did not include the date of implementation or identification number. The Facility's Nursing Department needs to include observations for PNMP items and privacy issues on the Medication Administration Observation Checklist. The Facility's Nursing Department needs to always include the date of implementation and identification number when new forms are created. Otherwise, the correct form may not be used and has the potential to cause non-compliance. The Nurse Managers need to purge the old	

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		Medication Administration Observation forms and replace them with the revised form. Review of 10 Medication Error Reports, as requested through document request, indicated the follow: o Seven of 10 (70%) were due to omissions. o One of 10 (10%) was due to improper dose/quantity o One of 10 (10%) was due to an extra dose o One of 10 (10%)was due to wrong drug preparation o Six of 10 (60%) were discovered within 24 hours after occurrence o Four of ten (40%) were discovered longer than 24 hours after occurrence • Medication Error Reports showed some improvement in the completeness of the form but need continued improvement to ensure that all applicable items are documented. Five of the 10 (50%) contained the alpha letter for the location where the initial error occurred. All units have alpha letters that represents homes. Including the alpha letter and not the unit name makes accurate data collection difficult. The Follow-up of Nursing Supervisor sections of the forms did not consistently contain substantive information. In four of the forms the information stated, "nurse notified", two described the errors and contributing factors that lead to the errors, two described the counseling provided to the nurse committing the error, one contained the Nurse Case Manager's signature and title, and one had no entry or signature. The Facility's Nursing Department needs to monitor the Medication Error Reports for completeness and accuracy. The Facility's Nursing Department needs to ensure that Nursing Case Managers thoroughly review Medication Error Reports and complete the Follow-up of Nursing Supervisor sections with a description of their clinical response as well as corrective action taken with the nurse committing the medication error. Review of the Medication Error Committee Meeting Minutes, January 27, 2010, March 31, 2010, April 29, 2010, and May 26, 2010 as well as the Medication Error Trending Report for Medication Errors on Campus, January through June, 2010, and observation of the Medication Error Committee meeting, July 29, 2010 revealed that the Nursing Department has made progress in reducing the incidence of medication errors through quarterly Medication Administration Observation of nurses responsible for administering medication. They have begun counting medications in the med cart at each medication pass, implementing monitoring tool for Medication Administration, and counseling and retraining, nurses who make medication errors and holding problem solving discussions at the Medication Error Committee Meeting . The omission of medications continues to be the most frequently occurring medication error. The Medication Errors Trending Reports calculated percentage of medication errors	

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		occurring monthly as compared to the number of medications administered in each unit and cottage. Making comparisons from unit to unit using percentages based on the number of medications administered may be misleading because of the variation in the number of medications administered unit/cottage to unit/cottage. The Facility should consider calculating number of medications administered per unit by calculating rates as opposed to percentages. The Quality Assurance Nurse was developing a computerized program and using data generated from the Medication Error Report forms to perform a "root cause analysis". Once this system becomes operational the quality of the trend analysis should provide more comprehensive information to apply toward developing and implementing corrective action plans. While trending and analyzing raw medication errors data from the perspective of type, number, and location of occurrence may provide some meaningful information from which to draw conclusions; it does not provide the depth of information necessary to identify and isolate systemic or specific problems that contribute to medication errors. In order to gain the best understanding of factors contributing to medication errors the data should be honed down to identify: Specific nurses frequently making errors, units with most frequent errors, medication pass times with frequently occurring medication errors, shifts with most frequent errors, days of week when errors most frequently occur, as well as other contributing factors like, inadequate knowledge and skills of the nurse, limited time to pass high volumes of medication, number of individuals with complex medication regimens, individuals who are administered medication via enteral route, cramped and/or noisy work space, and poor lighting. The value of examining these causative factors can provide the Facility with information to assist with corrective action plans such as, indications and signals of major system breakdowns, benchmarks for quality improvements and best practices, focus resource deployment for error correction and prevention, evaluate expense of interventions, provide a source of examples for problem-solving, continuing-education programs, and focus for root-cause analyses. The Facility's Pharmacy Department recently developed and implemented a Medication Adverse Drug Reaction (ADR) Reporting Form. This was evidenced by review of ADRs completed on individuals #386 and #403. Review of individual #403's record demonstrated active participation by the Nurse Case Manager in identifying signs and symptoms of possible ADRs related to the new administration of Buspar. The Nurse Case Manager researched the potential Buspar had for causing ADRs, and discovered it had the remote potential to cause blistering of the feet, such as individual #403 began experiencing soon after taking Buspar. This information was related to the Physician, the medication was stopped, and the blistering stopped shortly afterwards. The Nurse Case Manager also worked collaboratively with the Facility's Pharm.D. in problem solving the	

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		ADR to Buspar, a good example of integrated services.	

Recommendations:

1. The Facility Nursing Department needs to ensure that nurses also receive training in Physical Management due to the potential risk many medically fragile have for developing skin breakdown.
2. The Facility's Nursing Department needs to ensure that all RNs receive training as soon as possible. Training on the Health Care Protocols – A Handbook for Developmental Disability (DD) Nurses needs to be included as part of orientation for all RNs as well as included in the annual competency-based training.
3. The Facility's Nursing Department needs to continue to refine the Peer Review Process toward the American Nurses Association (ANA).
4. The Facility in conjunction with the State Office needs to develop instructions for each monitoring tool to ensure that all auditors are using the documentation and criteria to determine item compliance. This will assist in establishing inter-rater reliability.
5. As the Facility's Nursing Department's Peer Review Process matures the audit sample size needs to be increased with the goal of auditing 20% of the records each month in order to provide confidence that the findings of the audits can be applied to all of the records.
6. The Facility needs to develop and implement a procedure that clarifies the communication flow of documentation noted on the printed weight records into the individuals medical and/or integrated progress notes.
7. The Facility's Nursing Department needs to ensure that when there is a change in the dose of psychoactive medications or when new such medications are prescribed that Acute Care Plans are developed, implemented and the Home Leaders and direct care staff are trained in the plan. The Facility's Nursing Department needs to add a line for date on the form to validate the day the review was actually completed. The Facility's Nursing Department needs to continue to strengthen the quality of the Quarterly Nursing Assessments.
8. The Facility's Nursing Department needs to date the Annual Nursing Assessments when signed and therapeutic responses to medications, particularly psychoactive and antiepileptic medications are described properly.
9. The Facility's Nursing Department needs to evaluate their practice regarding establishing Health Maintenance Plans for individuals with chronic conditions who were considered stable for the past year or who have a low Health Risk Screening score.
10. The Facility's Nursing Department needs to ensure that Health Maintenance Plans are reviewed at the time of the Quarterly Nursing Assessment as well as when health status changes.
11. The Care Plan form includes a line for the date care plans were reviewed and/or resolved. The form needs to include both the date reviewed and resolved. Additionally, the Care plan form needs to include a line for the Home Leader's name and date to validate training occurred.
12. The Facility's Nursing Department needs to ensure Health Maintenance Plans are continued at the time of the Annual Nursing Assessment, the Home Leaders and direct care staff are retrained, or are retrained anytime there are changes in the Home Leader and or direct care staff.
13. The Facility's Nursing Department needs to provide staff nurses with additional training on how to assess and document wounds.
14. The Facility's Medical and Nursing Departments need to regularly contact their local Health Department Epidemiology Department regarding the current CDC requirements for performing chest x-rays on individuals with past tuberculin-positive Mantoux tests as well as management of other reportable contagious diseases.
15. The Facility needs to develop and implement the use of Antibiogram to improve appropriate antibiotic therapy.
16. The Facility needs to develop and implement a centralized-computerized database to track and flag when immunizations are due for periodic updates.
17. The Facility needs to consider securing the services of an expert in the area of infection control to provide consultation and onsite technical assistance in order to strengthen the infection control program.

18. The Facility's Nursing Department needs to evaluate Nurse Case Managers' caseload ratios. Without a reasonable caseload, no matter how motivated, dedicated, and well intended the Nurse Case Managers are they will not be able to meet their weight of responsibility with too high of caseloads.
19. The Facility's Nursing Department needs to develop and implement a formal procedure for reporting infections to the Infection Control Nurse.
20. The Facility's Nursing Department needs to ensure:
    - Med carts are stocked with an adequate supply of Mothercare or Maroon spoons for individuals whose PNMPs requires their use and that these spoons are properly sanitized after use.
    - Arrangements for privacy are provided in all areas where medications are administered.
    - Medication Error data are reviewed to identify nurses who frequently commit medication errors and for those nurses perform more frequent Medication Administration Observations than quarterly until the frequency is reduced or eliminated.
21. The Facility's Nursing Department needs to include observations for PNMP items and privacy issues measures on the Medication Administration Observation Checklist.
22. The Facility's Nursing Department needs to always include the date of implementation and identification number when new forms are created. Otherwise, the correct form may not be used and has the potential to cause non-compliance. The Nurse Managers need to purge the old Medication Administration Observation forms and replace them with the revised form.
23. The Facility's Nursing Department needs to continue monitor the Medication Error Reports for completeness and accuracy.
24. The Facility's Nursing Department needs to ensure that Nursing Case Managers thoroughly review Medication Error Reports and complete the Follow-up of Nursing Supervisor sections with a description of their clinical response as well as corrective action taken with the nurse committing the medication error.
25. The Facility should consider calculating number of medications administered per unit by calculating rates as opposed to percentages.

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:** 1. Clinical documentation for the following individuals: #3, #9, #50, #51, #68, #77, #84, #89, #111, #165, #167, #209, #231, #237, #305, #353, #386, #473, and #594 2. Physician orders 3. Physician notes 4. Medication administration record 5. Hospital discharge summary 6. Annual medical summary 7. Laboratory assessment 8. Medication list 9. Problem list 10. MOSES 11. DISCUS 12. Quarterly Drug Regimen Review (QDRR) 13. Personal Support Plans and Addendums 14. Quarterly Medication Review Worksheet **People Interviewed:** 1. Joseph Williams, R.Ph, Pharmacy Director 2. Trey Knittel, Pharm. D., R.Ph. **Meeting Attended/Observations:** 41. Medication Error Committee Meeting, July 28, 2010 42. Pharmacy and Therapeutics meeting, July 29, 2010
	Facility Self-Assessment: The Facility reported that it did not comply with any of the provisions of this Section. The Facility reported compliance with several actions to lead toward compliance. The Facility reported that pharmacy completed pharmacist documentation and review of physicians' orders. The monitoring team found that clinical reviews were present but needed to be enhanced. The Facility reported pharmacist review of labs when doing QDRRs. The monitoring team confirmed that this was done but found a need for more aggressive follow-up on abnormal labs. The Facility reported documentation that physicians considered pharmacists' recommendations. The monitoring team confirmed this occurred but found that documentation of physician reasoning for not following pharmacists' recommendations needed improvement.

	The Facility reported compliance regarding monitoring of side effects including tardive dyskinesia The monitoring team found documentation of assessments within the clinical record but found that a substantial number of DISCUS and MOSES assessment forms were not appropriately completed by the prescribing physician.
	Summary of Monitor's Assessment: At the time of this review, none of the provisions were found to be compliant. Progress has, however, been made in some elements of each provision: The Center has made significant strides to ensure a quality review of medication related issues. A Clinical Pharmacist has been hired by the center to enhance outcomes. **For provision N.1,** the clinical reviews were present but must be enhanced. Assertive follow-up of abnormal laboratory result and notification to the physician is critical. Allergies must be better addressed by the prescribing physician and nursing staff. Each QDRR reviewed demonstrated completeness based on the centers drug review "tool" that is used to facilitate Pharmacy reviews. Each review was completed within expected time frames, laboratory diagnostics were appropriately assessed, side effects allergies were noted, and recommendations were documented for the prescribing physicians review. The Quarterly Medication Review Worksheet which is used to complete each QDRR review is limiting and does not enable a comprehensive review, if strictly adhered to. **For provision N.2,** the pharmacist must assertively follow up on abnormal laboratory findings with the prescribing physician and ensure that appropriate clinical action is taken to prevent adverse outcomes. Recommendations to the physicians were noted to be present on each QDRR reviewed; however, when potentially serious issues, such as when commenting of toxic drug levels, assertive action was not evident, by review of the QDRR form. Other then the quarterly review, there is no apparent tracking mechanism, for the pharmacist, to ensure that critical drug monitoring is completed when necessary, or when laboratory data is returned abnormal. In the context of the quarterly review, the process for review of laboratory data is functional, and considered adequate; however, because there is no meaningful method for the pharmacist to track important laboratory data, outside of the quarterly review, the process does not meet the needs of individuals served. **For provision N.3,** the monitoring team was unable to assess compliance during this visit.. **For provision N.4,** although Pharmacist's recommendations were noted on each completed QDRR, pharmacy recommendations that were not followed were not addressed within the context of the team process. **For provision N.5,** the monitoring team does not concur with the Facilities assessment of compliance with

	action step two. The monitoring team found deficiency with completeness of DISCUS assessment when reviewing records at the living area. In all cases reviewed, MOSES assessments and when appropriate DISCUS assessments were noted within the clinical record. It was noted, however, that a substantial number of DISCUS and MOSES assessment forms were not appropriately completed by the prescribing physician. Additional assessments for medication side effects, other then routine MOSES and DISCUS assessments, were not noted when clinically indicated. **For provision N.6,** the monitoring team concurs with the Facilities self assessment. Non of the six action steps are in compliance. The Facility continues to develop an internal process that will enhance awareness of significant and unexpected adverse drug reactions. **For provision N.7,** the monitoring team was unable to assess this provision during the on-site review. **For provision N.8,** the monitoring team concurs with the Facility that action steps determined to be in compliance, are in compliance. The pharmacy department does an excellent review of orders, once they have been submitted for processing.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	The Center has made significant strides to ensure a quality review of medication related issues. A Clinical Pharmacist has been hired by the center to enhance outcomes. The monitoring team evaluated fifteen QDRR reports during the on-site review. Each QDRR reviewed demonstrated completeness based on the centers drug review "tool" that is used to facilitate Pharmacy reviews. Each review was completed within expected time frames, laboratory diagnostics were appropriately assessed, side effects allergies were noted, and recommendations were documented for the prescribing physicians review. Following discussions with the Director of Pharmacy Services, and the Clinical Pharmacist, and after conducting record reviews, concerns were raised as to the comprehensiveness of the review process and integration of the pharmacy reviews in the team process. 1. The Quarterly Medication Review Worksheet which is used to complete each QDRR review is limiting and does not enable a comprehensive review, if strictly adhered to. For example, when employing the use of the tool when reviewing the use of antiepileptic drugs, if an individual is only on one medication for seizure control, consideration for a medication taper or drug class change will not be reviewed by the pharmacist. When strictly followed, the tool does not enable the pharmacist latitude to explore other issues outside of what is evaluated by the review worksheet. 2. Recommendations to the physicians were noted to be present on each QDRR reviewed; however, when potentially serious issues, such as when commenting	N

#	Provision	Assessment of Status	Compliance
		of toxic drug levels, assertive action was not evident, by review of the QDRR form. In one particular situation, an individual was noted to have significantly elevated Dilantin levels on multiple occasions, and over a prolonged period of time. The issue was minimally addressed on the QDRR, and although the issue was discussed among the clinical pharmacist and the prescribing physician, assertive management was not apparent. Importantly, the "team" was not made aware of the clinical relevance of prolonged toxicity to Dilantin. 3. When reviewing completed physician orders within the pharmacy department, the orders were noted to be complete and included medication, dose, frequency, route of administration, timed, dated and signed, but review of physician orders in the clinical records per document request identified many orders found to be incomplete. Importantly, allergies were not consistently, nor accurately documented on the physician order sheet. During the monitoring teams review, several instances of prescribing medications to allergic individuals were noted.	
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.	At present, the clinical pharmacist's review of laboratory data is limited to the QDRR process or when specifically asked to review data. This process may be considered limiting, because of the prolonged interval between reviews (three months). Other than the quarterly review, there is no apparent tracking mechanism, for the pharmacist, to ensure that critical drug monitoring is completed when necessary, or when laboratory data is returned abnormal. In the context of the quarterly review, the process for review of laboratory data is functional, and considered adequate; however, because there is no meaningful method for the pharmacist to track important laboratory data, outside of the quarterly review, the process does not meet the needs of individuals served. This issue is delineated by the monitoring team's review of abnormal drug levels that were not adequately addressed during the interim of pharmacy reviews.	N
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	The monitoring team was unable to assess compliance during this review.	Not Rated

#	Provision	Assessment of Status	Compliance
	treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.		
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.	. Of the QDRRs reviewed by the monitoring team, Pharmacist's recommendations were noted on each completed QDRR. When recommendations were not accepted by the prescribing physician only limited documentation was present to support their reasoning for not following the recommendation. Importantly, pharmacy recommendations that were not followed were not addressed within the context of the team process.	N
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 clinical records of five individuals at their homes, six records reviewed for polypharmacy and review of 12 individuals receiving anticonvulsant medications were reviewed for drug monitoring. In all cases reviewed, MOSES assessments and when appropriate DISCUS assessments were noted within the clinical record. At the time of this review, the monitoring team was unable to determine the effectiveness of these assessments with regards to clinical outcomes. It was noted, however, that a substantial number of DISCUS and MOSES assessment forms were not appropriately completed by the prescribing physician. In all cases reviewed, the evaluating nurse completed the assessment and signed the document. With regards to the DISCUS, the physician had not completed the diagnoses component, nor had the prescribing physician signed their name to the assessment reviewed. Importantly, additional assessments for medication side effects, other then routine MOSES and DISCUS assessments, were not noted when clinically indicated. This issue is delineated by the review of individuals with known elevated drug levels, without clear documented physical examination and clinical review by the physician to ensure that the individual was clinically free from side effects. The interdisciplinary team process did not address the review of side effects. Annual support plans and addendums make no comments on side effects to medications or	N

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		abnormal drug monitoring diagnostics. It is important that the team, including the individual's LAR, is made aware of side effects to medication and abnormal monitoring diagnostics.	
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.	Following attendance of the Medication Error Review Committee meeting, the monitoring team understands that the Facility continues to develop an internal process that will enhance awareness of significant and unexpected adverse drug reactions. Since the process is in the beginning stages the monitoring review team is unable to assess functionality of the process at this time. The Facility's Pharmacy Department recently developed and implemented a Medication Adverse Drug Reaction (ADR) Reporting Form. This was evidenced by review of ADRs completed on individuals #386 and #403. Review of individual #403's record demonstrated active participation by the Nurse Case Manager in identifying signs and symptoms of possible ADRs related to the new administration of Buspar.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The monitoring team was unable to assess compliance at the time of this review.	Not Rated
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.	Following attendance of the Medication Error Review Committee meeting, the monitoring team understands that the Facility continues to develop an internal process that will enhance awareness of significant and unexpected adverse drug reactions. Since the process is in the beginning stages the monitoring review team is unable to assess functionality of the process at this time.	N

Recommendations:

1. Given the number of pharmacy reviews required at the Facility and to ensure a comprehensive review process, the Facility must explore the possibility of adding additional Clinical Pharmacists to the process.
2. It is critical that the worksheet used to complete the QDRR either be enhanced to ensure a more comprehensive review process or the Clinical Pharmacist should only rely on the tool as a guide and evoke a more through review when clinically indicated. For example, all persons receiving anticonvulsant medications, regardless of the number of drugs prescribed, should be reviewed for medication reduction.
3. The clinical pharmacist is a valuable resource that should be embraced and relied upon by all clinical professionals at the centers. Importantly, when relevant, the clinical pharmacist should be involved in clinical decision making specific to pharmacotherapy.
4. A system for allergy awareness and notification must be either enhanced or developed. Before any medication is prescribed by a physician, the physician must actively review the individual's list of allergies and other known contraindications. When taking verbal orders and when processing medication orders, nursing staff must similarly review for allergies and known contraindications.A tracking system (database) should be considered to assist in the monitoring of important drug levels and other laboratory studies, relevant to monitoring side effects of medications by the pharmacist.
5. The process of laboratory monitoring should be regularly reviewed to ensure appropriate follow-up and management by clinical staff. When the physician does not support a pharmacist's recommendation, the physician must document a rational explanation for not supporting the recommendation, one that is supported by prudent clinical judgment.
6. All non-supported recommendations by the pharmacist should be reviewed by the team process, which includes participation or notification of the individual's legally authorized representative (LAR).
7. In-service training for physicians, nurses and pharmacists should be routinely provided to enhance a continued understanding of the DISCUS and MOSES assessment tools.
8. Periodic Inter-rater reliability assessments should be conducted for physicians, nurses and pharmacists to ensure validity of the results of the DISCUS and MOSES
9. Primary care physicians, psychiatrists and consultants should enhance their attention to potential medication side effects when exploring acute and unexplained medical issues
10. Side effect monitoring must be intensified when drug levels are noted to be elevated and when adding new medications. When developing a process to review medication variances, ensure that all necessary data are statistically relevant to the process. This may necessitate the involvement of a person with more then a general understanding of statistical analysis.
11. When developing the medication variance review process, consider the use of relevant technology for data collection and analysis, such as database software that can manage large amounts of data, and over prolonged periods. It is important to have a full understanding of what is to be accomplished by collecting data before embarking on database development.
12. When reviewing medication variances, it is imperative that the process is "active" and not "passive". Information must be completely reviewed and issues explored in depth by the committee.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record Reviews for Individuals #5, #8, #9, #11, #30, #33, #54, #59, #60, #68, #69, #70, #77, #83, #85, #87, #93, #96, #97, #122, #138, #202, #230, #275, #283, #284, #298, #303, #316, #335, #343, #374, #375, #390, #395, #404, #408, #413, #428, #434, #505, #514, #527, #554 2. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management (PNM) team members, including credentials. 3. Policies, procedures, and/or other documents related to Physical and Nutritional Management Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 4. Curriculum vitae (CVs) for Physical and Nutritional Management Team (PNMT) members 5. A list of continuing education sessions or activities participated in by PNMT members since 1/2010 6. Minutes, including documentation of attendance, for the following meetings i. PNMT meetings, ii. Nutritional Management Team (NMT) meetings, and iii. Health Support Team (HST) meetings (1/5/2010 to 6/9/10) 7. Individual PNMT reports for individuals reviewed above 8. Tools used to screen and identify individuals' PNM health risk level. 9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order. 10. Tools used to assess PNM status and needs. 11. A list of PNM assessments and updates completed in the last two (2) quarters. 12. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter. 13. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs. 14. Tools used to monitor implementation of PNM procedures and plans. 15. A list of individuals for whom PNM monitoring tools were completed in the last quarter. 16. Tools utilized for validation of PNM monitoring. 17. For the past two quarters, any data or trend summaries used by the facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans. 18. Nutritional management plan template and any instructions for use of template. 19. Dining Plan template. 20. PNM spreadsheets generated by the facility. 21. Lists of individuals: (a) On modified diets/thickened liquids; (b) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (c) With BMI equal to greater than 30;

	(d) With BMI equal to less than 20; (e) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; (f) During the past 12 months, have had a choking incident; (g) During the past 12 months, have had a pneumonia incident; (h) During the past 12 months, have had skin breakdown; (i) During the past 12 months, have had a fall; (j) During the past 12 months, have had a fecal impaction; (k) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (l) With poor oral hygiene; and (m) Who receive nutrition through non-oral methods. 22. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year. 23. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials. 24. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans. 25. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM. 26. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. 27. BSSLC Plan of Improvement (POI), dated 5/17/10 **Interviews with**: 1. Kori Kelm (Habilitation Director) 2. Direct Care Professionals on Bowie A, B and Driscoll A,B,C, and D **Observations of**: 1. Individual #390 PSP 2. Daily activities on Bowie A, Bowie B, Driscoll A, B, C, and D 3. Mealtimes on Bowie A, B, and Driscoll A,B, C, and D
	The Facility stated it is not yet in compliance with any of the provisions of this Section but has implemented a number of actions to lead toward compliance. For example, the Facility reported that PNMPs are being revised to include oral intake strategies for medication administration and oral hygiene. The monitoring team agrees that these are not yet included in PNMPs. The Facility reported that implementation of positioning plans was not yet in compliance and that competency based training of staff (while in process for orientation of new staff) is not provided periodically nor is competency-based person-specific training in place. The monitoring team agrees.

	The Facility needs to understand that action steps that relate to provision of training and to understandability of plans are not complete until there is clear demonstration that they are effective. The Facility reported that PNMPs reflect interventions that are understood by staff. The monitoring team found numerous occurrences in which PNMPs were not being followed accurately.
	Summary of Monitor's Assessment: **Provision O.1,** this provision was determined to be not in compliance. An area of improvement included the expansion of training regarding nutritional management to all professional staff. Areas of need include the consolidation of paperwork between the HST and NMT minutes and the need to meet and investigate the etiology of any change in status (i.e., skin breakdown or pneumonia) **Provision O.2, t**his provision was determined to be not in compliance. DADS was in the process of developing a new risk process that is planned to address the need to more accurately identify an individual's risk. Additionally, supports regarding the areas of oral care and medication administration are missing from the assessment process and are not included in the PNMP. Nutritional assessments are also not being provided at a frequency that is sufficient to meet the individuals' needs. **Provision O.3, t**his provision was determined to be not in compliance. PNMPs are not regularly reviewed in the occurrence of a change in status and are not comprehensive due to the plans lacking information regarding oral care and medication administration. Additionally, PNMPs are not developed with clear input from the PST. **Provision O.4, t**his provision was determined to be not in compliance. Staff were observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Per interview, staff again were not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. It should be noted that BSSLC has increased their level of training and has recently completed nutritional management training for all professionals. **Provision O.5, t**his provision was determined to be not in compliance. There was no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. **Provision O.6,** this provision was determined to be not in compliance. BSSLC has increased monitoring but there was not evidence that staff or the individual were being monitored in all aspects in which the individual was determined to be at increased risk. BSSLC has improved their overall monitoring system through the development of a database that will assist in the ability to assess the acquired data and establish trends for future training and interventions. BSSLC has also consolidated their bathing, and mealtime /snacks forms into a single comprehensive tool. This consolidation should assist in streamlining the monitoring process.

	Provision O.7, this provision was determined to be not in compliance. There was not a formal process in place that ensures individuals with increased PNM issues are provided with increased monitoring. At this time, this process is informal and directed by the attending clinician. **Provision O.8,** this provision was determined to be not in compliance. All Individuals did not receive an annual assessment that addressed the medical necessity of the tube or potential pathways to PO status. Those individuals that did receive assessments did not have clear justification as to why the tube was necessary nor did the assessments list possible pathways to oral intake. **Other Issues:** Per review of the Nutritional Management Team Policy (12/17/2009) and the Physical Nutritional Management Policy (12/17/2009), there is still not a policy that speaks to the need to have a single cohesive team or meeting that reviews all aspects of physical and nutritional management. The NMT is focused on reviewing the nutritional aspects and the HST remains focused on risk issues. Although a PNM team is mentioned in the PNM policy, it is not clear what role the team plays other than to develop PNMPs. There is no direction as to the frequency in which the team meets or if the team meets at all. The Nutritional Management Team is clearly identified and provides information regarding roles. but again, this focuses only on the nutritional aspects of physical and nutritional management

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan	A combination of the Health Status Team (HST) and Nutritional Management Team (NMT) is considered to function as the PNM team at BSSLC. The team consists of the Physician, Pharmacist, Physical Therapist, Occupational Therapist, Speech Therapist, Registered Nurse, and QMRP among other professionals. All members reviewed had current licenses and experience in ID/DD field. While this team has all the needed members, there is still not a single team that focuses on PNM issues. Currently, one must review both the HST notes and NMT notes to gain an understanding of the individuals' current status. The current system results in issues often being overlooked or not addressed in a comprehensive manner. Examples of this are listed further below in section O.1. Based on a review of PNM (NMT and HST) Team attendance records and meeting minutes from 1/5/2010 to 6/9/10 documented 100% of attendance by PNM (NMT and HST) Team standing members. Review of facility documentation (CV, copy of current licenses) submitted for each PNM (NMT and HST) Team standing member **did** demonstrate the following qualifications for PNM (NMT and HST) Team standing members: • In 11 of 11 licenses reviewed, a copy of the license was current. • In 11 of 11 CVs reviewed, experience in respective field was documented.	N

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	meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	Review of PNM (NMT and HST) clinical instruction documentation submitted revealed that some PNM (NMT and HST) Team members **did** have training and professional development in related PNM areas but Nursing, Dietitians, and Supervisors were lacking in training regarding the physical management component of PNM: • In 6 of 11 individual clinical instruction records reviewed, clinical instruction within the last 12 months related to physical and nutritional supports had been completed. Per Habilitation Director, this is an area that is lacking and would logically be the next step in training to occur. Per state policy, meetings were to be held at least quarterly, with additional meetings held related to the following: eating/health problems, changes in risk, after medical or other diagnostic tests, and to address follow up activities. Based on a review of 8 out of 10 individual records, documentation supported that the PNM (NMT and HST) Team **did not** meet regularly to address change in status, assessment, clinical data and monitoring results. Additionally, no assessments were conducted in response to identified issues. The HST and NMT minutes reviewed did not show evidence of active discussion or problem solving and provided only a summary of the events and does not provide adequate detail. For example: • Individual # 83 had aspiration pneumonia on 4/8/2010. The HST minutes of 5/26/2010 mentioned measures were put in place to address aspiration but these measures were not listed. • Individual #77 had aspiration pneumonia on 10/1/2009. HST minutes from 10/29/2009 and 1/28/2010 stated that all preventive measures are in place but does not mention what these are and there was no evidence that additional investigations were provided. Individual examples of where the PNM (NMT) Team **did not** meet regularly to address change in status, assessment, clinical data and monitoring results as well as lack of new assessment included: • Individual #390's diet was downgraded to puree on 1/8/2010. There was no immediate meeting to address this issue nor was it discussed during the HST/NMT meeting on 2/3/2010. • Individual #30 had a choking event on 2/20/2010. No HST/NMT was held in response to this event and there was no discussion of event during the 5/13/2010 HST/NMT meeting. • Individual#5's diet was downgraded to puree and nectar liquids on 4/9/2010.	

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		There was no HST /NMT meeting in response to this issue nor was it discussed during the HST/NMT meeting on 5/5/2010. • Individual #69 had a fecal impaction on 5/17/2010. There was no HST /NMT meeting in response to this issue. • Individual #475 had a modified barium swallow study on 5/5/2010 but there is no discussion of this during the HST/NMT meeting on 5/13/2010 • Individual #59 had a fall on 3/19/2010. There was no HST /NMT meeting in response to this issue nor was it discussed during the HST/NMT meeting on 4/13/2010. • Individual #83 had aspiration pneumonia on 4/8/2010. There was no HST /NMT meeting in response to this issue nor was it discussed during the HST/NMT meeting on 5/26/2010. • Individual #77 had coughing and vomiting episodes on 6/13/10 and 7/2/10 but there is no evidence there was a HST /NMT meeting in response to this issue nor was a referral made to OT/PT for evaluation of positioning. Therapists did not actively participate in the PSP meetings although the individuals may have identified issues relevant to their field. This was identified through interviews with therapists and observation of Individual #390's PSP and Individual # 122's discharge planning. Therapists stated the reason behind not attending was due to not being invited or not having time secondary to staffing issues.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall	Based on a review of 25 individuals, 25 of 25 Individuals identified as being at an increased risk level are not 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. Currently oral care and medication administration are missing from the assessment process. Additionally, 15 of 17 assessments reviewed did not contain the rationale behind many interventions listed in the PNMP. For example: • Individual #475 requires a chin tuck during mealtime but the reasoning behind this strategy was not listed in the OT/PT assessment. • Individual #284 needs to swallow 2-4 times between bites but the rationale for why this must occur was not clearly listed in the OT/PT assessment. • Individual #428 requires that staff present her spoon to the left side of her mouth but no rationale was listed as to why this strategy must be utilized. • Individual #33 requires alternating liquids and solids but no rationale was listed as to why this strategy must be utilized. Based on a review of 17 records involving individuals revealed: • In 17 of the 17 records reviewed (100%), there was no documentation of PNM	N

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	assess each individual having physical and nutritional management problems to identify the causes of such problems.	(NMT) review/analysis of the findings, including but not limited to, of relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. The summary did not address: • Oral care • Medication administration • Mealtime strategies in a method that clear as to why the strategies are relevant. • In 17 of the 17 records reviewed (0%), there were no documentation of PNMPs developed with input from the PNM (NMT) for those individuals at highest risk. Currently PNMPs are developed by Habilitation Therapists based on their clinical judgment. PNMPs are reviewed at the PSP annually and HST quarterly but based on observation of Individuals #390's, PSP and review of HST meeting minutes, there is little to no discussion of the plans of care. • In 17 of the 17 records reviewed, there was lack of congruency between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. Congruency was not noted with regards to Oral Motor/Swallowing as it is unclear as to what the rationale or justification was for multiple dining strategies. See above information regarding lack of justification and reasoning for examples. Nine of 13 individuals reviewed did not have updated nutritional assessments Examples of individuals who did not have their nutrition adequately assessed: • Individual #138 has a BMI below 20 but her last assessment was 2008. • Individual #9 has a BMI of 40 but does not have an assessment. • Individual #343 has a BMI of 17 but his last assessment is dated 2007. Per interview with the Director of Habilitation Services, an additional Dietitian was recently hired so this issue should begin to be addressed. The risk policy is currently being reviewed by state office. 17 of 17 records reviewed (100%) did not accurately identify individuals who are at an increased risk of physical and/or nutritional decline. The system that was in place continued to incorrectly identify individuals who are at an increased risk. Examples of individuals not being appropriately identified include:	

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		• Individual #30 had a choking incident on 2/20/2010 but was listed as being at a "medium risk" • Individual #69 had a fecal impaction in the past 12 months but was listed as being "low risk" of constipation • Individual #554 had a fecal impaction in the past 12 months but was listed as being at a "medium risk" of constipation • Individual # 413 had aspiration pneumonia on 5/2/2010 but was listed as being at a "low risk" of aspiration. • Individual #59 had serious falls occurring in June 2010, March 2010, and February 2010. He also had a non-serious fall in January 2010 but was listed as being at a "low risk" of injury • Individual # 475's PSP addendum 5/13/2010 states she was at a high risk of aspiration but she was listed as being "medium risk" according to risk screenings. Forty-seven individuals were routinely being provided with enteral nutrition while positioned in bean bags and recliners. Recliners and beanbags are soft in nature and are not made to adequately support an individual over an extended period of time. Providing nutrition while using these supports resulted in a poor ability to maintain appropriate positioning. Poor positioning results in an increased risk of abdominal compression or less than ideal elevation to prevent reflux aspiration. Examples of individuals using beanbags and/or recliners include Individuals #77, #303, #413 and #505.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	All persons identified as being at risk (requiring PNM supports) were provided with a Physical and Nutritional Management Plan (PNMP); however, the plans are not comprehensive as they are missing the primary components of oral care, medication administration, behavioral issues, and strategies related to personal care and bathing Based on a review of an identified sample of 17 individual records, individuals were not provided with a comprehensive PNMP: • In 17 of 17 records reviewed (100%) positioning instructions for wheelchair and/or alternate positions instructions were included. • In 17 of 17 records reviewed (100%) transfer instructions were included. • In 17 of 17 records reviewed (100%) the mealtime/dining plan included intake strategies for mealtime and snacks • In 17 of 17 records reviewed (100%) the mealtime/dining plan included diet consistency. • In 0 of 17 records reviewed (0%) the mealtime/dining plan included behavioral concerns related to intake.	N

#	Provision	Assessment of Status	Compliance
		- In 0 of 17records reviewed (0%) strategies for medication administration were included. - In 17 of 17 records reviewed (0%) strategies for oral hygiene were included. - In 17 of 17 records reviewed (100%) individual adaptive equipment was included. - In 2 of 17 records reviewed (11%) bathing/showering positioning and instructions were included. - In 1 of 17 records reviewed (5%) personal care instructions were included. - In 17 of 17 records reviewed (100%) communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: - Individual # #428's PNMP did not contain information regarding positioning during personal care or bathing - Individual #303's PNMP did not contain information on oral care or medication administration - Individual #33's PNMP did not contain behavioral strategies to address PICA behavior. PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff. In 0 of 17 records reviewed (100%), PNMPs were clearly developed with input from the IDT with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there is evidence in the PSPs that the PNMPs are included, but there was no evidence of discussion or input from other team members. This was evident during Individual #390's PSP where recommendations were read with no discussion provided by the PST. This was also noted during the discharge planning of Individual #122. Examples of where individual PNMPs were not developed with input from the IDT included: - Individual #30 has a history of stealing food but there is no evidence of behavioral staff assisting in the development of the plan. - There was no evidence of staff participation during the development of PNMPs for Individuals #33, #434, and #60. - No discussion of PNMPs by the PST; refer to discussion of Individual #390 above. In 20 of 20 records reviewed (100%), there was documentation that the PNMPs were reviewed annually at the PSP meeting but as mentioned above, there was no active	

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		discussion of the plan. In eight of ten records reviewed, PNMPs **were not** reviewed and updated as indicated by a change in the individual's status, transition (change in setting) or as dictated by monitoring results. Examples of when PNMPs were not reviewed and updated as indicated by a change in the individual's status, transition (change in setting) or as dictated by monitoring results. • Individual #5's diet was downgraded on 4/9/2010 but the PNMP was not revised until 5/19/2010 • See O.1 for additional examples	
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.	Two mealtime and Home observations demonstrated that staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan which were most likely to provoke swallowing difficulties and/or increased risk of aspiration in the following areas: • In 15 of 22 individual observations, staff were following mealtime plans. • In three of five individual observations, staff were following wheelchair positioning instructions. • In three of six observations staff were following alternate positioning instructions. • In two of two observations staff were following transfer instructions, and • In three of six observations, staff were not following tooth brushing instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: • Individual #275 was observed eating at an unsafe rate when her plans calls for her to eat at a slow pace. • Individual #475 was observed hyperextending her neck and chugging liquids with no cues to slow down or tuck her chin. • Individual #514 was provided no liquids when her plans calls for alternating liquids every 2-3 bites. • Individual #335 was observed shoveling food with her hands and placing a whole piece of bread in her mouth when the plan calls for all items to be chopped prior to the table and cues for small bites. • Individual #475 mealtime harness was not available. • Individual #122 leaning over her plate with no cues or encouragement to improve posture. • Individual #96 did not have side pillows for support as stated in the PNMP.	N

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		• Individual #508 did not have elbows supported by the arm rests or pillows as specified by the PNMP. • Individual #505 was not positioned with a pillow between her legs as stated per PNMP. • Individual #505 was not provided with a nosey cup or thickened liquids as stated per PNMP. • Individual #138 was slid down in bed resulting in less than 30 degree Head of Bed (HOB) elevation as stated per PNMP. Staff reported that they received training but still lack the knowledge regarding why certain strategies identified by therapy are important and what condition they are addressing. • In ten of ten interviews with staff, they were able to identify the location of PNMP and/or mealtime plan. • In five of ten interviews with staff , staff could describe individual-specific PNMP strategies. • In four of ten interviews with staff , staff could describe the schedule for implementation of PNMP strategies. • In four of ten interviews with staff , staff stated they had received individual-specific training for PNMP strategies. Examples of direct support professionals who were not able to describe the following PNMP indicators: • DCP stated that they received general training but not individual specific training with regards to Individual #475's PNMP. • DCP stated that they had not been trained on the PNM referral process.	
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	Based on information provided by BSSLC, 100 % of Staff were provided initially with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. Per interview with Habilitation Director, these trainings will be conducted annually in a condensed version. Staff who are found to be noncompliant multiple times will be required to attend the full version of the class. Review of the Facility's training curricula revealed that it did include adequate PNM	N

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	have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	training in the following areas: • Body mechanics • Handling techniques • Optimal alignment and support in seating systems and alternate positions • Mechanical lift transfers • Manual transfers approved by facility policy • Mealtime positioning • Food and fluid consistency • Safe presentation techniques for food and fluid • PNMPs. Per the POI, there is no process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk were only provided by staff who have received the competency based training specific to the individual. Currently, welcome books are available for review but training does not consistently occur. Person-specific training and training in response to changes to plans of care were provided to staff who routinely work at a specific unit; however there was no process in place to provide this additional training should a unit have to utilize floating or pull staff from another area. It is essential that PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual. Much training relevant to the PNMPs was conducted by the PNMP coordinators who do not have the training or the expertise to appropriately provide this type of training in detail or provide the rationale for the use of the strategies and/or equipment. This results in poor staff knowledge as they may know that they need to use a specific strategy or piece of equipment but do not have the understanding of why it is so important to the individuals' level of care. This lack of understanding often leads to inconsistent implementation.	
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	DADS is currently in the process of developing and revising a monitoring policy. Per monitoring database, PNMP coordinators and Therapists are monitoring their caseload as directed by Habilitation Services. In addition, Supervisors and Nurse Case Managers are assisting in the process. BSSLC has improved their overall monitoring system through the development of a	N

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	safely and appropriately implementing such plans.	database that will assist in the ability to assess the acquired data and establish trends for future training and interventions. BSSLC has also consolidated their bathing, and mealtime /snacks forms into a single comprehensive tool. This consolidation should assist in streamlining the monitoring process. • A review of Facility monitoring reports from 2/2010 to 6/2010 documented that staff were not being monitored in all aspects in which the individual was determined to be at increased risk. For example, Individual #85 was not provided with monitoring during bathing • All individuals were not provided with oral care and or medication administration monitoring. As mentioned above, a data base has been developed that will assist BSSLC in analyzing and trending data. At this time the data base is nearing the point at which data can begin to be analyzed and trended.	
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.	There was not a formal process in place that ensured individuals with increased PNM issues were provided with increased monitoring. At this time, this process is informal and directed by the attending clinician. DADS is currently in the process of developing a monitoring policy that is intended to address this issue. While the PNM status is scheduled to be regularly reviewed during the HST/NMT meetings, there is no clear indicator that status is reviewed by the team in the event of a change in status. See Section O.1.	N
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.	Based on the review of nine individual records, nine of nine who were enterally nourished revealed these individuals did not receive an annual assessment that addressed the medical necessity of the tube or potential pathways to PO status. Examples of individuals who received enteral nutrition and did not receive an appropriate annual assessment: • Individual #83 did not receive an assessment. • Individual #291 did not receive an assessment. • Individual #87 did not receive an assessment.	N

#	Provision	Assessment of Status	Compliance
		• Individual #138 did not receive an assessment. • Individuals #318, #190 and #54, received an assessment but no discussion or plan for possible pathways to PO intake. Per Director of Habilitation Services, Oral Assessments were being completed on all individuals who receive enteral nutrition. As of this review, nine individuals have been upgraded so that they are receiving some form of oral intake. This is a positive step not only for BSSLC but for the individuals and their quality of life. Nine of nine individual PNMPs (100%) who received enteral nutrition and/or therapeutic/pleasure feedings were provided with PNMPs. These PNMPS, however, were missing the same information as listed in section O.3. PSP s for nine of nine individuals who received enteral nutrition did not clearly document the rationale for the continued need for enteral nutrition. Examples of individual PSPs that did not document the rationale for the continued need for enteral nutrition were: • It was mentioned in the PSP that Individual's #83, #85, #291, #283 were tolerating tube feedings but did not specify why enteral nutrition was appropriate or possible pathways to PO intake. A policy does not exist that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT) as it relates to the assessment of individuals who are NPO. Per the POI, this policy will be developed and/or revised.	

Recommendations:

1. Individuals with nutritional needs are beginning to be to be evaluated. A plan should be implemented that ensures all individuals who have a BMI lower than 20 and greater than 30 are given priority.
2. Assessments should be reviewed and revised so that all aspects of physical and nutritional management are addressed. This includes assessing oral care, medication administration and positioning for these activities as well as positioning for improved GERD management and stomach emptying. BSSLC should also focus on improving the use of measurable terminology and consistency between assessments and clinicians.
3. Staff recently underwent training that focused on nutritional aspects of physical and nutritional management. Positioning is a large component of appropriate care and is as important as the nutritional aspects of PNM. Training should be developed and provided to address this issue.
4. Individuals who receive enteral nourishment should be assessed annually to determine appropriateness of continued enteral status and the possible return to oral intake. Assessments must clearly indicate possible pathways to resume oral intake.
5. Beanbags and recliners do not provide proper support to maintain an adequate position while receiving enteral nutrition. Other positions should

be investigated by BSSLC.

6. Ensure the policy and procedure for monitoring defines the process of analysis of monitoring reports to formulate corrective strategies to address specific and/or systemic areas of deficiency.
7. The Monitoring system must include a mechanism to ensure that issues and concerns are appropriately identified, recorded and addressed with documentation of resolution. Each identified concern must be addressed via an action plan with evidence of completion such as staff training, submission of work order, and equipment replacement.
8. A formal process should be developed that ensures individuals who are at an increased risk receive more intensive monitoring.
9. All individuals who are determined to be at an increased risk should only be provided assistance from staff who have received competency based training specific to that individual. Identifying a sister home where all staff and cross training all staff is a possible option.
10. All developed processes should be detailed so that those reviewing an individual's history and monitoring care are easily able to ensure the loop of care was closed (onset to resolution).
11. PNMPs should be expanded to include oral care and medication administration. Strategies should not only include positioning for these activities but strategies and adaptive equipment that will assist in minimizing the individuals' risk.
12. The PNM meeting should be a collaborative meeting in which all parties bring their area of expertise to the table to investigate the etiology of such illness as pneumonia, skin breakdown, and constipation and how to prevent or minimize the reoccurrence. Change of status should result in additional meetings in an effort to provide more comprehensive problem solving and timely implementation.

<table>
<tr><th>SECTION P: Physical and Occupational Therapy</th><th></th></tr>
<tr><td>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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
Review of Following Documents:
1. Record Reviews for Individuals #8, #9, #11, #30, #33, #54, #59, #60, #68, #69, #70, #77, #83, #85, #87, #93, #96, #97, #122, #138, #202, #230, #275, #283, #284, #298, #303, #316, #335, #343, #374, #375, #390, #395, #404, #408, #413, #428, #434, #475, #505, #514, #527
2. Policies, procedures and/or other documents related to the provision of OT/PT supports and services (Policies 012 dated 1/31/2010, 013 dated 1/31/2010, and 014 dated 10/7/2009)
3. Current Lists of people:
(a) Who use wheelchair as primary mobility;
(b) With transport wheelchairs;
(c) With other ambulation assistive devices, including the name of the device;
(d) With orthotics and/or braces;
(e) Who have had a decubitus/pressure ulcer during the past year, including name of individual, date of onset, stage, location, and date of resolution.
(f) Who have experienced a falling incident during the past three (3) months, including name of individual, date, location, whether there was injury, and, if so, type of injury.
4. PNM maintenance Logs (Jan 2010-present)
5. OT/PT assessments template.
6. Five (5) most current OT/PT assessments conducted by each therapist and corresponding PSPs.
7. Wheelchair seating, PNM clinic assessment templates and related documentation
8. Five (5) most current wheelchair seating/PNM clinic assessments conducted by each therapist and related documentation.
9. OT/PT-related spreadsheets.
10. Completed OT/PT monitoring forms (1-5-2010 to 6-2010).
11. For the past 12 months, any summary reports or analyses of monitoring results related to OT/PT generated by the facility, including but not limited to quality assurance reports, including action plans.
12. List of individuals receiving direct OT and/or PT services and focus of intervention.
13. BSSLC Plan of Improvement (POI), dated 5/17/10
Interviews with:
1. Kori Kelm PT Director of Habilitation Services
2. Direct Care Professionals on Bowie A, B, and Driscoll A, B, C, and D
Observations of:
1. Daily activities on Bowie A, Bowie B, Driscoll A, B, C, and D
2. Mealtimes on Bowie A, B, and Driscoll A,B,C, and D</td></tr>
<tr><td></td><td>.Facility Self-Assessment:
The Facility stated it is not yet in compliance with any of the provisions of this Section but has implemented a number of actions to lead toward compliance.</td></tr>
</table>

	The Facility reported compliance with regards to 1) providing comprehensive integrated assessments, 2) assessments upon admission and upon a change in status, and 3) assessments provide a rationale for recommendations. However, based on the Monitoring Team's review, the facility is not in compliance with these Action Steps. The Facility reported compliance with regards to plans being integrated into the PSP and therapy providing rationale for recommended interventions. However, based on the Monitoring Team's review, the facility is not in compliance with these Action Steps. The Facility accurately reported to be not in compliance included: staff knowledge regarding interventions, and staff implementation of recommendations. BSSLC has opened up two more Physical Therapist (PT)positions. These two additional positions will assist in lowering the caseload thus allowing the therapist more time to address the identified issues. As stated in section O, additional monitoring has begun and data has started to be acquired.
	Summary of Monitor's Assessment: **Provision P.1,** this provision was determined to be not in compliance. BSSLC has opened up two more positions for PT which should assist in lowering the caseload but these positions have not been filled as of this review. Assessments are completed in accordance to the schedule set forth by BSSLC, however, assessments are not being consistently completed in response to a change in status. **Provision P.2,** this provision was determined to be not in compliance. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. **Provision P.3,** this provision was determined to be not in compliance. Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. **Provision P.4,** this provision was determined to be not in compliance. A system does not exist that ensures staff responsible for positioning and transferring high risk individuals, receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff

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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	In an effort to improve clinician to individual ratio, the facility has listed 2 additional PT positions and 2 additional OT positions. As of this review, all four positions remain open.	N

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	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.	Based on a review of CVs for each therapy clinician (3) and interviews with therapy staff, the Department did document appropriate qualifications for licensed OTs, PTs and assistants mobility specialists, assistive technology technicians and fabricators. Clinical instruction was documented in the following areas in the last 12 months: • Physical and Nutritional Management • Breathing, Digestion, and Swallowing Based on review of OT/PT tracking spreadsheet, all individuals have received an OT/PT assessment and/or screening. This was validated via review of 21 records for completed OT/PT assessment/screening, including those who were recently admitted within the last 12 months. Assessment/screening indicated whether or not the individual required OT/PT supports and services for 21 of 21 records reviewed. If receiving services, direct or indirect, 17 of 17 individuals were provided a comprehensive OT and/or PT assessment a minimum of every 3 years, with annual interim updates (as applicable). At a minimum, the comprehensive OT/PT assessment addressed the following elements: a. Movement; b. Mobility; c. Range of motion; Independence The problem lies that plans are not consistently developed to address issues: For example: • Individual #390 is above ideal body weight (IBW), and has an increased risk of skin breakdown but there is no exercise program in place • Individual #122 uses a gait belt to assist with stability but there is no plan in place to minimize regression. • Individual #122's wheelchair does not adequately provide support as evidenced by individual being observed leaning forward and collapsing in on herself with the current wheelchair. Based on record review of individuals who had experienced a change in health or physical status, seven of ten individuals had not received a comprehensive OT/PT	

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		assessment within 30 days or sooner as indicated to address health and/or safety. See O.1 for examples. While OT/PT is responding to referrals within an appropriate timeframe, issues are not consistently being identified and brought to the attention of Habilitation Services. Examples of this include: • Individual #77 coughing and requiring suctioning, but there is no evidence that Habilitation Services was consulted. • Individual #475 coughing during her meal but no evidence of PNM notification The system is currently informal and there is no clear process that is consistently utilized to notify professional staff and document this notification. This is resulting in inconsistent identification of potentially severe issues. 21 of the 21 assessments reviewed (100%) contained probes that identified the need for additional assessment. Based on review of 21 OT/PT assessments, 100% included signatures and date of both OT and PT. Based on review of 21 OT/PT assessments, 0 of21 were comprehensive with content from each discipline as indicated. See O.1 for examples. Based on review of 21 OT/PT assessments 100% included evidence of active collaboration between OT and PT.	
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	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 21 individuals receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. See section O.1 regarding assessments in response to a change in status and Section P.1 for issues with plan development. Intervention plans were not based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies for 15 of 17 individuals reviewed. See O.2 for specifics Based on reviews of PNMPs and other positioning plans for 21 individuals, equipment is	N

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	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.	specified for 21 of 21 plans reviewed. See O.2 for concerns related to positioning Based on review of OT/PT documentation for individuals receiving direct services, there was evidence that each individual receiving direct services was reviewed at least monthly for OT/PT Status for four of four individuals reviewed. Individuals not receiving direct services are not consistently reviewed by OT/PT should there be a change in status. An example is Individual #77 who returned from the hospital with pneumonia but there is no evidence that positioning was reassessed. See O.1 for additional information	
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.	Based on observations of OT/PT interventions all PNMPs or other intervention plans were not implemented as written for 15 of 22 individuals reviewed in the sample, Examples of Plans not implemented included positioning and use of adaptive equipment; See O.4 for examples Based on review of training rosters and in-service outlines, DCPs , PNMP Coordinators and therapy aides were identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs and other activity plans for five of five individuals reviewed in the sample. Based on interviews of DCPs, PNMP coordinators and therapy aides, staff did not consistently understand rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. Based on interviews with five DCPs: • In five of five interviews with staff, they were able to identify the location of the OT/PT plans. • In two of five interviews with staff , staff could describe individual-specific strategies outlined in the plan. • In one of five interviews with staff, staff could describe the schedule for implementation of the OT/PT plans. • In two of five interviews with staff , staff stated they had received individual-specific training for OT/PT intervention/support plans. Examples of direct support professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP on Driscoll A was not able to identify reasoning for positioning schedules. • DCP on Driscoll B was not able to describe rationale for maintaining appropriate elevation.	N

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		• DCP on Bowie A was not able to describe why individuals used modified dining equipment.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	Per maintenance spreadsheet and OT/PT monitors, a system exists that is designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. BSSLC was using a priority system. The timeframes for delivery ranged from immediate repairs or modifications made on site (when possible), to 30 days (Priority Group 1), to 60 to 180 days (Priority Group 2), to 180 to 365 days (Priority Group 3). Per review of the wheelchair database, all Priority level 1 and level 2 have been provided with wheelchair modifications as needed. Per POI, all staff are monitored for their continued competence in implementing the OT/PT programs but this is inconsistent due to lack of a formalized process. A policy does not exist that clearly defines the details of the monitoring system including frequency, and implementation. At this time, DADS is reviewing and revising all policies. A system does not exist that ensures staff responsible for positioning and transferring high risk individuals, receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff (Refer to Section O-5). Based on a review of OT/PT monitoring forms for the past 30 days, monitoring findings and responses are not clearly documented from identification to resolution of any issues identified. Examples include: • Monitoring form dated 5/27/10 on Cottage A: PNMP schedule not being followed is noted on form as is notification to the PNMP coordinator but closure of incident is missing. • Monitoring form dated 5/20/10 on Cottage B: PNMP schedule not being signed is noted on form as is notification to the home leader but closure of incident is missing. Person-specific monitoring that focuses on plan effectiveness and how the plan addresses the identified needs is inconsistently and informally provided by therapy. At this time, the majority of monitors are completed by PNMP coordinators, Nurse Case Managers, Supervisors, and Residential Directors. See O.5 for specifics. Per POI, there is no formal process to ensure data collection method is validated by the program's author(s). As of this review, this area is in the process of being developed	N

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		and outlined. This validation process was reported to occur quarterly for all PNMP coordinators and potentially every 6 months for other professionals.	

Recommendations:

1. The current assessment format needs to be reviewed to determine if it is sufficiently comprehensive to identify the needs of the individuals at BSSLC. Special care should be given to the areas of oral care and medication administration as well to improving overall detail.
2. Habilitation Therapies should participate more actively in the annual PSP process. Individuals who have OT/PT needs are not being represented by those who have the most expertise in the area.
3. Changes in status should trigger an automatic OT/PT assessment or review if related to area of practice (i.e.., fecal impaction, skin breakdown, aspiration, pneumonia, choking, and/or neurological event). The action taken by OT/OT should be clearly documented and followed to resolution.
4. See Section O for recommendations regarding monitoring.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Individuals Records Reviewed: #122, #70, #16, #11, #8, #417, #399, #377, #400, #139, #425, #152, #593, #570, #599, #465, #49, #259, #20, #17, #152, #593, #465, #49, #259, and #21 2. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Dental Services, Policy Number: 015, Date: 07/21/2010 (draft) 3. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Post Anesthesia Care, Date June, 2010 4. BSSLC Medical Services/Nursing Policy: Conscious Sedation, Date Developed: Unknown, Implemented: Unknown 5. BSSLC Health Services: Dental/Medical Sedation and Restraint Policy 6. BSSLC Dental Desensitization List 7. BSSLC Admissions Since 01/01/2010 List 8. BSSLC Dental Office Job Duties 9. BSSLC Plan of Improvement (POI), dated 5/17/10 **People Interviewed:** 1. Gary Johnson, Dentist 2. Vicky Kenjura, Registered Dental Hygienist 3. Jennifer Pampell, Registered Dental Assistant **Meeting Attended/Observations:** Dental Sedation Meeting, 07/27/10
	Facility Self-Assessment: The Facility reported it was not yet in compliance with either provision of this Section but had completed actions toward compliance. The Facility reported individuals receive comprehensive dental exams upon admission and annually. The monitoring team found dental exams were completed timely. The monitoring team found some aspects of documentation of these exams to be missing for some individuals, including assessment for prosthetics at the admission exam and the status of their teeth documented on the dental chart. The quality of dental examinations did not represent a comprehensive status of individuals' current dentition, including pictures of teeth with status of missing teeth, fillings, medical history, medications, use of restraint and/or pre-treatment sedation, behavioral issues, findings, and recommendations. The Facility reported compliance with actions related to use of restraint for dental procedures. Because of inconsistent documentation on the Initial Dental Examination records and in the dental progress notes regarding the use of restraints, it was not possible to determine compliance. The Facility reported that individuals with dental problems identified in exams received follow-up. Dental

	records reviewed indicated that one of ten (10%) individuals was identified on initial dental examination as needing a filling; there was no evidence documented in the dental progress notes that an appointment for the filling was scheduled or completed. The Facility accurately reported providing preventative dental care. The Facility reported having a tracking system in place for Dental sedation and Restraint use. The monitoring team confirmed the Facility did track the use of Dental and Medical Pre-treatment sedation and restraints.
	Summary of Monitor's Assessment: BSSLC's Dental Services demonstrated some improvements since the baseline visit. The Facility has developed and implemented two new policies and procedures for improving the health and safety of individual receiving pre-treatment sedation, e.g., Nursing Protocol: Post Anesthesia Care and Medical Services/Nursing Policy: Conscious Sedation. The Personal Support Teams, including psychologists/Behavior Analysts were evaluating, developing and implementing desensitization plans for individuals who would benefit from such plans. **For Provision Q.1**, this provision was determined not in compliance. BSSLC's Dental Services demonstrated some improvements since the baseline visit. The Facility has developed and implemented two new policies and procedures for improving the health and safety of individuals receiving pre-treatment sedation, e.g., Nursing Protocol: Post Anesthesia Care and Medical Services/Nursing Policy: Conscious Sedation. The Personal Support Teams, including psychologists/Behavior Analysts were in the process of evaluating, developing and implementing desensitization plans for individuals who would benefit from such plans. Dental services were documented on numerous records, e.g., Initial Dental Examination, Dental Progress Notes, Dental Visit Records, Work Sheet for Annual Dental Exams, and Dental Staffing Reports. The duplication of dental services' documentation on numerous forms and/or records has the potential to provide fragmented information and has the potential to interfere with of continuity of care. Because of the numerous reporting forms and/or records used to report dental care it was not possible to tie the information together for one single individual to determine compliance. The Facility needs to evaluate all dental report forms in an effort to prevent fragmentation of information that has the potential to interfere with continuity of care and cause duplication of documentation. Annual dental examinations were recorded in the dental progress notes and did not represent a comprehensive dental examination. Individuals' annual examinations need to be as comprehensive as the

	initial dental examination. The Facility needs to develop and implement a standardized dental record for annual examinations that describes in detail the current dentition, including pictures of teeth with status documented, e.g., missing teeth, fillings, etc, as well as medical history, medications, use of restraint and/or pre-treatment sedation, behavioral issues, findings and recommendations. The Facility's Dental Office lacks sufficient clerical support to perform the numerous required administrative functions. Providing the Dental Office with clerical support would free-up the professional staff to provide more direct dental services. Dental Services need a monitoring system in place to ensure that follow-up recommendations for dental treatments and preventative care are scheduled and carried out in a timely manner. As well as, to monitor desensitization plans to ensure that strategies are carried out as designed, data collected, and recorded as scheduled. **For Provision Q.2,** this provision was determined not in compliance with this provision of the SA. Component B. stated, "Policies and procedures will be developed." The accompanying action step stated, "State Office will developed policies and procedure governing dental services as required in Section Q." The comments section stated, "Status updates are not to be entered in the SSLC for this action step since direct responsibility lines with the State Office."

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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.	BSSLC's Dental Office was staffed with a full-time Dentist, contract anesthesiologist, two Registered Dental Hygienists, and one Registered Dental Assistant. The Dental Office does not have clerical support. In addition to assisting the dentist and dental hygienists provide direct dental services, the dental assistant was responsible for administrative functions. Some of the functions included but were not limited to: • Completing and executing different consent forms, consultation sheets, pre op and post op forms for both TIVA and oral sedation that go out to guardians, nurses QMRPs, Doctors, HRC coordinators, etc. • Each time TIVA or oral sedation was scheduled, e-mails were sent to nurse case managers, QMRPs, HRC coordinators, and physicians. • Anytime an individual needed a tooth extraction as well as TIVA or oral sedation the Dental Office staff must immediately contact the family/guardian to inform them of the procedures and send a consent form for them to sign and return. This required tracking the consent to ensure that it is returned. Once the consents were returned, copies were made and sent to the Qualified Mental Retardation Professionals (QMRPs), Nurse Case Managers, and file clerks. If there were no families or guardians to provide consent, then a "Three Dr. Rule" must be obtained. This required considerable time obtaining all three signatures. • When the dentist makes a referral to an off campus dentist, the appointment was	N

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		scheduled. Then an e-mail was sent to the nurse case manager, to fill out the medical information for the referral. When the nurse case manager sent back the medical information to the Dental Office, it was combined with the consult and taken to the off campus appointment. • Each day for each individual a dental visit report must be completed. Multiple copies of each individual's report must be made and sent to the QMRPs, nurse case managers, and residential directors. • A worksheet was completed for each individual's annual dental examination. • A dental log must be completed daily to track each individual seen and what dental services they received. • Dental appointments were scheduled daily. If individuals were late or did not show up for an appointment the home was called to find out why the appointment were not kept and to reschedule. Appointments were tracked to ensure that individuals received annual and routine dental care. • Responded to phone calls and e-mails. • Staffing Reports were completed daily. Considering the weight of responsibility the dental assistant had for administrative functions, the Facility needs to evaluate the need for clerical support in the Dental Office. This would free up the dental assistant to provide more direct dental services. Dental records for seven individuals #417, #377, #399, #400, #139, #425, and #21 admitted over the past year provided evidence that seven of seven (100%) were scheduled for an initial dental examination with 30 days of admission. Five of seven (71%) individuals had their initial dental examinations completed within the required 30 days. Two of the individuals (# 21 and #425) either failed to show-up for their appointment or refused to be examined. There was documentation that appointments were rescheduled. Individual #425 was placed on a desensitization program. There was documentation in individuals #425's dental progress notes that the program was being carried out. There was documentation in dental progress notes that dental staff was working with individual #21 to increase comfort level with dental procedures and they were able to complete cleaning at the second visit. There was no documentation in the dental progress note that a referral had been made for a desensitization plan. Documentation for seven of seven (100%) newly admitted individuals examined revealed that none had received pre-treatment sedation or used restraints since admission. Six of ten (60%) individuals whose dental records were reviewed (individuals #8, #417, #399, #400, #377, #139, #122, #70, #11, and #85) were admitted after November 1, 2010. These individuals had initial dental examinations documented on the Initial Dental	

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		Examination Record, which included assessments for presence of prosthetics and a summary of current dentition, including pictures of teeth with status documented, i.e., missing teeth, and fillings. Four of four (100%) individuals whose dental records were reviewed (#122, #70, #11, and #85) were admitted prior to November 1, 2009. Although 100% of the individuals had annual dental examinations within the anniversary month of admission or the last dental examination; annual dental examinations were documented in the dental progress notes in a narrative format as opposed to a standardized form like the Initial Dental Assessment Record. The quality of dental examinations did not represent a comprehensive status of individuals' current dentition, including pictures of teeth with status of missing teeth and, fillings, , as well as medical history, medications, use of restraint and/or pre-treatment sedation, behavioral issues, findings and recommendations. Dental records for individuals #8, #417, #399, #400, #21, #377, #139, #122, #70, #11, and #85 indicated that restraint use for the past six months was not consistently documented on either the Initial Dental Examination records on in the dental progress notes. Initial Dental Examination records for two of the individuals indicated that no restraints were used. Initial Dental Examination records for three individuals indicated restraint use was not applicable. Initial Dental Examination records for six individuals' restraint use were not documented. Refer to Drs. Sherer and Curtis reports for information regarding use of restraints and pre-treatment sedation for dental services. Review of dental records the above records for evidence of recommended follow-up care showed the following: • Individual #400's need for a filling in tooth #9 was documented on the dental progress notes at the 04/28/10 dental visit; there was no evidence documented in the dental progress notes that an appointment was scheduled or completed for the filling procedure. • The need for follow-up preventative care was rarely documented in the dental progress notes. The Facility's Quality Assurance Department and dental staff need to routinely monitor dental records to ensure recommendations for follow-up treatments and/or preventive care are scheduled and completed timely. The records above were reviewed for properly reporting the use of pre-treatment sedation and restraint. BSSLC does track the use of Dental and Medical Pre-treatment	

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		sedation and restraints. None of the records reviewed indicated the use of pre-treatment sedation or restraints since January 2010. The Dental Office had recently developed and implemented a Worksheet for Annual Dental Exams. A blank copy of the worksheet was submitted for review. The Worksheet for Annual Dental Exams contained comprehensive dental information that summarizes individuals' dental status. None of the records submitted for review contained a completed Worksheet for Annual Dental Exams. Missing from the blank worksheet were picture charts of teeth for the dentist to mark missing teeth, existing restorations, and existing pathology/abnormalities. The date the worksheet was implemented, identification number, and instructions for its use were not included on the form. The Facility's Dental Services needs to ensure that when new forms/records are developed and implemented that they contain the date implemented, identification number, and instruction for usage. Dental services for individuals #152, #593, #570, and #599 were reported on a different form, Dental Visit Report. This report described procedures completed, dental findings, and recommendations for follow-up visits through the use of check marks and notes. Dental services reported on this form indicated that four of four (100%) received preventative care. The date the Dental Visit Report was implemented, identification number, and instructions for its use were not included on the form. The Facility's Dental Services needs to ensure that when new forms/records are developed and implemented that they contain the date implemented, identification number, and instruction for usage. Dental services for individuals # 20, #17, and #8 were reported on another form, Dental Staffing Report. This form reported such information as, summaries of treatments received since last staffing, treatment classifications, safety procedures, comments on behaviors, and specific recommendations. The date the Dental Staffing Report was implemented, identification number, and instructions for its use were not included on the form. The Facility's Dental Services needs to ensure that when new forms/records are developed and implemented that they contain the date implemented, identification number, and instruction for usage. During the review of dental records supplied by BSSLC, dental services were documented on numerous different records, e.g., Initial Dental Examination, Dental Progress Notes, Dental Visit Reports, Work Sheet for Annual Dental Exams, and Dental Staffing Report. The duplication of dental services documentation on numerous forms and/or records has the potential to provide fragmented information that interferes with continuity of care. Because of the numerous reporting forms and/or records used to report dental care it was not possible to tie the information together for one single individual to	

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		determine compliance. The Facility needs to evaluate all dental report forms used to document dental care in an effort to prevent fragmentation of information, which has the potential to interfere with continuity of care and cause duplication of documentation.
		
		Annual dental examinations were recorded in the dental progress notes and did not represent a comprehensive examination. Individuals' annual examinations need to be as comprehensive as the initial dental examination. The Facility needs to develop and implement a standardized dental record for annual examinations that describes in detail the current dentition, including pictures of teeth with status documented, e.g., missing teeth, fillings, etc, as well as medical history, medications, use of restraint and/or pre-treatment sedation, behavioral issues, findings and recommendations.
		
		BSSLC has begun developing and implementing desensitization plans since the baseline visit. This was evident through review of desensitization plans for the following individuals: #49, #465, and #259. Personal Support Team (PST) staff typically involved in the desensitization planning included but was not limited to: The individual, QMRP, Psychologist/Behavioral Analyst, Nurse Case Manager, and Direct Care Professional. Review of individuals' Personal Support Plans (PSPs) and/or PSP Addendums, and Specific Program Objective and Data Collection Records revealed the following information:
		• Individual #49's PST approved the desensitization plan 02/09/10 and it was implemented 02/24/10. Projected Completion Date (PCD): 05/31/10. The plan included:
		  ▪ Support Plan Objectives (SPO) 2B1: Remains in Dental Chair
		  ▪ Data Collection: Monitored by Dental Hygienist or Dental Assistant, once weekly on Thursday in the Dental Office.
		  ▪ Objective: Individual #49 will remain seated in the dental chair for 20 seconds and assessed once weekly for three sessions per month for two consecutive months.
		  ▪ Instructional Strategies:
		    o Staff will accompany individual #49 to the lab (should have been dental office) once weekly in the afternoon.
		    o Staff will inform individual #49 of the location in order to prevent the need for restrictive interventions.
		    o Individual #49 will need to remain seated in the chair for 20 seconds in order to perform task correctly.
		  ▪ Review of the monthly Specific Program Objective and Data Collections Records did not contain data for February, March, April, and June but did contain data for May and July. Data were recorded for three of four weeks during the month of May. The missing week was due to individual coming to the Dental Office at 4:35	

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		p.m., after the door was closed. July data were collected weekly through July 22, 2010. No documentation was supplied regarding the missing months' data. Failure to supply the missing months' data indicated that the desensitization plan was not implemented until May and data were not collected for June. Home staff responsible for training occurring in the dental office should have ensured that the individual was taken to the dental office during routine office hours. The PST needs to ensure that once desensitization plans were approved that they were implemented promptly and consistently to assist individuals meet their objectives without undue delay. • Individual #465's PST approved the desensitization plan 04/15/10, and it was implemented 04/22/10. PCD was not included. The plan included: ▪ SPO 2G1: Tolerate Touch: Washcloth to Face ▪ Data Collection: Monitored by the first shift, using washcloth, daily in Bowie Springs – Home C. ▪ Objective: Individual #465 will tolerate a washcloth being held to the face for five seconds, with no more than five verbal prompts for 15 sessions. ▪ Instructional Strategies: o Talk to individual #465 throughout training and provide verbal reinforcement for all his efforts. o Monitor will tell individual #465 that you will be touching the face with the washcloth. o Mark (+) if individual #465 tolerates the washcloth being held to face. o Mark (-) if individual #465 does not tolerate the facial touch with the washcloth when provided no more than five verbal prompts. o Record assistance given during person's **BEST** performance. ▪ Review of the monthly Specific Program Objective and Data Collections Records indicated that individual #465's desensitization plan was implemented on 04/22/10 as scheduled. Data were monitored, collected, and documented daily according to the training schedule for the remaining month of April, May, and June. Data reported indicated that individual #465 had not met the objective by the end of June. July data, to date, were not available for review. The PCD was not included on the Special Program Objective Record. It was important to include a PCD in an effort to measure progress toward the objective. PST staff need to consistently establish a PCD when developing and implementing desensitization plans and include the PCD on the Special Program Objective Record. • Individual #259's PST approved the desensitization plan (date not noted) and it was implemented 04/30/10. PCD: 08/31/10. The plan included: ▪ SPO 4B: Dental Desensitization ▪ Data Collection: Monitored by dental hygienist, two times per week, at Program	

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		Services. ▪ Objective: Individual #259 will respond positively to meeting the dental hygienist for five sessions per month for two consecutive months. ▪ Instructional Strategies: o The dental hygienist will visit individual #259 at Program Services. o The dental hygienist will speak to individual #259 about going to the dental office. o The dental hygienist will record individual #259's responses and interactions and document if marked Unavailable or Refused. ▪ Review of the monthly Specific Program Objective and Data Collections Records indicated that individual #259's desensitization plan was actually implemented on 05/02/10. Monitoring and data collection were not documented two times a week according to training schedule for May or June. July, to date, data were not available for review. The PST needs to monitor desensitization plans' Specific Program Objective and Data Collection Records to ensure that individuals were monitored and data collected and recorded according objectives and training schedules. One of three (33%) individuals' records reviewed for desensitization plans indicated that the objective and training schedule reported on Special Program Objective Records contained completed monitoring data, collection, and documentation according to the training schedule.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints;	The State Office was in the process of drafting a statewide Dental Policy. BSSLC had in place a Health Services Dental/Medical Sedation and Restraint Policy. Since the baseline visit the Facility has made improvements in the development and implementation of policies and procedures: Nursing Protocol: Post Anesthesia Care, Dated June, 2010, and Medical Services/Nursing Policy for Conscious Sedation, (date developed and implemented was not documented). The Facility's Conscious Sedation Policy needs to define Conscious Sedation in order to provide a clear understanding of the specific medications used for Conscious Sedation and route of administration. It needs to include the means of transportation to and from the individual's home to the Dental Office. It needs to include the nursing support required during transport to ensure that individuals are constantly monitored during transport.	N

#	Provision	Assessment of Status	Compliance
	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.		

Recommendations:.	**Recommenda**
1. The Facility needs to evaluate the weight of responsibility the dental assistant has for administrative functions and consider providing clerical support in the Dental Office. This would free up the dental assistant to provide more direct dental services. 2. The Facility's Quality Assurance Department and/or dental staffs need to routinely monitor dental records to ensure recommendations for follow-up treatments and/or preventive care are scheduled and completed timely. 3. The Facility needs to develop and implement a standardized dental record for annual examinations; that describes in detail the current dentition, including pictures of teeth with status documented, e.g., missing teeth, fillings, etc, as well as medical history, medications, use of restraint and/or pre-treatment sedation, behavioral issues, findings and recommendations. 4. The Facility's Dental Services needs to ensure when new forms/records are developed and implemented that they contain the date implemented, identification number, and instruction for usage. 5. The Facility's Dental Services needs to evaluate all dental report forms used to document dental care in an effort to prevent fragmentation of information, which has the potential to interfere with continuity of care and cause duplication of documentation. 6. The Facility's residential staff responsible for taking individuals to the Dental Office for desensitization training needs to ensure that individuals are taken to the dental office during routine office hours. 7. The Facility's PST needs to ensure that once desensitization plans were approved that they are implemented promptly and consistently to assist individuals meet their objectives without undue delay. 8. The Facility's PST staff needs to consistently establish a PCD when developing and implementing desensitization plans and include the PCD on the Special Program Objective Record. 9. The Facility's PST need to monitor desensitization plans' Specific Program Objective and Data Collection Records to ensure that individuals are monitored; data collected and recorded according objectives and training schedules. 10. The Facility's Conscious Sedation Policy needs to define Conscious Sedation in order to provide a clear understanding of the specific medications used for Conscious Sedation and route of administration. It needs to include the means of transportation used in transporting individuals to and from the home to the Dental Office. It also needs to include nursing support during transport to ensure that individuals are constantly monitored during transport.	

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:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record Reviews of Individuals @52, #53, #84, #121, #126, #134, #272, #281, #330, #366, #370, #440, #444, #473, #543 2. Communication services and supports (Policy 016 dated 10/7/2009) 3. A list of people with Alternative and Augmentative Communication (ACC) devices 4. AAC screening forms. 5. AAC evaluation and Speech Language assessment template. 6. Five (5) most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs. 7. Monitoring tools template for ACC and SLP programs. 8. Completed monitoring forms. 9. Communication dictionaries for individuals identified as having decreased communication. 10. AAC-related spreadsheets. 11. List of individuals receiving direct speech services, and focus of intervention. 12. BSSLC Plan of Improvement (POI), dated 5/17/10 **Interviews with**: 1. Liz Begly CCC-SLP, AAC specialist 2. Kori Kelm Director of Habilitation Services **Observations of**: 1. Transition and Mealtimes on Bowie A, and B, Driscoll A, B, C ,D
	Facility Self-Assessment: The Facility reported it was not yet in compliance with either provision of this Section but had completed actions toward compliance. The Facility reported it BSSLC has added 2 Speech openings that were posted on June 29, 2010; however, these positions have not yet been filled. The Facility accurately reported individuals who are need of AAC were still not receiving adequate supports. The Facility stated they are in compliance with regards to findings of assessments drive the need for AAC. However, based on the monitoring team's review, the facility is not in compliance with these Action Steps. The Facility accurately reported it does not have a process for assessment for AAC for individuals receiving behavior supports or interventions. The Facility reported actions determined to be not in compliance included: portability of AAC, meaningfulness of AAC, and staff training. BSSLC POI stated compliance with incorporation of devices into common areas, and PSP integration, However, based on the Monitoring Team's review, the facility is not in

	compliance with these Action Steps BSSLC has contracted an AAC specialist to assist them in increasing staff knowledge and broadening the presence of AAC. The AAC specialist is also planned to focus on improving AAC evaluations.
	Summary of Monitor's Assessment: **Provision R.1** was determined to be not in compliance. BSSLC has added 2 Speech openings that were posted on June 29, 2010; however, these positions have not yet been filled. Individuals who are in need of AAC were not receiving adequate supports. **Provision R.2** was determined to be not in compliance. The Communication Assessment did not consistently address expansion of current abilities and development of new skills. **Provision R.3** was determined to be not in compliance. AAC devices are not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. **Provision R.4** was determined to be not in compliance. BSSLC was monitoring the presence and working condition of the AAC device s but were not monitoring whether or not the device was effective and or meaningful to the individual. BSSLC has hired an AAC consultant to assist them in developing new system wide AAC strategies and to assist in expanding the knowledge base of their clinicians relevant to augmentative communication.

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Due to the lack of therapists, therapists are routinely passing the development of programs to individuals who lack the expertise needed to write functional and sequential goals. Through the IDT process, objectives should be clearly identified as well as the individual most appropriate to develop and follow said goal. This process will ensure that all goals and objectives are functional and relevant to the intended outcome. Since the topic is communication, the professional most likely to have the needed expertise in developing and revising communication programs would be the SLP. BSSLC has added 2 Speech openings that were posted on June 29, 2010. Once filled, this will increase the number of Speech Therapists from three to five. These additional therapists will lower the caseload thus it should allow more time for the therapists to participate at the house level with regards to meetings, trainings and goal review. BSSLC has also hired an augmentative communication expert who will be visiting BSSLC one to two times per week to provide AAC training to the Speech Pathologists and other staff at BSSLC. Her focus will also be on improving the overall presence of communication devices throughout the center.	N

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		Based on a review of CVs for each therapy clinician (3) and interviews with therapy staff, the Department did document appropriate qualifications for licensed SLPs and assistants (proof of current license) and/or continuing education in the last 12 months. Based on a review of 15 records involving individuals who were identified with moderate-severe expressive or receptive language 50 % were not receiving supports designed to improve or augment existing language. Examples include: • Individual #52 is listed as having decreased expressive language skills. It is stated that Home boards and devices will be utilized but this is not occurring on a consistent basis. • Individual #390 has decreased receptive language and unintelligible speech yet the PST discontinued his communication dictionary and did not recommend augmentative support. • Observations on Bowie A, B and Driscoll A, B, C, and D revealed no interaction with individuals using the boards.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	15 of 15 records reviewed indicated individuals identified with severe expressive/receptive language did have AAC reviewed, however, only 5/15 contained what is considered to be an Augmentative evaluation and not a review. An assessment dives deeper into what the individual can not only currently do but strategies and device trials that may lead to future language. Examples of individuals diagnosed with severe language difficulties where AAC was not assessed or investigated. • Individual #330 has the ability to point to object of interest but the need for AAC was not fully assessed. • Individual # 121 has a history of utilizing a voice output device prior to living at BSSLC. but the individual is not currently utilizing a device. There is no evidence why AAC was not implemented. In 3 of the 15 records reviewed, the Communication Assessment addressed: • verbal and nonverbal skills, • expansion of current abilities, • development of new skills. and • whether the individual requires direct or indirect Speech Language services. Examples of the communication assessment not addressing all areas:	N

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		• Individuals #126, #440, and #543 did not contain methods to expand upon existing language or the development of new language. In 4 of the 4 records of individuals receiving direct services reviewed (100 %), goals and objectives were determined to be functional and meaningful as evidenced by review of the PSP preferred activities The majority of individuals at BSSLC have communication dictionaries; however, individuals who are primarily nonverbal are not provided with low, mid, or high tech devices. Additionally, throughout the survey, there was no evidence of the existing devices being utilized by an individual or encouraged to be used by staff. Per interview and document review, there is no clear policy or process that defines the schedule or criteria regarding whether an individual receives a speech update or full assessment.	
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.	Results from the speech assessment are only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit are not clearly integrated into the PSP. Strategies may be listed but these strategies are not consistently integrated into Action Plans or activities of daily living. Lack of integration results in a lack of generalization of objectives. Zero of the four records reviewed had a a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated: • Individual #272 states that he should use his communication builder and it should be integrated into daily activities but no further information is supplied. • Individual #413 has a communication builder and an objective that focuses on the use of the device but there is no mention in the PSP how the device can be utilized outside of specified training. AAC devices are not consistently portable and functional in a variety of settings. Three of the Five Communication programs with an AAC component included AAC devices that were portable and functional in a variety of settings (i.e., mealtime, work, ADLS). Examples of Communication programs that did not contain AAC equipment that was determined to be functional or portable in a variety of settings included:	N

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		• Individual # 330 and Individuals # 52's devices are Home based devices which are posted on the walls of the home. 4 of the 15 records reviewed clearly indicated how the individual communication programs were functional and meaningful to the individual and how it improved his/her daily living. DCPs interviewed were not knowledgeable of the communication programs as evidenced by: • In three of five interviews, direct support professionals were not able to locate adaptive equipment. • In three of five interviews with staff , staff could not describe individual-specific communication strategies. • In five of five interviews with staff, staff could not describe the schedule for implementation of communication strategies. • In two of five interviews with staff , staff stated they had not received individual-specific training for communication strategies. Instances in which individuals' communication plans were not able to be described by staff included: • DCP on DRA was not able to locate Individual #84's Communication Dictionary or describe strategies listed on the plan. • DCP on BOC was not able to identify what device Individual #440 should utilize to augment communication. • DCP on BOC was not able to describe communication strategies to use with Individual # 126. Six of the six homes had general AAC devices present in the Common areas, however, zero of the six common area AAC devices contained clear directives on how staff should utilize general AAC devices. Six observations demonstrated that staff did not utilize common area AAC devices. Staff were observed walking by devices with no effort given to utilize devices to communicate to individuals or have individuals attempt to initiate conversation.	

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R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	A review of Facility monitoring reports from 9/2009 to 6/2010 documented that staff were not being monitored in all aspects of AAC utilizations: This included: • In 175 of 175 reports reviewed the presence of the AAC was documented ; • In 175 of 175 reports reviewed the working condition of the AAC was addressed; • In 0 of 175 reports reviewed the implementation of the device was addressed; and • In 5 of 175 reports reviewed the effectiveness of the device was documented. A review of Facility monitoring reports from 9/2009 to 6/2010 documented that staff were monitoring the presence of the devices but not the implementation therefore whether AAC is being monitored during all aspects of the person's day cannot be assessed at this time.	N

Recommendations:

1. Provide continued opportunities for continuing education for SLPs in the area of AAC. Education focusing on those individuals with less than overt communicative intent would be ideal as this is the population most in need at BSSLC.
2. Continue to expand the presence of common area AAC as well as the implementation of such devices. There are multiple opportunities for Communication training, especially during times of transition and day programming. Because of this, these areas should be integrated into the overallplan of care and should be included in the PSP.
3. Expand integration of communication strategies and devices into the individual's daily life. Training of augmentative communication must occur throughout the day and not only during structured treatment sessions.
4. SLPs should participate more actively in the annual PSP process. Individuals who have communication needs are not being represented by those who have the most expertise in the area.
5. Work closely with Psychology so that individuals who have behavioral issues related to lack of communication are provided with collaborative services from Psychology and Speech Therapy.
6. All goals written for individuals regarding communication should be developed by the person with the most experience. In the case of communication, this person is often the SLP. All written goals should be followed by the SLP or individual determined by the team to be most closely related to the determined goal. Frequency should be monthly if receiving direct services and quarterly for all others.
7. Assessments should focus on the expansion of skills or development of new skills and not just provide summarization of current abilities.

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** Annual PSP, PSP updates, SPOs, PBSPs, treatment data, teaching data, progress notes, psychology and psychiatry evaluations, physician's notes, psychotropic drug reviews, consents and approvals for restrictive interventions, safety and risk assessments, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #3, #4, #7, #9, #11, #12, #15, #19, #35, #38, #41, #51, #53, #55, #75, #83, #95, #185, #206, #281, #321, #327, #358, #390, #403, #427, #467, #471, #474, #514, #539, #556. **People Interviewed:** 1. Andrea Miller – Program Services Director 2. Terry Hancock, Ph.D. – Chief Psychologist 3. Shawn Cureton, MS – Psychology Manager 4. Kathleen Williamson, MEd – Psychology Manager 5. Mellisa Waters, MBS, BCBA 6. Direct Care Professionals (Bowie - A, Bowie - B, Bowie - C, Childress - A, Childress - A, Childress - B, Cottage - A, Cottage - B, Cottage - C, Cottage - D, Cottage - F, Cottage - G, Driscoll - C, Driscoll - C, Driscoll - D, Fannin - B, Fannin - C, Fannin - C, Fannin - D, Fannin – D, on-campus vocational sites, off-campus workshop and Blue Bell Ice Cream worksite) **7.** BSSLC Plan of Improvement (POI), dated 5/17/10 **Meeting Attended/Observations:** 1. Meeting with multiple Facility staff to discuss the use of sedation for dental procedures 2. Observations in campus residences (Bowie - A, Bowie - B, Bowie - C, Childress - A, Childress - B, Cottage - A, Cottage - B, Cottage - C, Cottage - D, Cottage - F, Cottage - G, Driscoll - C, Driscoll - D, Fannin - B, Fannin - C, Fannin – D) 3. On-site vocational programs 4. Off-site vocational programs (off-campus workshop and Blue Bell Ice Cream worksite) 5. Program Services classrooms 6. Classrooms located in residences (Driscoll - C, Driscoll - D, Fannin - B, Fannin - C, Fannin - D)
	Facility Self-Assessment: The Facility stated it is not yet in compliance with any of the provisions of this Section but has implemented a number of actions to lead toward compliance. The Facility accurately reported that skill acquisition plans are not targeting needs identified in assessments and that skill acquisition plans are not adequate for skill development and learning. The Facility reported the provision of community awareness programs. The monitoring confirmed the

	presence of these programs as well as vocational services provided in community settings.
	Summary of Monitor's Assessment: **For Provision S.1,** this provision was determined to be not in compliance. BSSLC had conducted an audit of skill acquisition programs and assessments, training had been provided on the PSP and PSPA process, and workgroups were continuing the review of assessment procedures. Further remedial action was awaiting approval from State Office. Additional time will be needed to assess progress. In order to provide effective and meaningful training opportunities that promote the development of personal adaptive skills, it is essential that adequate assessment be completed. Training programs did not include task analyses or methodologies that would be expected to be effective. **For Provision S.2, t**his provision was determined to be not in compliance. BSSLC reported that no action had been implemented relative to this Provision pending approvals from State Office. Additional time will be needed to assess progress. **For Provision S.3, t**his provision was determined to be not in compliance. Increased community opportunities were occurring at the time of the site visit, but further remedial actions were awaiting approval from State Office. Additional time will be needed to assess progress.

#	Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	At the time of the site visit, the Facility indicated that no components of this Provision were in compliance. BSSLC had conducted an audit of skill acquisition programs and assessments, training had been provided on the PSP and PSPA process, and workgroups were continuing the review of assessment procedures. It was reported by the Facility that the State Office was in the process of reviewing the audit findings and other materials, and that BSSLC was awaiting instructions from State Office before taking further remedial steps. Observations, record reviews and comments from Facility staff reflected the following status of Provision S1. In order to provide effective and meaningful training opportunities that promote the development of personal adaptive skills, it is essential that adequate assessment be completed. • Limitations in psychological and psychiatric assessments are detailed in Provisions K5, K6, K7 and K9. • None of 32 records reviewed contained assessments adequate to the task of identifying specific programmatic needs.	N

#	Provision	Assessment of Status	Compliance
		Skill acquisition programs must contain a formal and valid methodology for increasing or strengthening the skill being taught. The records reviewed during the site visit contained the following limitations. • 0 of 32 records reviewed contained plans that reflected development based upon a task analysis. • 0 of 32 records reviewed contained behavioral objective(s). • 0 of 32 records reviewed contained operational definitions of target behavior(s). • 0 of 32 records reviewed contained an adequate description of teaching conditions. • 0 of 32 records reviewed contained a schedule of implementation comprised of sufficient trials for learning to occur. • 0 of 32 records reviewed contained relevant discriminative stimuli. • 0 of 32 records reviewed contained specific instructions. • 0 of 32 records reviewed contained opportunities for the behavior to occur. • 0 of 32 records reviewed contained specific consequences for correct responses. • 0 of 32 records reviewed contained specific consequences for incorrect responses. • 0 of 32 records reviewed contained a plan for maintenance and generalization • 0 of 32 records reviewed contained an adequate documentation methodology The limitations noted under this Provision, as reflected in observations and record reviews, substantially curtail the habilitation and learning process. Based upon the conditions at the time of the site visit, the following conditions were noted during the on-site review. • 0 of 32 records reviewed contained skill acquisition programs that promoted growth, development or independence. • 0 of 32 records reviewed contained a plan to monitor and maintain adequate levels of individual engagement. • 0 of 32 records reviewed contained an adequate array skill acquisition programs and work and leisure opportunities. Examples of weaknesses in the documentation and monitoring process for skill acquisition programs at BSSLC as observed during the site visit are included below. • For Individual #4, all data cells were marked I(Independent) in November, 2009 (except for four consecutive days marked H (Hand over Hand) the first week of November, followed by one unreadable data point, followed by one more day	

#	Provision	Assessment of Status	Compliance
		marked H), all cells were marked H (except for one unreadable entry and one with narrative that appears to indicate the materials needed were unavailable but does not use that code) from December 1, 2009 through March 31, 2010, followed by one unreadable entry and then entries of V (Verbal) through May 31, 2010. The criterion for completion of the goal was "no more than 3 verbal prompts for 24 days per month for 2 consecutive months). This criterion was met (assuming the data were accurate) on May 25, 2010. The objective was not revised, and all data entries for June, 2010, were G (Gestural)—apparently indicating that there was regression from November, 2009 through June, 2010 with no revision to the program procedures as well as showing no change in objective when the criterion was met. QMRP interviews did not indicate this was noted or provide any explanation. • For Individual #31, there were several objectives for which criteria were met but the same objective remained for an extended time. Out of the first 5 ITP goals reviewed, four had met criterion but were not changed. o ITP 1B1 met criterion March, 2010, but the objective remained through June, 2010. This ITP has been changed for reasons unrelated to meeting the criterion. o ITP 1C1 relate to compliance with instructions met criterion in April, 2010, but the objective remained through June, 2010. Per QMRP interview, what is to be complied has changed, which is not clear in objectives. o ITP 1D1 met criterion in January, 2010, but the objective remained through June, 2010. This ITP was discontinued in July, 2010 as no longer a priority need. o ITP 1E1 met criterion in December, 2009 but the objective remained through June, 2010. The criterion was changed in July, 2010 to reduce the prompt needed for a successful instance of the behavior.	
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.	At the time of the site visit, the Facility indicated that no Action Steps of this Provision were in compliance. Information regarding limitations in the assessment process are discussed in Provisions K5, K6, K7 and S1. The Facility indicated that no steps had been taken to address the weaknesses identified during the baseline process.	N
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the	At the time of the site visit, the Facility indicated that one Action Step of this Provision was in compliance.	N

#	Provision	Assessment of Status	Compliance
	assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	The provision of skill acquisition training requires adequate assessments and well-designed skill acquisition programs. As documented under Provisions K5, K6, K7, S1 and S2, adequate assessments had not been conducted by BSSLC at the time of the site visit and skill acquisition program reviewed were not sufficient to effectively increase or strengthen skills. Without the assessment and program development components in place it was not possible for BSSLC to implement effective skill acquisition programs.	
	(b) Include to the degree practicable training opportunities in community settings.	At the time of the site visit, observations reflected a number of community opportunities. • BSSLC operates a community-based workshop that provides vocational opportunities through contracts with local business. During observations conducted on 7/28/2010, individuals were observed engaging in shredding, assembly work and packaging. All individuals were focused upon their work and openly voiced their enjoyment of the vocational opportunities and the worksite in general. • Employment opportunities are also provided to individuals at the Blue Bell Ice Cream plant located in Brenham. During observations on 7/28/2010, the individuals employed at Blue Bell were very enthusiastic about their jobs and welcomed the opportunity to share their experiences. • The Facility has implemented bi-weekly outings to various community and regional points of interest. At the time of the site visit, four outings had taken place. Increased community opportunities are highly desired. However, acceptable practice and successful compliance requires the provision of training opportunities within the community. Without the assessment and program development components in place it was not possible for BSSLC to implement effective skill acquisition programs in the community.	

Recommendations:

Implementation of skill acquisition programs requires that the staff implementing those programs possess knowledge regarding positive reinforcement, the skills to deliver reinforcement, the ability to document displays of skills with objectivity and reliability, and the ability to select functional tasks and activities and to break tasks into steps that can be taught. It is therefore recommended that BSSLC aggressively implement a competency-based training program for staff that emphasizes the basic concepts of learning and applied behavior analysis.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), dated 5/17/10 2. BSSLC Supplemental POI, dated 5/17/10 3. Since January 1, 2010, a list of all individuals who have been referred for community placement by his or her PST, including name, date of recommendation and current residential status. 4. Since January 1, 2010, a list of all individuals who have requested community placement, but have not been referred for placement. 5. Since January 1, 2010, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge." 6. Since January 1, 2010, a list of all individuals who have been discharged pursuant to an alternative discharge. 7. A current list of all alleged offenders committed to the facility following court-ordered evaluations. 8. Since July 1, 2009, list of all individuals who have been assessed for placement since, date of assessment, and resulting recommendation(s). 9. For the last six (6) months, a list of all trainings/educational opportunities provided to individuals, families and LARs to enable them to make informed choices. 10. Since January 1, 2010, a list of all individuals who have had a Community Living Discharge Plan developed. 11. BSSLC Provider Fair flyer for the event held on July 20, 2010 12. Completed Post Move Monitoring (PMM) checklists for 12 individuals: Individuals #28, #40, #48, #72, #170, #183, #255, #274, #296, #490, #512,#540, 13. Personal Support Plans (PSPs) for 15 individuals: Individuals #2, #61, #121, #122, #139, #274, #334, # 350, #385, #399, #417, #425, #467, #581, #594 14. Permanency Plans for six individuals: Individuals #121, #139, #399, #417, #425, #467 15. Community Living Discharge Plans (CLDP) for 12 individuals: Individuals #40, # 47, #48, #72, #170, #183, #255, #274, #296, #490, #512, #540, 16. Community Placement Obstacles report, dated 1/1/10-6/22/10 **Persons Interviewed**: 1. Debra Green, Director of Admissions and Placements 2. Sherri Gilliland, Post-Move Monitor **Meeting Attended/Observations:** 1. PSPs for two individuals: Individuals #52, #390 2. Post Move-Monitoring Visits for three individuals: Individuals #201, #236, #396 3. CLOIP Tour 4. CLDP Meeting for Individual #122 5. PST Meetings to evaluate community living trial visits for two individuals: #334, #385

	Facility Self-Assessment: The Monitoring team reviewed the BSSLC POI and Supplemental POI. The POI indicates that the DADS State Office Policy Unit will be responsible for the development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA. It should be noted that the Action Steps listed by BSSLC are not fully in congruence with components that are being reviewed. Areas being reviewed by the Monitor's team are addressed in the Summary of the Monitor's assessments and findings section. Overall, the Facility indicated it was not in full compliance with any of the provisions of Section T. It did indicate compliance in several sub-sections, including the Community Placement Report and certain aspects of Community Living Discharge Plans and post-move monitoring. The Facility indicated accurately it had not yet developed policies and procedures to implement this Section of the SA but noted that policies were undergoing review and approval. The Facility also indicated it was not in compliance with the completion of record reviews to ensure that community placement decisions are consistent with the SA. The Facility has delegated much of this responsibility to the QMRP Coordinator, a position which is currently vacant. The Facility indicated it had not yet addressed the identification of protections, supports and services in the PSP that were needed to ensure safety and adequate habilitation in the most integrated setting, the identification of obstacles in the PSP to movement to the most integrated setting, the provision of adequate education about community living and the completion of assessments of individuals for community placement. Action Steps were also defined to develop quality assurance and corrective action plans in these areas. The Facility noted that certain items related to the development of the PSP were being monitored by the facilitators. Since it is the facilitators who are responsible for guiding the PST through the development of the plan, the Facility should consider assignment of the monitoring to an objective third party. The Facility reported compliance with the development of the CLDP when required and on a timely basis in coordination with the MRA, and that the CLDPs included all the requisite information. This was not congruent with findings of the monitoring team. Although the monitoring team found progress had been made in better defining the process of the CLDP meeting, and important information was less likely to be overlooked, this did not yet result in better outcomes as significant health and safety issues were not adequately identified. The Facility reported compliance in the implementation of the actual post-move monitoring process, stating that the PMM Checklist had been completed on all individuals who transitioned to the community. The monitoring team found that the PMM Checklists were being completed in a timely manner, for the most part, but not universally. There appeared to be some potential for PMM visits to be missed when the

	process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. There was one such instance found during this compliance visit. Furthermore, although the PMM Checklists reviewed were being completed in a timely manner in general, the process used to complete them was not thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. The PMM visits observed during the compliance visit did not adequately confirm the presence of these supports. The Facility accurately identified that indicated it was not in compliance with six of six Action Steps related to the discovery and analysis of obstacles to movement to the community. The Facility stated it that no alleged offenders residing at BSSLC. It did not address compliance with this provision. The Facility state there had been no alternate discharges.
	Summary of Monitor's Assessment: BSSLC indicated that it was not in compliance with any of the provisions of this Section, but did report it had achieved some level of compliance in three key component areas, those being the CLDP process and the Community Placemen Report under Provision T1and PMM process under Provision T2. Assessments of these two areas were then the primary focus of this compliance visit. Since the Facility indicated it was not in compliance with the remainder of those provisions or with the other provisions as a whole, the monitoring team did not examine these in tremendous detail. Instead, the team reviewed a small sample of documents in order to be able to assess progress, if any, from the baseline tour and provide any additional recommendations that may be helpful to the Facility as it undertakes action in these provisions. The findings are as follows: **Provision T1, t**his provision was determined to be not in compliance. In most instances this was consistent with the Facility's self-assessment. The Facility continues to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting and development of individualized strategies for education about community living options to promote informed choice. The Facility did report it believed it was in compliance with some key indicators related to the CLDP and the monitoring team found there had been progress in better defining the process, organization and structure of the CLDP meeting. As a result, it seemed that important information was less likely to be overlooked during the meeting. There was also a better process for ensuring the required 45-day comprehensive assessment documents were obtained and reflected in the CLDP documentation. The monitoring team did not find that these improved processes were yet resulting in better outcomes. Instead, the monitoring team found that some very significant health and safety issues, that could put an individual moving to the community at increased risk, were not adequately identified in the 45-day assessment nor in the resulting CLDP.

	The Facility also reported it was in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The monitoring team found that the Facility does collect all the required information but had not assimilated it into the required report. The monitoring team suggested that other documents the Facility had produced could be combined to create the Community Placement Report, but a final document was not provided prior to the end of the site visit. Overall, however, the Facility would appear to be in substantial compliance with this component, as it collects the necessary information and had produced two separate documents that, combined, would meet the intent of the requirement. **Provision T2,** this provision was determined to be not in compliance. The Facility had indicated it was achieving some level of compliance in the area of PMM. The monitoring team found that the PMM Checklists were being completed in a timely manner, for the most part, but not universally. There is potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. There was one such instance found during this compliance visit, and it is an issue that has potential to grow as more individuals move to community settings in other catchment areas. Although the PMM Checklists reviewed were being completed in a timely manner in general, the process used to complete them was not thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. The PMM visits observed during the compliance visit did not adequately confirm the presence of these supports, as records were not reviewed, direct support staff were not interviewed as to their knowledge of the individuals and the presence of each and every support was not methodically observed and documented. **Provision T3,** this provision was determined to be not in compliance. The Facility did not have policy and procedure, nor did it acknowledge a need to have policy and procedure, that defined how it would identify and implement discharge procedures for 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. Facility policies and procedures did not indicate that the provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations for individuals committed to the Facility. If the Facility will not admit alleged offenders, then Facility policy should so state. If not so stated, then Facility policy should address these requirements of the SA. **Provision T4, t**his provision was determined to be not in compliance. The Facility did not have policy and procedure, nor did it acknowledge in the POI a need to have policy and procedure, that defined how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T.1 (d), and (e), and T.2, for the individuals who are classified in the SA as alternate discharges. Such alternate discharges could occur at any point, and the Facility should have policies and procedures in place to define its processes.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**	This Provision was found to be not in compliance.	N
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	The SA requires the State to take action to encourage and assist individuals to move to the most integrated settings as identified in the provision. The number of children being served in the Facility indicates that more work needs to be done to assist individuals to move to community living when they do not object to moving. Although not specifically related to the SA, the monitoring team would also like to point out that this will require the establishment of community capacity to provide those supports. The following information and examples illuminate the lack of such capacity. Commonly accepted professional standards mitigate against serving children in institutional settings, yet during the past six months, five of seven individuals admitted to the Facility were under the age of 21. It is not entirely within the purview of BSSLC to address these needs, nor are these issues confined to the BSSLC catchment area. The State should further evaluate to what extent supports and services are provided in the community in order to prevent unnecessary institutionalization, particularly in the case of people under the age of 21. At the time of this compliance visit, BSSLC was serving 24 children under the age of 21, ranging in age from 9-20. The monitoring team reviewed six Permanency Planning documents for individuals as a part of its effort to understand how the Facility assessed individuals for the most integrated setting possible. In general, families had limited services and resources available in the community before making these difficult decisions. Examples include: • Individual #121, age 11, was admitted in late 2009 because the grandmother could no longer provide care. According to the Permanency Plan, the family "sought to receive Service Coordination and Respite services, but stated that they needed long term placement rather than temporary relief in the home." There was no reference to any other family home setting, which is the appropriate therapeutic setting for an 11 year old child, being sought. • For Individual #139, the Permanency Plan documented that "limited support" was provided to the family as it was "trying to meet her needs and were unable to deal with her escalating behaviors." • For Individual #399, placement was precipitated when the grandmother was "no longer able to care for her in the home based on behaviors and no other caregivers available." Community ICF-MR placement was explored, but she was not offered placement by the provider due to behaviors.	N

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		• For Individual #467, also age 11, admission was sought when the family "was not able to properly care for her due to her unpredictable behavior problems." Supports received prior to placement were documented as "therapy on a weekly basis." In each of these instances, the Permanency Plan reported minimal services were provided to the individuals and families, when intensive supports would have more likely been in order. More intensive and in-home supports may have allowed the individuals to remain at home or at least in the community.	
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:	This component was found to be not in compliance.	N
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The PSTs at BSSLC continue to need additional training and mentoring in the identification of protections, supports and services individuals will need in the most integrated setting, as well as in the identification of obstacles to movement to the most integrated setting. This is consistent with a need to improve their overall abilities to function as effective interdisciplinary teams in the assessment of individual needs. There is a tendency on the part of the PSTs to focus on form, format, tool or process in front of them as opposed to true interdisciplinary consideration. This was evidenced in the two PSPs attended: • For Individual #390, the PST reviewed the Water Safety Assessment, which had been completed at an earlier date and had recommended the individual should not be on or in the water, even though the individual's sister indicated he enjoyed the water and just needed to be supervised. Later on in the meeting, the PST asked the individual if he wanted to attend Camp for All and suggested he would enjoy it because of the lake and the boats. The PST never stepped back from these apparent conflicts to discuss what might make sense for the individual based on his own specific needs and what supports he would need to be able to engage in an activity that he enjoyed. • For Individual #390, the nurse case manager reviewed the medications, reading from the individual's record. She indicated that, among other things, the	

#	Provision	Assessment of Status	Compliance
		individual was receiving Risperdal. The Psychology Assistant then read the Med Review which indicated the Risperdal had been discontinued in March 2010 and replaced with Abilify. The PST then agreed with the medication regime. This agreement took place before the individual's psychologist discussed the potential side effects. The team did not seem to understand how to use the process to engage in thoughtful consideration of the individual's needs. • For Individual #390, this continued into the Community Living Options discussion. The individual had lived with his sister in the past and expressed a desire to live with her again. She indicated this would not be possible. The PST did not, at that point, focus the discussion on what she believed would be required for the individual to live in the community; for example, would she like for him to be close enough to visit more frequently, but with enough distance to ensure the both could continue to lead their own lives? Instead the PST appeared to take this to mean the sister was opposed to community placement and there was a suggestion that the individual should not visit any group homes if his sister was opposed. The sister replied that, no, visits to a group home would be fine. The team did not then pursue what the sister might hope to see in such a group home. • For Individual #52, resistance to change was identified as an obstacle to movement to community living. The action plan to overcome this obstacle involved improving "safety in the community," which was apparently unrelated to the obstacle. The intervention involved an objective to identify pictures of safety signs, which would not be considered a functional activity, as opposed, for example, to receiving training in the community with actual safety signs in real situations. A nonfunctional activity was thus selected to train a skill that was ultimately unrelated to the identified obstacle. • For Individual #52, the individual's father indicated in prior documentation that his goal was to have his son move back to the family home, once he was ready. During the meeting, he repeated this desire and noted that the family had just purchased a new home where they had prepared for the individual his own room. The individual also indicated that he would like to live at home. During the Community Living Options Discussion, however, the PST focused on what supports and services the individual would need in a community group home, and recommended that he visit such homes. There was no discussion with the father about what supports and services would be needed in the family home to assist the individual and family to reach their expressed preference. The SA requires the IDT to " 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."	

#	Provision	Assessment of Status	Compliance
		The first two bullets address the IDTs ability to *adequately* assess and identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. Water safety, the ability to participate in a preferred activity (in this case, water activities) and having the appropriate medication regime are likely to be significant factors in safety and habilitation in the most integrated setting, but the IDT in question did not adequately assess those needs. This speaks directly to the IDT's ability to identify the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs.	
	2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	The monitoring team reviewed documents related to education and awareness activities, interviewed the APC and Post-Move Monitor, and attended a CLOIP tour. Since January 2010, only 16 individuals had participated in tours of community homes and programs. The Facility reported that it had begun scheduling CLOIP tours every other Tuesday and Thursday, which represents progress and should result in significantly more opportunities for individuals to gain awareness of community living options. However, this routine scheduling of tours began on 6/15/10, so it is too soon to evaluate the efficacy of this strategy as a component of an overall plan to ensure the provision of adequate education to enable individuals to make informed choices. Data were not being kept on the participation of staff in these tours, but should be in order to ensure Facility staff at all levels are adequately prepared to engage individuals, families and LARs in discussions about community living options. BSSLC also held a Provider Fair on July 20, 2010, with 31 providers participating. Eighty-four individuals attended, as did 150 BSSLC staff. Only one family member was reported to have attended. It is not clear what actions the Facility implemented to ensure families and LARs were notified of the event. Email messages from the APC requesting that clerical staff mail the flyer announcing the event were reviewed, including a request to obtain the list of family mailings completed which was to be used as evidence for the monitoring team. This documentation was not included in the evidence provided. The Facility has made some additional efforts to support education of PST members beyond the Provider Fair. The APC provided a training on April 14, 2010 on the community referral process to 36 social workers and QMRPs. The Post-Move Monitor has begun attending PSP meetings in order to assist in the education of PST members regarding community living options. BSSLC is taking some actions to increase education and awareness, but these do not	

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		appear to have been well thought-out with clear goals in mind. The Facility did not include any curriculum regarding most integrated setting in its Competency Training and Development for new or existing staff. The Facility should develop a comprehensive strategic plan with assigned responsibilities, timelines and outcome measures. Partners in this effort should include all those with responsibility for education and training: the APC, the Post-Move Monitor, the QMRP Coordinator (once hired) the Competency Training and Development department at the Facility, the Contract MRA and other MRAs, with input from self-advocates at the Facility. The monitoring team did not examine the annual MRA CLOIP process during this compliance visit, but it will continue to be an important part of the Facility's overall plan for education and awareness.	
	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.	The Facility takes the position that the assessment for placement process is the Community Living Options Discussion Record(CLODR) that takes place at least annually as a part of the PSP as described in Texas DADS SSLC Policy 018: Most Integrated Setting Practices, 3/31/10. The Facility provided a list of approximately 170 individuals (some duplicates were noted) who had been assessed for placement, using this definition. From observations and document reviews as described in T1a and T1b above, the Community Living Options discussion does not appear to be implemented in such a manner that it could yet be considered an effective assessment for placement. A number of improvements should be made to how the process is implemented before the facility begins to consider that individuals have been truly assessed for placement. These improvements should begin with a focus on the ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning. This will not be accomplished simply by prescribing additional formats and processes, but will require considerable staff training and mentoring. As described in T1a, there is some tendency on the part of the PSTs to focus on the format and process to the detriment of the desired outcome. For this reason, the addition of more "check-box" selections to the identification of supports and services in the CLODR, while well-intentioned, is a disturbing trend that should be reconsidered.	
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	This component was found to be not in compliance. The Facility did not always ensure that PST identification and recommendation of an appropriate integrated community setting resulted in a timely referral and/or placement. For example, the Community Placement Obstacles report, dated 1/1/10-6/22/10, listed identified obstacles for 16 individuals that had a preference for community placement, but were not recommended for placement by their PST. For the four individuals for whom the obstacle was listed as "MRA Not Present," each was eventually referred for placement. The addendum meetings to complete the referral with the Designated MRA present for three of the four were within the two-week requirement as outlined in Texas DADS SSLC Policy: Most	N

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	community living discharge plan in a timely manner. Such a plan shall:	Integrated Setting Practices 018.1, 3/31/10. For the fourth person (#557), the addendum meeting was not held until 23 days past the PSP date. The monitoring team also reviewed a list of placements from 1/22/10-6/04/10. For the 20 individuals on the list, only two moved to the community within the 180-day time frame prescribed by Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10. Of the remaining 18 individuals, transitions were delayed on an average of 107 days beyond the 180-day time-frame, with a range of 36 to 254 days beyond the time-frame. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Section T1f.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The CLDP process is a continuation of the Facility's responsibility to assess the needs of an individual who will be moving to a more integrated community setting, and to ensure that the community setting adequately meets those needs. The identification of essential and non-essential supports must begin by considering those things identified in the PSP. The PST did appear to rely heavily on the PSP and the assessments associated with the PSP to guide the identification of the essential and non-essential supports. The potential problem with this was that it was not clear the PSTs were proficient in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or finally, the identification of the supports and services needed and desired in a community setting during the PSP, as described in Section T1b, Section F1c and Section F2a. Examination of this item of the Settlement Agreement will therefore be contingent to some degree on a positive evaluation of these items at some point in the future. Also see T1d for further discussion of the Facility's failure to adequately assess and identify the support needs of an individual for the CLDP.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	For 12 of 12 CLDPs reviewed, the Facility did not assign specific Facility staff responsibility for the essential and non-essential supports. Instead, staff from the selected provider were identified rather than Facility staff. It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness. Facility policy and procedure should specify the expectations in this regard.	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-	For 1of 12 CLDPs reviewed (Individual #183), the review of the CLDP with the individual and/or LAR was not documented. The signature sheet was blank, and no other form documentation was provided as evidence. The Facility has reported that the signature sheet is available, but it was not provided at the time of the compliance visit.	

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	making regarding the supports and services to be provided at the new setting.		
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.	This component was found to be not in compliance. There was improvement in the Facility's process for ensuring the required 45-day comprehensive assessment documents were obtained and reflected in the CLDP documentation. Beginning with those CLDPs held after 3/30/10, the APC obtained updates from each of the disciplines and included these in each of the CLDP packets presented at the meeting and shared with the provider. This was a positive step. The monitoring team did not find that these improved processes were yet resulting in better outcomes. Instead, the monitoring team found that some very significant health and safety issues that could put an individual moving to the community at increased risk were not adequately identified in the 45-day assessment nor in the CLDP meeting. A CLDP for Individual #122 was scheduled to be held during the compliance visit. In order to test for compliance, the monitoring team undertook an interdisciplinary review of the record, spoke with and observed the individual and interviewed staff who worked with her. The monitoring team shared any findings, issues and concerns with each other. This was an interdisciplinary process, as one would expect the 45-day comprehensive assessment to be, albeit on a larger scale. The monitoring team identified a number of concerns that should have been addressed by the individual's PST at the CLDP (and on an ongoing basis at the Facility,) but were not so addressed. Examples include: • Individual #122 has kyphoscoliosis and osteoporosis. In the past year, she has lost mobility, her gait has become increasingly abnormal and she has experienced a number of falls. She sits in a wheelchair without postural supports other than a lap belt, and does not hold herself upright. She is very hunched over and seems to have difficulty holding her head upright as well. She also has GERD and a history of chronic constipation which may be exacerbated by her lack of proper positioning. Physical Therapy had recommended a wheelchair seating system on 1/5/10. The individual was placed on the waiting list for an evaluation. At the time of the CLDP, the documentation provided at the meeting indicated that a wheelchair evaluation had been done on the existing chair and that it was acceptable. This was not a seating evaluation. There was no mention of the need to have a complete seating evaluation nor the reasons this might be needed. • In the individual's annual medical summary, dated 1/26/10, the physician noted the individual was overdue for a colonoscopy for follow-up of polyp removal in 2006. No follow-up has been completed, even though she continues to be	N

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		treated on an ongoing basis for GERD and chronic constipation. This was not discussed at the CLDP meeting. • Individual #122 has had a diagnosis of prerenal azotemia, and it is essential that she be followed by a nephrologist. This was not discussed at the CLDP. • Individual #122 also has a diagnosis of left atrial dilation and mild valve disease. Cardiology follow-up will be needed, but this was not addressed at the CLDP meeting. It was also noted by the monitoring team that her current positioning can put undue pressure on her heart. This reinforces the need to be evaluated for an appropriate seating system. The 45-day assessment is intended to both provide a framework for ensuring that all current needs for essential and non-essential supports are identified in the CLDP and as a resource for the community providers to fully understand the scope of the individual's needs. Neither purpose was fulfilled for this individual, which could have resulted in increased risk and possible negative outcomes in the community setting. This experience also calls into question whether other 45-day comprehensive assessments were similarly incomplete, as well as the overall interdisciplinary assessment processes of the Facility. Future assessment of the compliance with this component will require a thorough review of these processes as well.	
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.	This component was found to be not in compliance. For 12 of the 12 CLDPs reviewed, the Designated MRA was appointed to complete an assessment of the community residence prior to the individual's move. The monitoring team requested this verification for all individuals who had transitioned since 1/01/10 and then matched these with the CLDPs under review. For 6 of the 12 CLDPs reviewed the Facility did not provide documentation of the MRA action prior to the individuals' transition as evidenced by the signed and dated Continuity of Care Pre-Move Site Review Instrument for the Community Living Discharge Plan. For one of the six Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan, the MRA did not indicate that all supports were in place. For Individual #512, the MRA and provider only had a copy of the Essential/Non-essential page of the individual's CLDP.	N
T1f	Each Facility shall develop and	This component was found to be not in compliance. The Facility did not have quality	N

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	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.	assurance policies, procedures and/or processes to ensure that community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible. It was reported in the POI that these processes had not yet been developed. The reviews of the CLDPs from this site visit, as described in sections T1d and T1e above, and of the progress of referrals, as described in Section T1c, would suggest the Facility needed to develop or otherwise promulgate written quality assurance procedures that would ensure CLDPs are tracked from the process of referral through move to the community. This should include written procedures for ensuring, at a minimum: • PST recommendations for community living for individuals result in a timely meeting with the Designated MRA to consider making the referral; • Referrals are routinely tracked and are completed within the 180 day timeframe unless a waiver is granted; • CLDPs assign responsibility to Facility staff to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity;	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with	This component was found to be not in compliance. The Facility provided a 2 page document, entitled Community Placement Obstacles, dated 1/1/10-6/22/10. It listed identified obstacles for 16 individuals that had a preference for community placement, but were not recommended for placement by their PST. The identified obstacle for 75% of these individuals was LAR Choice. For the remaining 25%, the obstacle, apparently to referral, was listed as MRA Not Present. (See Section T1c for further comments on this finding.) The monitoring team did not find this to be an adequate approach to the requirements of this component. It is expected that the Facility will gather obstacle data on a more comprehensive basis, not just for individuals who have indicated a preference for community placement but were not referred. It is also expected the Facility will perform some type of analysis or interpretation of the data (i.e., a comprehensive assessment), such as a narrative in which they can provide more depth to the straight numbers, and provide that to DADS. The analysis should be predicated on a consistent methodology for collecting information that is described at the outset of the report. Examples of possible sources for relevant data that could inform a truly comprehensive assessment include: • Barriers perceived and/or encountered by individuals, families and LARs, as documented by the PSTs and through Parents and Self-Advocacy groups • Post-Move Monitoring Checklists could be analyzed and common issues	N

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	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.	identified. Since DADS is responsible under this component to take appropriate steps, based on the Facility's comprehensive assessment, to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, it may be helpful for the State Office to provide some guidance to the Centers as to this methodology in order to ensure it receives comparable data from each one. The monitoring team is aware that DADS is in the process of drafting its initial compilation and analysis of the obstacles identified by all of the SSLCs, and will look forward to reviewing it when available.	
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	BSSLC indicated that it was in compliance with this component, but the monitoring team could not substantiate full compliance. The Facility provided, in response to the document request for the most current Community Placement Report, a document that listed separations for all individuals from the SSLCs for the month of June, 2010. At the same time, BSSLC clearly had collected the information needed to provide the requirements of the Community Placement Report, to wit: 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. These data had been provided separately in response to other items in the document request. The monitoring team suggested to the APC that other documents the Facility had produced could be combined to create the Community Placement Report, but a final document was not provided prior to the end of the site visit. Overall, however, the Facility would appear to be in substantial compliance with this component, as it collects the necessary information and had produced two separate documents that, combined, would meet the intent of the requirement. In the future, the Facility should ensure that the data are compiled and issued as the Community Placement Report as required.	S

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	Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**	This Provision was found to be not in compliance.	N
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.	This component was found to be not in compliance. The monitoring team reviewed the PMM checklists, including the CLDPs, for 12 individuals. For one of the 12 individuals, the Facility did not ensure that each of the required PMM visits were completed in a timely manner: • For Individual #40, who moved to a community home in another SSLC catchment area on 6/02/10, the first PMM visit was not made until 6/21/10, well after the requirement of making the initial visit within seven days of transition. In addition, the Post-Move Monitor from Brenham did not followup with the Post-Move Monitor from the other catchment area to request confirmation the visit had been made until 6/30/10. This means that 28 days elapsed from the time the individual moved from BSSLC until the Facility had any knowledge of the success of the transition or the health and safety of the individual. This may indicate some potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. This is an issue that has potential to grow as more individuals move to community settings in other catchment areas. BSSLC reported that it is currently providing PMM for 11 individuals from other SSLCs, while 14 individuals who moved from BSSLC are provided with PMM from another SSLC. Policy and careful procedure should be developed and implemented to ensure none of these critical visits fall through the cracks. The PMM process as implemented by BSSLC does not always ensure that supports called for in the individual's community living discharge plan are in place. First, the Post-Move Monitor did not routinely visit each of the sites in which supports were to be provided. In some instances, the Post-Move Monitor did not observe the individuals in their new home environments until the 45-day visit. This occurred on four occasions between 1/25/10 and 6/21/10, according the Post-Move Monitor's documentation. In another	N

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		six instances, the Post Move Monitor visited the individual at home on the 7-day visit, but did not return to the home for either the 45 or 90 day visits. Relying solely on staff report and written documentation to assess how well the services and supports are provided is not a sufficiently reliable practice. Individuals should be seen in their home environments with direct care professional present in order to observe interactions and evaluate level of comfort, and in all settings in which supports are to be provided in order to be able to verify supports are available. Second, the PMM checklists reviewed could not be considered reliable indicators that supports were in place, given the failure of the current process to methodically and adequately ensure the presence of all supports, as exhibited during the PMM visits attended during this site visit. See T2b. The design and use of the PMM Checklist provide very little information as to the presence of supports and even less information that would allow the Facility to assess how well an individual is actually adjusting to his/her new environment. Of all the PMM Checklists reviewed during this compliance visit, only those for Individual #512 provided in-depth information that actually painted a picture of the individual's adjustment. These were completed by the Post-Move Monitor at Lufkin SSLC for an individual who had moved from BSSLC. This necessary sharing of monitoring responsibilities across catchment areas calls even more for sufficient information to be gathered and provided to the sending Facility.	
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.	This component was found to be not in compliance. The Facility had indicated it was achieving some level of compliance in the area of PMM. In order to assess the Facility's assertion that it had achieved compliance in this component, the monitoring team accompanied the Post-Move Monitor on a 7-day monitoring visit for three individuals, (#201, #236, #396), all of whom had moved to the community from Mexia SSLC. Prior to the visits, the CLDPs were reviewed. For three of three post-move monitoring visits observed, the Post-Move Monitor did not accurately nor adequately assess whether the supports called for in the individual's community living discharge plan were in place. As evidenced in the individuals' CLDPs, each had an intensive set of support needs. The Post-Move Monitor failed to observe for the presence of all supports and services prescribed in the CLDP, review the individuals' records, nor interview staff to assess knowledge. Most of the visit was spent touring the home with the owner and vice-president of the agency. Both of these staff appeared to be knowledgeable about the individuals and reported on the presence and/or plans for	N

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		the provision of essential and non-essential supports. However, the confidence the Post-Move Monitor has in the provider cannot take the place of a careful and observable verification process. Examples of the failure to adequately assess the presence of the required supports included: • For Individual #201, the CLDP indicated she would need support services to include a barrier free environment, 24 hour awake staff and day programming. Other essential supports included staff inservice on the use of check and change schedule, wheelchair, hospital bed/rail pads, rolling walker, gait belt, alternate seating, safety belt, geo mattress, bed sensor, bumper wedges, horseshoe wedge, communicator, communication dictionary, diet texture, fluid consistency, dining instructions and behavior support plan. Individual #201 was seen in the home during the PMM visit. She was reported to also be enrolled in a day program operated by the residential provider. The provision of supports and services in the day program were not monitored, even though the individual routinely receives essential supports related to dining, mobility, positioning and behavior support in that setting. No meals were observed during the PMM visit, even though the individual has a Physical and Nutritional Management Plan (PNMP) that requires, among other supports, a pureed texture, nectar thick liquids by spoon, and that foods must be presented from below the chin. No staff responsible for implementing this plan were interviewed, nor were the individual's special dining needs discussed. The only documentation of staff training on the plan, or on any of the individual's supports, was a single sheet of paper that stated the staff person whose signature appeared had received Special Needs training. It did not provide any further specific details about what was covered in the training. The PMM did not review any other documentation, including the individual's record. The same circumstances applied to the failure to verify the presence of the communicator, communication dictionary and behavior support plan. • For Individual #236, the essential supports included home and day habilitation training on the behavior support plan, pureed diet texture, nectar consistency fluids, check and change schedule, tilt-in-space wheelchair, hospital bed with rails, hand grips, compression sock, and use of mechanical lift. The PMM visit took place in the home and did not review training or supports being provided in the day habilitation program. No meals were observed and no staff interviewed to assess their level of knowledge about the PNMP or any of her other essential or non essential needs. Only the Special Needs training signature sheets were reviewed. • For individual#396, the provider volunteered a great deal of information about	

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		her essential and non-essential needs. Because the individual requires enhanced supervision due to wandering and pica, the provider had chosen to assign a 24-hour 1:1 staff during the first few weeks. The individual also required a bed sensor, which had not yet arrived, so this supervision was also intended to cover that need on a temporary basis. This information was not solicited by the Post-Move Monitor, but was volunteered by the provider in conversation. The essential supports also included training on the behavior support plan and regular environmental sweeps. No staff were interviewed as to the implementation of these supports and no documentation other than the Special Needs training signature sheets were reviewed. This individual also had a PNMP that included pureed texture, honey consistency fluids and no pepper on her food. The PNMP noted she was at risk for choking and aspiration. The Post-Move Monitor did not observe meals nor verify staff knowledge of this information. For this particular group of individuals, the PMM process is especially critical to ensuring health and safety. It needs to be implemented in a methodical and detailed manner that includes observation, documentation and assessment of staff training and competency. This is required regardless of the positive reputation of and experience with the provider. This PMM visit was competed in under an hour. To effectively and adequately assess the provision of supports for these three individuals in all settings, especially on the 7-day visit, it should be expected that additional time must be taken. The Post-Move Monitor was very receptive to the feedback from the monitoring team. She stated that the entire PMM process was being re-vamped by a workgroup coordinated through DADS state office and that she would share this feedback with that group. She also noted that the PMM Checklist was being revised, which is a positive step.	
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	BSSLC reported no alleged offenders residing at the Facility. The Facility did not have policy and procedure, nor did it acknowledge a need to have policy and procedure, that defined how it would identify and implement discharge procedures for 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. Facility policies and procedures did not indicate that the provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations. If the Facility will not admit alleged offenders under any circumstances, then Facility policy should so state. If not so stated, then Facility policy should address these requirements of the SA.	Not Rated

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	provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	The Facility reported that no individuals have been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. The Facility did not currently have a policy and procedure in place describing how it would comply with the requirements of this provision if such a circumstance arose. As it is possible that such an alternative discharge could occur at any time, a Facility policy and procedure should be in place to identify how the Facility will identify alternate discharges and implement discharge procedures consistent with CMS-required discharge planning procedures There were no deficiencies in the area of discharge planning cited in the most recent CMS Statement of Deficiencies, indicating that the Facility was generally in compliance with CMS-required discharge planning procedures if an alternate discharge were to occur.	Not Rated

Recommendations:

1. In its POI, the Facility noted that certain items related to the development of the PSP were being monitored by the facilitators. Since it is the facilitators who are responsible for guiding the PST through the development of the plan, the Facility should consider assignment of the monitoring to an objective third party.
2. The Action Steps listed in some portions of the POI were based on achieving 100% compliance in record reviews; however, the requirements of some components would not seem to lend themselves to record reviews, even for the purpose of providing evidence of compliance, much less as a plan for achieving compliance. The Facility and DADS may want to review these Action Steps.
3. The State should further evaluate to what extent supports and services are provided in the community in order to prevent unnecessary institutionalization, particularly in the case of people under the age of 21.
4. There is some tendency on the part of the PSTs to focus on the format and process to the detriment of the desired outcome. For this reason, the addition of more "check-box" selections to the identification of supports and services in the CLODR, while well-intentioned, is a disturbing trend that should be reconsidered.
5. BSSLC is taking some actions to increase education and awareness about community living options, but these do not appear to have been well thought-out with clear goals in mind. The Facility should develop a comprehensive strategic plan for such education with assigned responsibilities, timelines and outcome measures.
6. Data were not being kept on the participation of staff in these tours, but should be in order to ensure Facility staff at all levels are adequately prepared to engage individuals, families and LARs in discussions about community living options.
7. BSSLC did not always ensure that PST identification and recommendation of an appropriate integrated community setting resulted in a timely referral and/or placement. The Facility should ensure that timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Section T1f.
8. For the CLDP, It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness. Facility policy and procedure should specify the expectations in this regard.
9. BSSLC clearly had collected the information needed to provide the requirements of the Community Placement Report, to wit: 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. In the future, the Facility should ensure that the data are compiled and issued as the Community Placement Report as required.
10. There was some potential for PMM visits to be missed when the process takes place across catchment areas, and the Post-Move Monitor from one SSLC is responsible for the PMM visits for an individual from a different SSLC. This is an issue that has potential to grow as more individuals move to community settings in other catchment areas. Policy and careful procedure should be developed and implemented to ensure none of these critical visits fall through the cracks.
11. The PMM process is especially critical to ensuring health and safety. It needs to be implemented in a methodical and detailed manner that includes observation, documentation and assessment of staff training and competency and must occur in all settings in which supports are to be provided. This is required regardless of the positive reputation of and prior acceptable experience with the provider.
12. BSSLC reported no alleged offenders residing at the Facility. The Facility did not have policy and procedure, nor did it acknowledge a need to have policy and procedure in this area. If the Facility will not admit alleged offenders under any circumstances, then Facility policy should so state. If not so stated, then Facility policy should address these requirements of the SA.
13. Since alternate discharges could occur at any point, the Facility should develop and implement policy and procedure that defines how it would identify and implement alternate discharges consistent with CMS-required discharge planning procedures, rather than the provisions of Section T.1I,(d), and (e), and T.2, for the following individuals:
    (a) individuals who move out of state;
    (b) individuals discharged at the expiration of an emergency admission;
    (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day

timeframe;

(d) individuals receiving respite services at the Facility for a maximum period of 60 days;

(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;

(f) individuals discharged pursuant to a court order vacating the commitment order.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), dated 5/17/10 2. BSSLC Supplemental POI, dated 5/17/10 3. Prioritized list of 95 individuals who are in need of an LAR, undated 4. List of eight individuals for whom an LAR has been obtained since 1/1/10 5. DADS draft Policy Number: 019 Rights and Protection (including Consent & Guardianship) 6. Personal Support Plans for Individuals #2, #61, #274, #334, # 350, #385, #581, #594 7. Rights Assessments for Individuals, # 274, #390, #594 **People Interviewed:** **1.** Debra Green, Admissions/Placement Coordinator (APC) **Meeting Attended/Observations:** 1. PSPs for one individual: Individuals # 52
	Facility Self-Assessment: The Facility reported it was not yet in compliance with either of the provisions of this Section but had completed actions toward compliance. The Facility reported it was in process of developing Facility-specific policies and procedures governing consent, maintaining a prioritized 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, and updating the list on a semi-annual basis. The Facility did state that it was in the process of fully prioritizing the list. It also indicated the list was being updated as needs and individual situations change. The monitoring confirmed the presence of a prioritized list but found the criteria for prioritization remain informal. The Facility accurately reported it was not in compliance with the development and implementation of a written plan that describes how it will solicit LARs for those in need, and the development and implementation of a written plan that describes how it will provide guidance to potential LARs in the process of becoming a guardian.
	Summary of Monitor's Assessment: Since BSSLC did not indicate it was in compliance with any of the provisions of this Section, and particularly since it indicated it was waiting on the final statewide policy before taking most actions, the monitoring team did not examine these provisions in tremendous detail. Instead, the team reviewed a small sample of documents in order to be able to assess progress, if any, from the baseline tour and provide any additional recommendations that may be helpful to the Facility when it does undertake action in these provisions. The findings are as follows:

	Provision U1, this provision was determined to be not in compliance. While the Facility does maintain a list of individuals needing an LAR, there is no standard approach to assessing and determining the actual need for an LAR on an individualized basis that is consistent with commonly accepted professional standards of practice. The list is updated on an ongoing basis, which is a good practice. The list does assign a prioritization to each individual, which is a step forward from the baseline tour, but the criteria and process for this prioritization are informal and not based on an individualized assessment. **Provision U2, t**his provision was determined to be not in compliance. The Facility reported no activity or planning to solicit guardians for those determined to be in need. It is, however, appropriate that the Facility has not undertaken a large-scale effort to solicit guardians until it can be assured that its processes for assessing the actual need for guardianship are individualized and completed in a manner in accordance with commonly accepted professional standards of practice. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite. The Facility did not have policy or procedure to address the criteria it planned to use when soliciting guardians, nor did it address its understanding of what roles and responsibilities in education, or assuring the education, of guardians and potential guardians may be associated with the responsibility of soliciting guardians. If the Facility actively solicits guardians, it has an interest in not only ensuring the qualifications of the guardians, but also their preparation to take on the role in a manner that protects the interest of the individuals.

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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 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	BSSLC did not have a policy and procedure describing its processes for developing and maintaining a list of individuals lacking both functional capacities to render a decision regarding the individual's health or welfare and an LAR to render such a decision. DADS had made available a draft copy of Policy Number: 019 Rights and Protection (including Consent & Guardianship) for review and comment. The Facility indicated that it plans to take action in these areas once the policy is finalized. BSSLC did maintain a list of individuals lacking both functional capacities to render a decision regarding the individual's health or welfare and an LAR to render such a decision. There were 95 individuals on the list provided. It did not have a current date, so it was not possible to ascertain how recently it had been updated per the six month requirement of the SA, but the Facility indicated in its Supplemental POI that the list was updated routinely as individual needs and situations change. This is an appropriate approach that should be included in any policy and procedure the Facility promulgates. The Facility should also provide a date reference on the list whenever it undergoes any change as a result of this updating. The list was prioritized. The prioritization criteria, as documented at the end of the list, was as follows:	N

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	restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	• Priority 1: No Family/Correspondent, Needs Guardian • Priority 2: Medication, Behavioral Support Plan • Priority 3: Active Family/Correspondent There was no policy, procedure nor written documentation as to how these priorities were to be assessed or implemented. The APC stated that she was responsible for assigning the priorities based on information she receives from the PSTs. The PSTs did not use an individualized assessment process to determine that an individual was in need of an LAR, or to what extent or for what discrete purposes guardianship was required. In eight of eight PSPs reviewed for individuals who were adults without a guardian, there was no specific discussion of the individualized need for an LAR. Examples include: • For Individual #61, the PST documented the individual was an adult without a guardian, but that a sibling had reported a renewal of guardianship. There was no further discussion regarding the individual's specific needs in this area. • For Individual #594, the Rights Assessment indicated the individual's mother acted as advocate. The section of the PSP that requires "Discussion of identifying those individuals who would benefit from a LAR to assist in decision-making with regards to treatment and programming" also indicated the individual's mother acted as advocate; however, other documentation in the PSP indicated that the Pre-planning Questionnaire had not been returned by the mother, even though it had been sent twice, and that the mother did not attend the PSP nor answer the phone when called during the meeting. There was no discussion as to the specific advocacy or guardianship needs of the individual and whether this level of attention by the designated advocate was commensurate with the individual's needs. • For Individual #334, the PST documented that the Social Worker had reported that a referral had been made for an advocate/guardian, but there was no discussion of what the individual's needs were that were to be addressed by guardianship. The PSP also documented in one place that the individual's mother was the advocate, but in another place indicated that the family desired no routine contact. • For Individual #581, the PSP documented that the individual's mother would like more information on guardianship and the PST agreed to send a referral, but there was no discussion as to the specific needs of the individual that would be addressed by guardianship.	

#	Provision	Assessment of Status	Compliance
		PSTs also did not routinely develop action plans to assist individuals to maintain or improve decision-making capacity. In eight of the eight PSPs reviewed, there were no specific action plans to address the individuals' capacity to make informed decisions, in part as a result of the failure of the PSTs to discuss and identify the specific needs of the individuals. Of the eight individuals included in this sample review, four were referred by their PST for community placement at the time of the PSP meeting. The remaining four were not referred, but were recommended to have action plans for community group home tours. In seven of the eight Community Living Options Discussion Records (CLODR) for these PSPs, there was no discussion of the projected specific needs of the individual for an advocate or LAR in the community setting. In the eighth (Individual #385), the PST did appropriately express a concern about making a placement near an aging family and recommended that a sibling be contacted. The nature of the need for the sibling's participation was not specified, but the PST's intent to ensure an advocacy role continued was clear.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	BSSLC did not have policy or procedure established to implement this provision of the SA. It reported it is awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before developing facility-specific documents. BSSLC did not report any efforts or planning to obtain LARs for individuals lacking LARs during this review period, although it did provide a list of eight individuals who had obtained or renewed guardians since 1/1/10. It is, however, appropriate that the Facility has not undertaken a large-scale effort to solicit guardians until it can be assured that its processes for assessing the actual need for guardianship are individualized and completed in a manner in accordance with commonly accepted professional standards of practice. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite. It is also appropriate that no large-scale effort to solicit guardians is made until the Facility has developed policy and procedure regarding: • Minimum criteria for individuals, organizations or entities the facility will solicit to act as an LAR for individuals, in order to assure individuals' rights and safety are protected. • The roles and responsibilities of the Facility in educating LARs and potential	N

#	Provision	Assessment of Status	Compliance
		LARs in the roles and responsibilities of guardianship.	

Recommendations:

1. Facility PSTs should receive guidance and training from DADS to prescribe a process for how an assessment should be done to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. The pending statewide policy should incorporate approaches in these areas.
2. Once the statewide policy and assessment process has been finalized, BSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements. The current process for prioritization should be in written form, if only on an interim basis, to ensure it is implemented correctly and consistently.
3. The Facility should ensure its policy and procedure, once developed, include:
   - Minimum criteria for individuals, organizations or entities the facility will solicit to act as an LAR for individuals, in order to assure individuals' rights and safety are protected.
   - The roles and responsibilities of the Facility in educating LARs and potential LARs in the roles and responsibilities of guardianship.
4. The Facility indicated in its Supplemental POI that its prioritized list of individuals in need of an LAR was updated routinely as individual needs and situations change. This is an appropriate approach that should be included in any policy and procedure the Facility promulgates. The Facility should also provide a date reference on the list whenever it undergoes any change as a result of this updating.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI), dated 5/17/10 2. BSSLC Supplemental Plan of Improvement 1007.pdf 3. Document request responses for Section V (XVIII.1, 2, 3) 4. DADS Policy Number 020.1, Recordkeeping, dated 03/05/10 5. DADS Policy Number 010, Nursing Services, revised 12/17/109, implemented 1/31/10 6. DADS Policy Number 012, Physical Nutritional Management, revised 12/17/109, implemented 1/31/10 7. DADS Policy Number 013, Nutritional Management Team, revised 12/17/109, implemented 1/31/10 8. DADS Policy Number 018.1, Most Integrated Setting, dated 03/31/10 9. DADS Policy Number 021, Protection from Harm—Abuse, Neglect, and Exploitation, dated 6/18/10 10. DADS Policy Number 008.2 Psychological Policy (Draft), dated 7/21/10 11. Active Records for Individuals #4, #21, #31, #70, #122, #139, #390, #399, #417, #425, and #598 12. Monthly Checklist (6-2 Shift) for Individual #77 13. Psychiatric Consultation for Individual #502 on 6/3/09 14. Behavior Therapy Review and Psychiatric Consultation for Individual #009 on 3/4/09 15. Behavior Therapy Review and Psychiatric Consultation on 6/2/09 and 7/7/09 16. Psychiatric Consultation for Individual #758 on 11/13/08 and Behavior Therapy Review and Psychiatric Consultation on 06/01/09 and 07/01/09 **People Interviewed:** 1. Interview to review recordkeeping process and changes with Kim Littleton, Quality Enhancement (QE) Director, and Margaret Zwerneman and Deborah Borah, Records Coordinators 2. One DCP at Bowie Springs Home B on 7/29/10 **Meeting Attended/Observations:** 1. Entrance presentation by BSSLC staff on 7/26/10 2. PSP Addendum meeting for Individual #31 on 7/26/10 3. PSP Addendum meeting for Individual #4 on 7/26/10 4. Interview with QMRP Erin Cox, with team psychologist and RN Case Manager on 7/27/10 5. PSP meeting for Individual #390 on 7/27/10 6. PSP meeting for Individual #52 on 7/29/10 7. Meeting with QMRP D'Andrea Polk on 7/28/10
	Facility Self-Assessment: The Facility stated it is not yet in compliance with any of the provisions of this Section but has implemented a number of actions to lead toward compliance. The Facility reported that policies and procedures to implement Part II of the SA are in process of development.

	The Facility reported format of the unified record was revised; the Facility indicated conversion of the records is in process; assuring consistency with Appendix D of the SA awaits full conversion and time to audit records for compliance. The monitoring team confirmed that the rollout of the new record format was in process, and new records met the requirements of Appendix D, The Facility reported it is in process of revising tools for monitoring recordkeeping implementation and quality and developing a system to track the data. This includes monitoring to ensure records are completed as required by policy and that records are used to make care, medical treatment, and training decisions. Monitoring tools are being developed to capture data on recordkeeping; policy is being written and processes developed to formulate corrective action plans. The Facility accurately reported this is not yet in compliance. **For Provision V.1,** the Facility stated they are not in compliance. BSSLC stated that zero out of five Action Steps from the Plan of Implementation (POI) are complete. The format of the unified record was revised; the Facility indicated conversion of the records is in process; assuring consistency with Appendix D of the SA awaits full conversion and time to audit records for compliance. **For Provision V.2,** the Facility stated they are not in compliance. BSSLC stated that zero out of three Action Steps are complete. The process of developing and revising policies to implement Part II of the SA is ongoing at both the statewide DADS level and at the Facility. The DADS State Office is in process of developing and rolling out new policies on recordkeeping. Facility policies are undergoing review and revision. **For Provision V.3,** the Facility stated they are not in compliance. BSSLC stated that zero out of four Action Steps are complete. The process of developing and revising policies to implement Part II of the SA is ongoing at both the statewide DADS level and at the Facility. The Facility is in process of revising tools for monitoring recordkeeping implementation and quality and developing a system to track the data. This includes monitoring to ensure records are completed as required by policy and that records are used to make care, medical treatment, and training decisions. A process is being developed to formulate and track Corrective Action Plans (CAPs) when monitoring indicates a need for action. Implementation of a Quality Assurance process will occur following full implementation of the records conversion. **For Provision V.4**, the Facility stated they are not in compliance. BSSLC stated that zero out of two Action Steps are complete. The process described above in V.3 includes monitoring to ensure that records are used to make care, medical treatment, and training decisions. Monitoring tools are being developed to capture data; policy is being written and processes developed to formulate corrective action plans. Interviews with staff and review of documents supports that progress is occurring but no provisions are in substantial compliance

	Summary of Monitor's Assessment: **For Provision V.1,** this provision was determined to be not in compliance. Conversion to the new record system is in process. Current records do not meet all requirements of Appendix D. Records in the new format that were reviewed met requirements of Appendix D, but the names of documents did not always match the Table of Contents. Health Maintenance Plans are filed in the active record per policy. The Facility needs to make a decision on the practice of taking records when a person is hospitalized and leaving them with the person at the hospital. Rollout of the new unified record started with an overview orientation for residence directors, department heads, QMRP coordinator and other key staff who have a part in the active record, including supervisors. The monitoring team was provided with a schedule of rollout, and records provided to the team from homes where the record has been implemented were in the new format. The Facility reported that the rollout has been going well, with no major problems. The Facility also reported that two positions, Records Coordinators (two new positions) and Program Auditors, will have responsibility for carrying out audits of records to meet the provision V.3. The Records Coordinators currently provide training to staff during the rollout. **For Provision V.2,** this provision was determined to be not in compliance. DADS and BSSLC are in process of revising policies. Several policies have been developed or revised. **For Provision V.3,** this provision was determined to be not in compliance. Quality assurance reviews of unified records have been suspended due to the rollout of the revised format. Records Coordinators have been added; they will monitor and provide training. They currently are providing training as part of the rollout. **For Provision V.4,** this provision was determined to be not in compliance. Examples of inaccurate Active Records were found. Data documenting that individuals met goals did not result in using these data to prompt a change in goals.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Rollout of the revised Unified Record system had occurred at 10 homes. For the final 13 homes, rollout is expected to be completed on 9/24/10, but those dates are tentative. The revised order of the Unified Record improves ease of finding information. Although most components required for an accurate and usable record were available for most Active Records reviewed, 0 out of 11 Active Records met all requirements of Appendix D.	N

#	Provision	Assessment of Status	Compliance

		• Seven of 11 records were legible throughout the record.
		• Ten of 11 records reviewed met standards for presence of dates and times.
		• All records were written in ball point pen or typed.
		• Seven of 11 records had no gaps between entries.
		• Two of 11 records and the monthly checklist for Individual #7 were noted as having inaccurate information.
		  o For Individual #390, a list of medications currently prescribed was inaccurate; this information was presented at a PSP meeting and might have led to inaccurate decisions, but two participants had the correct list of medications. For the same individual, the PALS summary was missing; this information was not discussed at the PSP meeting.
		  o For Individual #4, data for one Individualized Training Program (ITP) was unlikely to be accurate, as all data each month were identical, and changes in the data occurred at the beginning of some months with no changes occurring at other times. Interviews with QMRPs did not clear up this consistent but unusual and unlikely finding. This did not occur for any other ITPs, Specific Program Objectives (SPOs), or Specific Service Objectives (SSOs) for this individual or any other individual reviewed.
		  o Individual #77 died the morning of 7/28/10 after several days in the hospital. The monthly Checklist showed him as being in the hospital on 7/29/10.
		• Although signature legends for initials were not available in the Active Records for data on ITPs, SSOs, and SPOs, staff reported these are available by day at each home; this will be checked at the next compliance review. For MARs, at 3 or 3 homes reviewed, the initial legend was present.
		
		There were several examples in which the same information could be entered on any of several different forms. This made it difficult to ascertain where to find information and to ensure all information was current, accurate, and consistent. For example:
		• The psychiatric evaluation could be found in several places. Sometimes there was a single dedicated document titled "Psychiatric Consultation" (for example individual # 502, on 6/3/09). More commonly, the examination was embedded with other clinical materials, typically titled "Behavior Therapy Review and Psychiatric Consultation" (for example, Individual #009 on 3/4/09). In some cases the evaluation seemed to have been divided into several sessions (For example, Individual # 298, for whom there were documents titled "Behavior Therapy Review and Psychiatric Consultation" on both 6/2/09 and 7/7/09), and sometimes the core information for the individual was divided over several	

#	Provision	Assessment of Status	Compliance
		formats. For example, individual #758 had a "Psychiatric Consultation" on 11/13/08," followed by "Behavior Therapy Review and Psychiatric Consultation" sessions on both 06/01/09 and 07/01/09. In addition to the difficulties BSSLC staffers experienced as they sought to retrieve archived materials, difficulties locating psychiatric evaluations were compounded by the existence of seemingly related (but in fact totally different) document formats, such as "Annual Psychiatric Medication Review." • Dental services were documented on a number of forms, including the Initial Dental Examination, Dental Progress Notes, Dental Visit Reports, Work Sheet for Annual Dental Exams, and Dental Staffing Report. For two Active Records provided as good examples of the revised record (and included in information above), both had tables of contents; the actual contents were available, but additional documents were also found in the records, and some documents appeared to be present but have a different title. The Facility should ensure that the table of contents uses the same titles as the actual documents. These two Active Records are in generally good condition, but there is already evidence of pages tearing out. The Facility should ensure that the materials are put in the Records in such a way that the Records will remain in good condition. For the two Active Records in the revised format checked, Individual Notebooks were accessible for both, and a DCP was able to describe and demonstrate where specific contents were to be found in them. The DCP reported that training had included requirement for the DCP to show where to find contents in the Record and how to complete documents.	
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.	DADS is in process of revising current and developing new policies for the SSLCs. As these are developed, the SSLCs revise or develop facility policies to ensure consistency with DADS policy and to provide information and procedures specific to each facility. DADS has revised or developed the following policies since January 1, 2010: • DADS Policy Number 020.1, Recordkeeping, dated 03/05/10 • DADS Policy Number 010, Nursing Services, revised 12/17/109, implemented 1/31/10 • DADS Policy Number 012, Physical Nutritional Management, revised 12/17/109, implemented 1/31/10 • DADS Policy Number 013, Nutritional Management Team, revised 12/17/109, implemented 1/31/10 • DADS Policy Number 018.1, Most Integrated Setting, dated 03/31/10	N

#	Provision	Assessment of Status	Compliance
		• DADS Policy Number 021, Protection from Harm—Abuse, Neglect, and Exploitation, dated 6/18/10 • DADS Policy Number 008.2 Psychological Policy (Draft), dated 7/21/10 BSSLC, in response to the document request, reported the following: "Brenham State Supported Living Center is in the process of revising all policies and procedures. No policies have been approved at this time. The Center is functioning by using current policy and procedures until the drafts are approved." Assessments made by the monitoring team of effectiveness and implementation of current policies are reflected in the appropriate Sections of this report.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The Facility reported that the quality assurance reviews of unified records have been suspended due to the rollout of the revised format. Two people have begun work in the new position of Records Coordinator. The Records Coordinators will be responsible for monthly reviews of records after the rollout is complete; the Facility reported an expectation that enough data will be available to begin trending in December, 2010. The Records Coordinators will also retrain staff as needed. Currently, the Records Coordinators are training staff on the new record format and are informally reviewing a sample of the new records. Four Program Auditors will review PSPs as part of the monthly audit.	N
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	During two of two PSP annual planning meetings, the Active Record was available. Information from the Active Record was read during one of those meetings, and that information was inaccurate. Because participants in the meeting had updated information, it was impossible to discern whether the updated information was also taken from the Active Record, or whether disciplines have separate records from which reports are prepared. The Facility needs to ensure that the information in Active Records is complete and accurate in order to be useful in making decisions. The QMRP Quarterly Review contains data for three months. Interviews of QMRPs indicated that the QMRP primarily used these data for decisions. Three months may not	N

#	Provision	Assessment of Status	Compliance

		be an adequate time frame for data to be used for decisions in many cases. The Active Record does contain data from prior to the latest quarterly review document; the Monitoring Team did not determine whether the practice of focusing on only the latest quarter is widespread.
		
		ITP, SSO, and SSP data were reviewed in detail for Individuals #4 and #31. In both cases, there was evidence that data were not used to make decisions.
		• For Individual #4, all data cells were marked I(Independent) in November, 2009 (except for four consecutive days marked H (Hand over Hand) the first week of November, followed by one unreadable data point, followed by one more day marked H), all cells were marked H (except for one unreadable entry and one with narrative that appears to indicate the materials needed were unavailable but does not use that code) from December 1, 2009 through March 31, 2010, followed by one unreadable entry and then entries of V (Verbal) through May 31, 2010. The criterion for completion of the goal was "no more than 3 verbal prompts for 24 days per month for 2 consecutive months). This criterion was met (assuming the data were accurate) on May 25, 2010. The objective was not revised, and all data entries for June, 2010, were G (Gestural)—apparently indicating that there was regression from November, 2009 through June, 2010 with no revision to the program procedures as well as showing no change in objective when the criterion was met. QMRP interviews did not indicate this was noted or provide any explanation.
		• For Individual #31, there were several objectives for which criteria were met but the same objective remained for an extended time. Out of the first 5 ITP goals reviewed, four had met criterion but were not changed.
		  o ITP 1B1 met criterion March, 2010, but the objective remained through June, 2010. This ITP has been changed for reasons unrelated to meeting the criterion.
		  o ITP 1C1 relate to compliance with instructions met criterion in April, 2010, but the objective remained through June, 2010. Per QMRP interview, what is to be complied has changed, which is not clear in objectives.
		  o ITP 1D1 met criterion in January, 2010, but the objective remained through June, 2010. This ITP was discontinued in July, 2010 as no longer a priority need.
		  o ITP 1E1 met criterion in December, 2009 but the objective remained through June, 2010. The criterion was changed in July, 2010 to reduce	

#	Provision	Assessment of Status	Compliance
		the prompt needed for a successful instance of the behavior. Active Records continue to be sent to stay with an individual who is in the hospital. When this occurs, the record is not available at the Facility to be used for making decisions. The Facility needs to make a decision on the practice of taking records when a person is hospitalized and leaving them with the person at the hospital.	

Recommendations:

1. Begin carrying out random reviews of the unified records in homes where rollout has occurred.
2. Ensure that the table of contents uses the same titles as the actual documents.
3. Ensure that the materials are put in the Records in such a way that the Records will remain in good condition.
4. Ensure that the information in Active Records is complete and accurate in order to be useful in making decisions.

List of Acronyms Used in This Report

Brenham SSLC

July, 2010 Baseline Tour

Acronym	Meaning
AAC	Alternative and Augmentative Communication
AED	Anti-Epileptic Drug/Automated External Defibrillator
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AIMS	Abnormal Involuntary Movement Scale
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
BSSLC	Brenham State Supported Living Center
CBC	Criminal Background Check
CDC	Centers for Disease Control and Prevention
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLODR	Community Living Options Discussion Record
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CEN	Certified Executive Nurse
CEU	Continuing Education Unit
COP	ICF/MR Condition of Participation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CTD	Competency Training and Development
CV	Curriculum vitae (resume)
DADS	Texas Department of Aging and Disability Services
DCS	Direct Care Staff
DD	Developmentally Delayed
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	U.S. Department of Justice
DMID	Diagnostic Manual-Intellectual Disability
DRO	Differential Reinforcement of Other Behavior
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association

DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
HMP	Health Maintenance Plan
HOB	Head of Bed
HRC	Human rights committee
HST	Health Status Team
IBW	Ideal Body Weight
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMC	Incident Management Committee
IMRT	Incident Management Review Team
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Authority
NCP	Nursing Care Plan
NMT	Nutritional Management Team
NP	Nurse Practitioner
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
P&P	Policies and Procedures
PBSP	Positive Behavior Support Plan
PCD	Planned Completion Date
PCP	Primary Care Physician
PDP	Personal Development Plan

PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PRN	Pro Re Nata (as needed)
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
SA	Settlement Agreement
SAM	Self-Administration of Medication
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SSLC	State Supported Living Center
SPO	Specific Program Objective
TB	Tuberculosis
TIVA	
UIR	Unusual Incident Review or Unusual Incident Report