United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
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Introduction

Background

In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In 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 (3) 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 (6) 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 are 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 (BSSLC).

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. However, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. Several sections of this report include information provided by multiple team members.

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

Methodology

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

(a) **Onsite review** – During the week of the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

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

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

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement.

The report 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, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;

b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report. It should be noted that the Action Steps listed by RSSLC are a plan of improvement and may not be fully in congruence with, or may not at a given time address all, components of the SA that are being reviewed. The Assessment of Status by the Monitoring Team, therefore, reports on the findings of the monitoring team in relation to the provisions of the SA and may differ from the self-assessment by the Facility;
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 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") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the SA. The recommendations for some provisions include a subsection of additional suggestions for the facility. These are presented in an effort to assist the facility in prioritizing activities as the facility staff work towards achieving substantial compliance with the provision.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual according to randomly assigned numbers (for example, as Individual #45, Individual #101, and so on.) The Monitors are using this methodology in response to a request form the parties to protect the confidentiality of each individual.

Executive Summary

First, the Monitoring Team wishes to acknowledge and thank the individuals, staff, clinicians, managers, and administrators of the Facility for their openness and responsiveness to the many activities, requests, and schedule disruptions caused by the onsite monitoring review. The Facility made available to the Monitoring Team a number of staff members in order to facilitate the many activities required, including setting up appointments and meetings, obtaining documents, and answering many questions regarding facility operations. During this review, as during past visits, staff of the Facility provided a great deal of information; the willingness of staff to provide this information and honest assessment of the status of compliance was appreciated. In addition, when issues were brought to the management team during the course of the review, they were addressed immediately.

The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Susie Johnson, and to Chelsea Howard for organizing the gathering of information and providing assistance.

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 the Facility. 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 and clinicians. 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.

As a result, a great deal of information was obtained, as evidenced by this lengthy and detailed report. Numerous records were reviewed, observations conducted, and interviews held. Specific information regarding many individuals is included in this report, providing a broad sampling from all homes and across a variety of individual needs and supports. It is the hope of the Monitoring Team that the information and recommendations contained in this report are credible and helpful to the facility.

As the findings in this report illustrate, BSSLC has made significant progress in a number of areas. In a number of areas in which improvement is still needed, the Facility had plans in place to make needed changes. This following provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements were needed.

Improvements and Positive Practices: Following is a brief summary of some of the improvements and positive practices noted during this visit.

<u>Restraints</u>

- Restraints used in response to behavior challenges at the BSSLC decreased significantly when comparing the second six months of calendar year 2010 to the first six months of 2010. The monitoring team believes there are multiple variables that contribute to this decline and as a whole the facility is to be commended for figuring out ways to manage individuals' behavior without resulting in the use of restraint.
- The Facility had begun to take a much more proactive approach with Personal Support Teams (PSTs) to prepare individuals for dental treatment without the use of pretreatment sedation.

Abuse, Neglect and Incident Management

- The Facility uses an Abuse and Neglect poster (separate from the rights poster required by the SA) that is displayed prominently throughout the facility.
- The Facility has created an organized methodology for use of monitoring tools and displays this is in a document (undated) titled FY2010 Quality Enhancement Plan. This identifies the monitoring tools in use, the frequency in which they are to be used, sample sizes, frequency of monitoring, and the person responsible to do the monitoring or see that it gets done. This process has been used long enough to be producing considerable summery data available for management review.

Quality Assurance

- Three important policies have been developed, been approved by facility management, and are in the process of being implemented: BSSLC Policy Quality Assurance Process (11/22/10), BSSLC Policy Quality Assurance/Quality Improvement Council (10/5/10), and BSSLC Nursing Peer Review Policy (12/10/10).
- The Facility had also initiated a process for staff competency checks. Program Auditors, on a regularly scheduled basis, test staff knowledge by interviewing staff at their worksite, using a standard set of questions that include an answer key from which the program auditor records whether the staff person gave a correct response. This process supplements a more formal monitoring process that includes use of monitoring tools for observation of actual staff performance (as opposed to just staff knowledge).

Integrated Protections, Services, Treatments and Supports

- The new PSP planning process had been initiated, and most staff had received training.

Integrated Clinical Services

- BSSLC had implemented a number of steps to begin integration of clinical services. New interdisciplinary committees were established to integrate planning on drug utilization, physical and nutritional management, and oversight of psychoactive medication.

Minimum Common Elements of Clinical Care

- A new behavioral data system was a significant step toward having and using indicators of behavior change to identify efficacy of interventions and to trigger new evaluation and revision of those interventions.

At-Risk Individuals

- The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. The monitoring team had an opportunity to review the first two risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the BSSLC.

Psychiatric Care and Services

- Provision J1, qualified psychiatric staff, was determined to be in substantial compliance: The Facility had hired a third qualified psychiatrist. Psychiatrists actively and appropriately participated in the interdisciplinary process, except that they had not yet begun routinely to participate in the annual PSP meetings, which they plan to begin doing.
- Reiss screens were administered to all individuals who required them.
- The Facility had established a process for facility-wide monitoring of side effects, in conjunction with the psychoactive medication oversight committee.
- The Lead Psychiatrist attended neurology clinics, review and oversight of medications prescribed by both neurology and psychiatry were in place, and a process was being developed, to allow the contract neurologist to collaborate with the consulting neurologist.

Psychological services

- The quality of functional assessment continued to improve, as the latest Structural and Functional Assessment (SFA) protocol revision reflected a coherent and logical approach to understanding behavior. Efforts to assess staff competence while providing support and mentoring was greatly enhanced by the development and implementation of the Fundamental Behavior Analysis Skills Evaluation (FBASE) process.
- A new data collection process had been initiated across the facility that addressed many of the limitations of the previous system.
- The Director of Behavior Services possessed all required qualifications and was scheduled to sit for the BCBA board certification exam within a few weeks following the site visit.

Medical Care

- The DADS State Office conducts regularly scheduled meetings with medical leadership from all Facilities to address medical-administrative issues. This has led to a more unified structure of medical services.
- The State Office, in collaboration with Facilities, is developing various clinical pathways, and their progress is commendable.
- The Facility developed a policy entitled "Physician Procedures and Best Practice Guidelines," which outlines quality standards for provision of care.

Nursing Care

- The Nursing Department had made improvements in nursing staffing and coverage since the last tour, particularly with regard to the hiring of two additional Registered Nurses for the 10 to 6 shift in the Cottages. The minimum staffing requirements were consistently met. The Nursing Department had added a Staffing Coordinator to ensure that staffing ratios were consistently maintained.
- The Infection Control Department worked collaboratively with the Data Analyst and had adopted and implemented the Infection Control Access Database developed by the Richmond State Supportive Living Center. The database was more comprehensive than the previous database. The purpose of this improved database system was to collect meaningful and valid data that can be utilized to trend over a designated date range as well as to quickly assist clinical staff in identifying emerging infectious issues so that the Facility staff can address them expeditiously.
- The Hospital Liaison Nurse consistently followed up on individuals who were hospitalized and documented findings in the Integrated Progress Notes as well as placing the information on the S drive for the Qualified Mental Retardation Professionals and other Personal Support Team Members to review.
- Antibiograms were put into use since the last tour and were used by the physicians to make clinical decisions regarding the selection of antibiotics in treating infections.

- Since the last tour the Infection Control Program had developed and implemented an Immunization database to track immunizations as well as tuberculosis testing status.
- The Medication Administration Observation Form was revised to include monitoring for following the individual's PNMP during medication administration.

Pharmacy Services and Safe Medication Practices

- In collaboration with physician and nursing services, Pharmacy Services developed a process and provided training that had essentially eliminated the writing of scripts, dispensing and administering of medications to persons with documented allergies.
- Another very impressive improvement is, under the direction of Pharmacy Services, and in collaboration with physicians, a methodical and clinically appropriate process was developed to review and provide on-going review of all persons on select classes of medications with the result of a significant reduction in the number of less desirable medication being prescribed.

Physical and Nutritional Management

- A Physical and Nutritional Management Team (PNMT) had been formed that consisted of the appropriate members. A process that outlines the responsibilities of the team as well as their scope had not yet been developed.
- On a positive note, the team had reviewed five individuals and the assessments reviewed were comprehensive and demonstrated active collaboration through multiple disciplines.
- Although the PNMT had reviewed only a small number of cases by the time of the compliance visit, assessments reviewed were comprehensive and demonstrated active collaboration through multiple disciplines.
- Positioning of individuals during medication administration and oral care were included in PNMPs. Although there were many observations of people who were receiving enteral nutrition while poorly positioned (for example, sitting in recliners), the Facility had begun the process of establishing better seating.

Physical and Occupational Therapy

- All individuals had received an OT/PT assessment and/or screening. This was validated via review of 12 records for completed OT/PT assessment/screening.
- Plans were developed within 30 days of assessments.
- For individuals receiving direct services, there was evidence that each individual receiving direct services was reviewed at least monthly for OT/PT Status for six of six individuals reviewed.

Dental Services

- The Facility had hired a new full-time dentist to serve as dental director.
- The Facility had made significant strides in working with direct care staff and employing the use of suction tooth brushing at the living areas to assist in the reduction of aspiration pneumonia.
- The Facility had also identified individuals at risk for osteonecrosis of the Jaw and is developing treatment strategies to ensure safe and effective dental services for such individuals.
- The Facility had revised its forms for dental examinations and assessments and had developed a daily dental report that will efficiently share dental issues, such as persons scheduled for dental services and outcomes, with relevant staff.

Communication

- BSSLC had hired two additional SLPs, which has brought their total number to five therapists.
- Many individuals are beginning to be provided with trials of communication equipment. Additionally, the newer assessments (completed in the last few months) were much more comprehensive and did a better job at identifying potential benefits of AAC.

Most Integrated Setting

- The monitoring team was gratified to learn of the recently implemented pilot to encourage and assist the children living at the Facility to move to an integrated setting and appreciated the leadership exhibited by the administration at BSSLC and by DADS in this important matter.
- PMM Checklists were being completed in a timely manner.
- The potential for PMM visits to be missed when the process takes place across catchment areas was an area of concern during the site visit in 7/10, but this appears to have been resolved through a tracking system devised and maintained through DADS state office.
- 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.

Recordkeeping and General Plan Implementation

- Conversion to the new unified record format was completed. BSSLC policy is consistent with DADS policy. The Active Record and Individual Notebooks (called All About Me books) were in place for each individual. Training had been provided to all staff.
- Records were generally neat and legible.
- The Facility has, in addition to the record, a Share drive on the computer network, set up by Unit, Home, and Individual. This drive provides a location for electronic files of assessments and other information. The information on the drive is available to clinicians on an individual's PST. This accessibility has the potential to improve interdisciplinary process by making information easily accessible.
- The Facility has at least three separate processes for auditing records.
- The Facility had developed or revised numerous policies. The Facility developed a process to review and revise policies and to approve newly developed policies. A Policy and Procedure Committee met regularly to carry out this responsibility.

Areas in Need of Improvement: Following is a summary of improvements that continue to be needed.

Restraints

- Direct care professionals need more knowledge with respect to restraint policies and procedures.
- There continued to be significant documentation errors or omissions that make it difficult to validate restraint practices occur according to policy and in a clinically justifiable manner.

Abuse, Neglect and Incident Management

- The cornerstone principle in a client protection system (reporting abuse/neglect) was not being implemented according to policy. Most staff believe they are to report abuse to the Incident Management Coordinator during regular business hours and the Duty Officer in the off hours; and, then get direction from that person as to whether or not what was reported needs to be called in to the DFPS 1-800 number. The Facility does expect staff to notify the above people before calling DFPS in order to provide immediate protection to individuals during sometimes long

delays until the DFPS phone is answered, but staff are expected to report all suspected all alleged abuse/neglect and not receive direction from BSSLC administrators.

Quality Assurance

- Reliability of data gathered and used in audits and for trending needs to be reviewed. For selected information, a process needs to be developed for ongoing checks of reliability of the data.
- The process for staff competency checks can be a good process to increase staff knowledge (and presumably staff performance) but a word of caution is in order. Summary data provided to the monitoring team indicated extremely high rates of correct answers and positive performance. The observations made by the monitoring team during the review week, and the monitoring teams review of DADS Regulatory reports, suggests these data are not reflective of actual staff performance. This calls into question the reliability of these data. Competency checks will only be useful if they are accurate and identify errors to be corrected and systemic errors needing process improvement.
- At the time of review the position of QA Director was vacant. The facility is in the process of filling this very important position.

Integrated Protections, Services, Treatments and Supports

- BSSLC indicated that 79% of staff had received training on the new PSP process. Observations of the PSP process and materials, however, revealed minimal changes over the pre-training PSP.
- Although the structure of an interdisciplinary team is in place at BSSLC, much of the discussion is multidisciplinary, and decisions about treatment are often made in the absence of team discussion.
- For the most part, PST members were having difficulty understanding the concept of providing integrated services and the need for a comprehensive PSP that describes the individual's strengths and abilities, and then translating this understanding to a functional and meaningful program of services and supports.
- Staff who were needed because of specific areas of concern or support for individuals were not always present at planning meetings.
- As a way to identify preferences, the Facility had begun to implement the new PFA in December 2010. The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs.

Integrated Clinical Services

- Documentation of review and of consideration of the recommendations was variable.

Minimum Common Elements of Clinical Care

- There was a great deal of variability across disciplines regarding completion of assessments. Some disciplines generally completed assessments timely and some scheduled assessments were done as scheduled, others were not.
- Changes in behavioral and health status did not routinely trigger assessments and evaluations. Interventions were not always implemented or revised as clinical indicators showed a change in status.

At-Risk Individuals

- The risk assessment system used prior to implementation of the new policy continued to inaccurately assess risk levels for individuals. This was the operative policy for nearly all of the time period for this compliance review,

Psychiatric Care and Services

- Many individuals receiving psychiatric services do not have an evaluation in place.
- In many cases the medical record did not document a rationale for the use of psychotropic medications, and in many cases there was no concordance between diagnoses, relevant behavioral symptoms, and psychotropic medications.
- Not all individuals who received pre-treatment sedation had the required plans in place, the team found that the plans that were in place were often very general, and the team found that there was no process in place to evaluate the effectiveness of the plans.
- The monitoring team confirmed that behavioral data were considered in decisions regarding pharmacological treatments. However, a process was not in place to provide integrated behavioral care through combined assessment and case formulation. This was exacerbated by the fact that no process was in place to determine which behavioral treatments were most likely to be most effective for an individual.

Psychological services

- The Facility had made substantial progress in providing training for Behavior Services staff, as well as developing a structured process for assessing the competence of staff in applied behavior analysis. At the time of the site visit, however, the staff training for BCBA certification was ongoing and the competency assessment process had only been partially implemented.
- Although new data collection procedures had been implemented, the process continued to limit the types of data that could be collected. In addition, it was not evident that data collection and presentation possessed adequate specificity or that available data were being used effectively in the formulation of treatment decisions.
- No changes had been implemented in psychological evaluation reports since the previous site visit. Psychological assessments were not adequately current, accurate or complete.
- Counseling/psychotherapy plans did not reflect the use of evidence-based practices.
- Systems for ensuring treatment integrity and staff competence in implementing programming had not been fully implemented.

Medical Care

- There is a lack of comprehensive understanding of the individual's health care needs, leading to appropriate follow-up and integration of health care issues by means of an interdisciplinary process. Many serious medical conditions go under-diagnosed and under-treated.
- There were cases in which the PST was unaware of significant health issues. As a result, important health supports were not provided and the information was not considered in development of behavioral interventions.
- The Facility had not implemented or developed a medical review process that would involve a non-SSLC physician's review of clinical practice at the Facility.
- The Facility utilized a mortality review process that included both a clinical review and an administrative review. This process had the potential to identify issues that could be addressed to improve medical care, but the Facility did not follow its own policies and procedures in conducting mortality reviews by not completing the reviews timely and as comprehensively as necessary to develop system improvements. The Facility's clinical review of deaths did not fully identify important clinical issues, and when issues were identified, there was no mechanism in place to provide on-going follow-up to ensure that when system enhancements are developed and implemented, that they are sustainable and efficacious.
- The Facility was unable to readily retrieve clinical information such as lists of people with common medical conditions.

Nursing Care

- The nursing assessments were beginning to show improvement in the content and quality, but they need to improve on how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing quality nursing assessments.
- Nursing Care Plans were beginning to be more individualized, but most contained information copied directly from the Health Care Protocols: Handbook for Developmental Disability Nurses and contained information that was not necessarily applicable to the individuals. The Nursing Department needs to continue to strengthen and refine their ability to individualize care plans to meet the special needs of the individuals and ensure that goals are realistic, achievable, and measurable as well as are preventative and proactive in nature.
- The Infection Control Program needs to begin tracking, analyzing, and trending data information related to all infection control issues to identify trends that are individual specific as well as systemic and take corrective action, as indicated. There needs to be closer collaboration between the Infection Control Committee and Safety Committee to address environment issues that affect the health and safety of individuals.
- Monitoring data relating to medication administration practices were not fully analyzed and trended to yield enough data to adequately develop comprehensive plans of corrective action.
- The Medication Error database system, developed and implemented in August, 2010, while it represented improvement from the previous database, was continuing to undergo refinement and modifications. The data points collected were changing from month to month as refinements were made.
- The Medication Error Reports needed continuous improvement to ensure that reports are complete, accurate, timely, and demonstrate that corrective actions were taken in response to medication errors.

Pharmacy Services and Safe Medication Practices

- When a pharmacy review of a physician order raised questions, and the pharmacist notified the physician of the concern, there was a lack of meaningful clinical follow-up of potentially serious adverse outcomes. The pharmacist did not request more details from the physician regarding his or her clinical rationale and/or did not offer or request from the physicians alternative pharmacologic treatments. The pharmacist simply documented what the physician's response was and dispensed the medication.
- Because of time constraint and the many other responsibilities the Clinical Pharmacist has, such as addressing ADRs and leading the utilization review process, he must significantly limit his review of each individual and does not have time to fully review the clinical record. The inability of the Clinical Pharmacist to complete a comprehensive review of the clinical record, assess the individual when necessary and meet with relevant staff, results in diminished quality of the review process.
- The Facility did not have a formalized and specific policy in place for ADRs that includes current standard of care practices for monitoring and reporting of ADRs; had no documented training of physicians, pharmacists and direct care staff on ADRs and no regular competency based training of relevant staff; lacked a standardized means to collect and analyze data specific to ADRs; had no process for consistently reporting ADRs to the IDT and LAR; and had no specific documentation and follow-up on ADRs by physicians and nurses, other then completing an ADR reporting form.

Physical and Nutritional Management

- PNMPs were not comprehensive due to the plans lacking information regarding oral care and medication administration. The risk of aspiration is not limited to just mealtime therefore there is a need to address all areas in which the risk may be increased.
- Staff were observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Safe dining strategies were not implemented. Individuals as well as staff were observed poorly positioned. Staff were not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being.
- 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.

- There was still no evidence that data regarding the occurrence of PNM triggers or outcomes are collected and that the PNMT is reviewing these data to better identify system issues or respond to recurrent issues on a regular basis.
- For people receiving enteral nutrition, the assessment of the medical necessity of the tube has shown much improvement but the identification of potential pathways to resume intake remained absent.

Physical and Occupational Therapy

- Record review of individuals who had experienced a change in health or physical status found that five of eight individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety.
- Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Additionally, therapy services were not consistently integrated into the PSP.
- 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.
- Plans were not implemented as written and staff were not knowledgeable of the OT/PT plans. Staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan.
- 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. This is an area that OT/PT was in the process of addressing during the visit.

Dental Services

- The Facility had yet to develop the necessary policies, procedures, and standard of care practices to comply with the Settlement Agreement.

Communication

- Although the numbers have increased, SLPS were not actively involved in all facets of care in which their expertise was needed. Speech and Language Pathologists (SLPs) did not routinely participate in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP.
- Individuals identified as having decreased communication have not consistently been provided with the needed assessments. Programs in place to assist some individuals are not being consistently implemented. Additionally, Individuals who are listed as having severe speech handicaps had not received a comprehensive assessment that investigates the possibilities of Alternative and Augmentative Communication (AAC).
- AAC devices were not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs.
- BSSLC was in the process of developing a monitoring process to address the presence and working condition of the AAC devices but were not monitoring whether or not the device was effective and or meaningful to the individual. Additionally, there was not a formal process that ensured monitoring occurred across all relevant locations and activities.

Habilitation, Training, Education, and Skill Acquisition Programs

- There was a continued lack of skill assessment while awaiting completion of the ongoing review of assessment strategies by DADS.
- No individuals were employed in Supported Employment or Competitive Employment jobs.
- Training on community skills lacked the formalized components necessary for learning to occur.

- Although the Facility was making an effort to improve skill acquisition programs through use of the Murdoch Center Program Library, attempts to modify existing skill acquisition programs using these materials had so far produced only minimal improvement.

Most Integrated Setting

- The Facility continued to need improvement in the areas of interdisciplinary assessment, individualized assessment of need for supports and services in the most integrated setting. The PSP process is the basis for identifying the need for supports; planning for more integrated living must flow from that process. Policy and procedure for a revised PSP process had been implemented, but much improvement was needed in identification of an optimistic vision of the future and in identifying needs for supports.
- The Facility needs to develop individualized strategies for education about community living options to promote informed choice.
- Although the PMM Checklists reviewed were being completed in a timely manner, the process used to complete them was not yet thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. A single PMM visit observed during the compliance visit appeared to be more thorough than those observed during the previous site visit, but not every support was methodically observed and documented.

Consent

- The Facility did maintain a list of individuals needing an LAR, but there was still no standardized approach to assessing and determining the actual need for an LAR on an individualized basis that was consistent with commonly accepted professional standards of practice. The list was updated on an ongoing basis as guardianships were obtained, renewed or lapsed.
- The list originally assigned a prioritization to each individual, but the prioritization process had been discontinued until the new DADS policy has been issued.
- The Facility reported no activity or planning to solicit guardians for those determined to be in need, other than maintaining a standard agenda item for the parents' association meeting to encourage family members to consider becoming guardians.

Recordkeeping and General Plan Implementation

- There were numerous examples of documents that were not filed in the correct location or order, and a few documents were missing. There were a few examples of gaps between entries.
- Records were accessible to staff. However, there were two cases during the visit in which binders were not found immediately and therefore were not accessible to staff.
- The Unified Record Keeping policy does not address this share drive and the records kept on it. The Facility should, in some manner, address this system in policy.
- Findings from the audits by the Unified Records Coordinators are sent to residence directors for corrective action. There was no procedure requiring confirmation that corrective actions have been done. Trending of the types of deficiencies had not begun for these audits.
- Many of the new and revised policies were recently implemented, and implementation was not yet complete or entirely accurate. The Facility did not have a system to assess utilization of records in making decisions. The BSSLC Unified Record Keeping policy (Step I.D) requires that information from the unified record be used at PSP and PST meetings in developing the individualized programs and services to be provided to individuals. However, examples found throughout this report demonstrate that this did not always occur.

Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: **Documents reviewed:** 1. DADS Policy 001 Use of Restraint dated 08/31/09 2. DADS Restraint Checklist dated "06032010" 3. BSSLC Restraint for Behavioral Crisis Policy approved 12/10/10 4. BSSLC Medical and Dental Restraint Policy approved 12/10/10 5. BSSLC Dental Services Policy approved 10/18/10 6. BSSLC Plan of Improvement (POI) updated 12/19/10 7. Log of all restraint use from 1/1/10 to date 8. Sample of restraint records (Sample C.1): Individual #3 (6/18/10, 7/27/10, 8/6/10, 9/1/10, 10/13/10, and 11/15/10, Individual #9 (7/1/10 and 10/8/10), Individual #61 (6/17/10, 6/19/10, 6/20/10, 7/28/10, 7/31/10, and 8/20/10), Individual #173 (6/4/10, 6/14/10, 7/19/10, 10/6/10, and 11/22/10), Individual #316(7/19/10), Individual #399 (6/20/10, 10/17/10, and 11/19/10), Individual #488 10/14/10 and 11/3/10, and Individual #493 (10/15/10 and 10/22/10). These records were to include the restraint checklist form, face-to-face form, the debriefing form, and the individual's Safety Plan, if applicable, and for each restraint, the documentation of any and all reviews of this restraint information. 9. Sample of medical restraint records: Individual #2 (7/16/10), Individual #13 (9/10/10), Individual #61 (6/17/10), Individual #62 (6/3/10), Individual #65 (6/3/10), Individual #81 (8/17/10), Individual #103 (6/10/10), Individual #113 (10/11/10), Individual # 233 (6/22/10, Individual #238 (10/22/10), Individual #332 (11-/9/10), Individual #334 (7/15/10), Individual #380 (6/25/10), Individual #420 (7/6/10), Individual #488 (9/23/10), and Individual #574 (6/4/10) 10. Medical restraint records for Individuals #332 (11/9/10), #407 (11/9/10) , and #462 (11/5/10) and, for each individual, PSP and PBSP 11. Sample of 25 staff training records (Sample C.2) 12. Minutes of Restraint Reduction Committee 9/2/10 and12/22/10 13. Log of restraint related injuries, both to individuals and to employees 12/1/10 14. Personal Support Plans (PSPs) and related documents for Individuals #3, #61, and #173 15. BSSLC Trend Report 11/30/10 **Interviews with**: 1. Kim Littleton, Assistant Director of Programs (ADOP) 2. Susie Johnson, Settlement Agreement Coordinator (SAC) 3. Terry Hancock, PhD, Chief Psychologist 4. Caitlin Connor, Program Compliance Auditor 5. Shawn Cureton, M.S., Psychology Manager 6. Kathleen Williamson, M.Ed., Psychology Manager 7. Debbie Williams, Chief Nurse Executive (CNE)

	8. Kim Stringfellow, Competency Training and Development (CTD) Director 9. Dr. Gary Johnston, DDS, Dentist 10. Julie Weideman, Dental Hygienist 11. Sample of 10 direct care professionals (DCPs) **Observations of**: 1. Facility Incident Management Team 1/10/11 2. QA/QI committee meeting 1/12/11 3. Restraint Reduction Committee Meeting 1/13/11 4. 30 day admission PST meeting for Individual #490 5. Risk meeting for Individual #490
	Facility Self-Assessment: BSSLC's Plan of Improvement (self-assessment) reported substantial compliance with Provision C.1 of the Settlement Agreement (SA). The monitoring team does not concur with this assessment. Several potential issues were identified with respect to prone restraint, particularly with regard to staff understanding and staff training. All other areas of the self-assessment indicated the current status as not in compliance. The monitoring team did not find sufficient evidence in any of these areas to warrant a determination of substantial compliance. Restraint use at the BSSLC declined significantly in the last six months of calendar year 2010. Restraint documentation improved and several new mechanisms were in place to train staff, check on staff competencies, and monitor the accuracy of, and processing, of various restraint related documents.
	Summary of Monitor's Assessment: Restraints used in response to behavior challenges at the BSSLC decreased significantly when comparing the second six months of calendar year 2010 to the first six months of 2010. Physical and chemical restraints were used 83 times in the first half of 2010. This decreased to 47 the second half of 2010 and 14 of the 47 were attributed to a recent new admission. When comparing restraint use in all of calendar year 2010 with 2009 there had also been a significant decline. In 2009 the BSSLC used physical and chemical restraint an average of 16 times a month. In 2010 this decreased to 11 times a month, dropping to an average of 8 per month the last six months of 2010. The average length of time an individual spent in a restraint also dropped significantly, from 8 minutes to 6 minutes. Finally, the number of injuries resulting from restraint decreased significantly, from 27 in 2009 to 5 in 2010. The monitoring team believes there are multiple variables that contribute to this decline and as a whole the facility is to be commended for figuring out ways to manage individuals' behavior without resulting in the use of restraint. There are a small number of individuals living at the BSSLC who account for the majority of restraint use; they represent the challenge ahead for the facility. In the area of medical restraint, limited data was being tracked and trended so there is little from which to determine if use of medical restraint is increasing or decreasing. From interviews with the dental staff it

	appears the Facility had begun to take a much more proactive approach with Personal Support Teams (PSTs) to prepare individuals for dental treatment without the use of pretreatment sedation. There are a number of issues related to staff training noted in this report. Of particular concern is the lack of knowledge of direct care professionals with respect to restraint policies and procedures. Finally, there continued to be significant documentation errors or omissions that make it difficult to validate restraint practices occur according to policy and in a clinically justifiable manner. The monitoring team did note improvement in this area since the first compliance review.

#	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.	BSSLC Restraint for Behavioral Crisis Policy approved 12/10/10 and BSSLC Medical and Dental Restraint Policy approved 12/10/10 are intended to guide facility practices with respect to restraint use. Both policies are comprehensive and are directed to the practices necessary to achieve compliance with the Settlement Agreement. A sample of restraint episodes, referred to as Sample #C.1, was selected. The source document used for the sample was the listing of restraints used in the last six months provided in response to the monitoring team's pre-visit document request. This included 8 individuals and 27 restraint episodes, representing 20% of restraint records over the last six-month period. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included. The individuals in this sample included: Individuals #3, #9, #61, #173, #316, #399, 488, and #493. Some of the sample included medical restraints so the data presented in this report, unless otherwise noted, are representative of the 23 crisis intervention restraint episodes. Four of the individuals in the sample had Safety Plans for Crisis Intervention (SPCI) and four did not. <u>Prone Restraint</u> Based on Facility policy review, prone restraint is prohibited. Based on review of restraint records, restraint reduction committee minutes, and minutes of the Incident Management Review Team (IMRT), no clear use of prone restraint was identified or the subject of any discussion in meeting minutes. The monitoring team does have a concern with respect to certain entries on the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint" (FFA) form. Based on a review of the restraint records for individuals in Sample #C.1 involving 8 individuals, three (38%) showed possible use of prone restraint. This is most likely the result of confusing questions on the FFA. Restraint monitors are responsible for completing the FFA.	Noncompliance

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		Item 2.2 on the FFA asks, "Not face down or face up physical restraint? Not face down mechanical restraint?" It would appear to the monitoring team that if prone restraint was not used the correct response would be yes. In fact, most restraint debriefing documents reviewed indicated "yes. " Occasionally, a document has a response of "no, " for example, a horizontal side-lying restraint to Individual #3 (7/28/10). From other document review it did not appear prone restraint was used but that the restraint monitor may have misinterpreted the question because of its awkward wording. A similar scenario was presented in the restraint documentation for Individuals #3 (10/13/10), #173 (6/15/10), and #399 (10/17/10). Because a side-lying restraint can inadvertently result in a momentary movement resulting in an individual being face up or face down (and potentially becoming a prone or supine restraint), and the ambiguity of the question being asked of the restraint monitor and the restraint monitor's response, the monitoring team cannot say with certainty prone restraint was not used. Based on interviews with 10 direct support professionals (DCPs), 7 were aware of the prohibition on prone restraint. The other 3 did not know what prone restraint was but when prompted by the monitoring team responded by indicating "we don't do that here." Several staff reported, "we just take them down." Only one staff (10%) of those interviewed was sufficiently knowledgeable in policies and procedures governing the use of restraint to instill confidence in the monitoring team that training was effective and staff knowledge was sufficient to ensure correct policy implementation. <u>Other Restraint Requirements</u> Based on document review, the Facility policies state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: 1. In 23 of the 23 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Most typically this was presented on both the restraint checklist and the debriefing form. In one case (Individual #3 - 6/18/10) the restraint checklist only indicated the individual was verbally and physically aggressive with no specific information to describe in behavioral terms the specific behavior exhibited by the individual. In other instances, the restraint debriefing form would provide more descriptive information; however, in this instance the debriefing form did not contain this information due to the unavailability of	

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		staff. 2. For 23 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 14 (61%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. Nine (39%) did not. In the restraint face-to-face assessment documentation one question posed is "not for punishment or convenience of staff?" It would appear to the monitoring team that if restraint was not used for punishment or the convenience of staff the correct response would be yes. In fact, most restraint debriefing documents reviewed indicated "yes. " "No" was recorded as the response in this documentation in several instances (Individuals #3 – 7/27/10 and 10/13/10, #173 – 6/15/10, 10/6/10, and 11/22/10, ##316 – 7/19/10, and #399 – 10/17/10). There were also several restraint files that did not contain the face-to-face assessment documentation, for example Individuals #3 (11/15/10) and #399 (11/19/10). The wording of this question is confusing and it could be that those responding "no" on the form merely misunderstood the question. Nothing else on the FFA or debriefing document would clearly indicate the restraint was used for the convenience of staff or not in a clinically justifiable manner. It is also plausible that restraint may on occasion be used for the convenience of staff or not in a clinically justifiable manner. This may be the case when a Positive Behavior Support Plan (PBSP) has not been effective and needed changes are not being addressed. As reported in section J the BSSLC has made significant improvements in its overall approach to behavioral programming that move it in the direction of SA compliance. Many of these changes are very recent and have only had impact in a small number of situations. Of concern to the monitoring team is the degree to which direct care professionals have been adequately trained in restraint policies and implementation of those policies. Direct care professionals interviewed during this review had a somewhat casual attitude towards the use of restraint. Only one provided good descriptive information of restraint policy and procedure and on interventions that can be attempted to avoid the use of restraint. Several responded to the monitoring team "we just take them down.' When asked what they meant the typical response was "we take them to the floor/ground." 3. In 23 of the records (100%), there was documentation that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Examples where this was the case included: Several restraint checklists indicated use of a large number of pre-	

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		restraint interventions. Individual #3 (6/18/10) included prompted replacement behavior, prompted coping skills, interventions in PBSP, interventions in Safety Plan, verbal prompt, redirection, and PMAB protection skills. Individual #61 (8/20/10) included prompted replacement behavior, prompted coping skills, interventions in PBSP, verbal prompt, redirection, PMAB protection skills, moved others away, traded out staff, moved furniture. All these were outlined in the individual's safety plan. Many restraint checklists only indicated verbal prompt and redirection as interventions attempted pre restraint. Some examples include were Individual #3 (7/27/10 and 8/6/10), Individual #9 (10/8/10), Individual #61 (6/19/10, 6/20/10, 7/28/10, and 7/31/10), and Individual #173 (6/4/10 and 11/22/10). In these cases the monitoring team is concerned that staff are sufficiently trained and knowledgeable with the full range of interventions that may be appropriate for each specific individual. The Settlement Agreement (SA) also requires that restraint be used in a clinically justifiable manner. Restraint may on occasion have been used without good clinical justification. For example, Individual #61's Positive Behavior Support Plan (PBSP) did not appear to have been effective and needed changes had not been addressed effectively enough or timely enough. This leaves direct care professionals with no choice but to use restraint to attempt to protect the individual from harm. As reported in section J the BSSLC has made significant improvements in its overall approach to behavioral programming that move the facility into closer compliance with the SA. Many of these changes are very recent and have only had impact in a small number of situations. Facility policies identify a list of approved restraints. Based on the review of 23 restraints, involving 8 of individuals, 23 (100%) were approved restraints. The monitoring team is concerned about documentation problems presented earlier in the report that could give the appearance of the use of prone restraint. The monitoring team is also concerned with staff knowledge of restraint policies and procedures, as described earlier in this report.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 8 individuals in Sample #C.1 were reviewed. Of these, four of the individuals had Safety Plans that defined the use of restraint. For the four individuals who had Safety Plans, none included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan. For example, five restraint episodes were reviewed for Individual #61. The Safety Plan called for release when the person "is no longer a danger to self or others (stops	Noncompliance

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		struggling for 30 seconds)." The release code on the restraint checklist for restraint on 6/19/10 is L which is "released immediately when no longer immediate and serious risk of harm to self or others." The safety plan calls for the person not to be released "immediately" but after 30 seconds without a struggle. There is also a release code J that is "met safety plan definition of calm and was released." It was not evident that the individual was released from restraint when the release criteria criterion in the Safety Plan were met. The form used to document this restraint was an outdated form. Criteria for release in both DADS and Brenham policy call for termination of restraint as soon as the individual no longer poses an immediate and serious risk of harm. Therefore, the release code indicating "met safety plan definition of calm" should not be available. For the four individuals who did not have Safety Plans, two (50%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Examples showing documentation that the individual was released when he/she was no longer a danger to self or others included: For Individual #399 (11/19/10) the Restraint Checklist indicated release code L – "released immediately because no longer an immediate and serious risk of harm to self/others." For Individual #316 (7/19/10) the Restraint Checklist indicated release code L – "released immediately because no longer an immediate and serious risk of harm to self/others." An example where this was not the case included: For Individual #399 (6/20/10) the Restraint Checklist indicated release code J –"met safety plan definition of calm and was released". This person does not have a safety plan. There cannot be an assumption that this individual met the criteria for release code L.	
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	The Facility's policies related to restraint are discussed, in part, in Section C.1. The Restraint for Behavioral Crisis Policy (approved 12/10/10) addresses the requirements of the SA associated with behavioral crisis restraint use. The Facility policy Medical and Dental Restraint (approved 12/10/10) also addresses the requirements of the SA. BSSLC also has a Dental Policy (approved 10/18/10) that describes, among other things, a process under a section titled "Flow Chart for Degrees of Dental Restraint" that evaluates, for each individual being assessed, the type and severity of dental disease and the expected behavior of the individual. This results in a "score" to determine if	Noncompliance

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	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.	pretreatment sedation or TIVA is going to be necessary to provide treatment. Upon interview the dental staff indicated they don't really use that process as the new dentist has more progressive ideas on methods to avoid pretreatment sedation that include collaboration with the individual's PST. If there are required practices described in the Dental Policy that are no longer used the policy should be updated. Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: 1. Policies governing the use of restraint; 2. Approved verbal and redirection techniques; 3. Approved restraint techniques; and 4. Adequate supervision of any individual in restraint. BSSLC Restraint for Behavioral Crisis policy does not include specific classes, by reference number, required of staff. In the absence of policy defined required training, the monitoring team checked 25 staff training records (selected by picking the last name on the bottom of each printout page of the list of employees) to validate completion of the following courses: 1. RES0105 Restraint: Prevention and Rules for Use at MR Facilities (RES0115 Supporting the Prevention and Safe Use of Restraint substituted for non-direct care staff) 2. PMA0400 PMAB4: Restraint 3. MEC1000 Application of Mechanical Restraints 4. RCM1000 New Restraint Checklist/Restraint Monitoring Note: MEC1000 and RCM1000 were not expected to have been completed by non-direct care staff. This document review showed that 11 out of 25 (44%) staff had taken MEC1000 and RCM1000. This included a number of direct care professionals. Because direct care professionals were not required to take these courses, staff likely to participate in implementing restraint did not have training in application of those restraints. Based on interviews with 10 direct care professionals, in which they were asked to tell the interviewer about the policies covering restraint and were prompted, if necessary, to add information about restraint techniques, 1. One was able to describe policies governing the use of restraint (10%); 2. Five were able to describe approved verbal and redirection techniques (50%); 3. None were able to describe approved restraint techniques (0%); and	

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		4. One was able to describe adequate supervision of any individual in restraint (10%). Seven of the 10 DCP's interviewed had been directly involved in using restraints. As noted in Section C.1 61% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 23 non-medical restraint records (Sample #C.1), in 18 (78%) there was evidence documenting that restraint was used as a crisis intervention. In the remaining 5 records the "type of restraint" section of the Restraint Checklist was not completed. In each of these 5 restraints a review of the FFA and debriefing, if present, suggested the restraint was a crisis intervention but was not documented as such on the restraint checklist. The Restraint Checklist is considered by the monitoring team to be a primary source of restraint documentation. It is imperative it be complete and accurate. In addition, the BSSLC Restraint for Behavioral Crisis policy states that such restraint "is limited to acute emergencies that place the individual or others at serious threat of violence or injury" and thus did not allow for the use of non-medical restraint for reasons other than crisis intervention. Documentation provided by the Facility relevant to the 23 non-medical restraint records reviewed did not contain information about whether a physician had provided a a medical order stating whether the individual could or could not be restrained, or if there were limitations on the type of restraint that could be used. Therefore, the Monitoring Team could not determine whether any restraints used were prohibited by medical orders. The Monitoring Team requested information on authorization for use of restraint medical or dental services (i.e., HRC approval and LAR consent) but did not receive it. A list was provided but no copies of actual approvals, consents, or descriptions of the programs and the context within which the restraint was to be used (information that would be needed for consent to be informed). The Monitoring Team reviewed PSPs and PBSPs for three individuals who had received pre-treatment sedation for a medical procedure; these were Individuals #332, #407, and #462. • For Individual #332, no program goals were listed in the PSP to reduce need for pre-treatment sedation; instead, the PSP stated the individual, "tolerates treatment from the Physician," "cooperated well with Ophthalmologist consults," and for dental services "is cooperative for most appointments." • For Individual #407, PSP Addendums of 1/27/10 and 11/8/10 addressed the	Noncompliance

#	Provision	Assessment of Status	Compliance
		need for pre-treatment sedation for eye appointments. The Addendum of 11/8/10 stated "the team will seek desensitization techniques suitable to the (individual) to assist him with his visits to the ophthalmologist." No such plan was provided to the Monitoring Team. • For Individual #462 PSP Addendums of 11/1/10 and 11/22/10 addressed the need for medical pre-treatment sedation; these referred to a PSP objective for desensitization for dental care, The PSP for this individual included objectives for a program to reduce need for pre-treatment sedation for dental care; no details of the program were provided to the Monitoring Team. Regarding pre-treatment sedation for dental care, the Facility provided a list (acknowledged to be incomplete) of individuals who had received either dental or medical pre-treatment sedation during the second half of 2010. Efforts to minimize the need for pre-treatment sedation were reviewed. Guidance on BSSLC procedure was provided by the document: M*ethods to Develop Cooperation for Medical and Dental Procedures and to Decrease the Need for Restraint and Sedation (Rev 06/04/09).* Please refer to Provision J4 for additional detail. The Facility reported that medical and dental support plans were in place for 88 individuals. This list was compared to the list of 43 individuals who had received pre-treatment sedation. The names of 20 of the individuals appeared on the list of individuals who had plans. The names of the other 23 did not. On the basis of the information provided above, the monitoring team was not able to confirm that all individuals who received pre-treatment sedation had treatment plans in place to reduce the need for such sedation. The Monitoring Team reviewed desensitization plans for 15 additional individuals. There was considerable variation between plans. Some were quite general in their approach, while others were more specific. Therefore, the Monitoring Team was not able to confirm compliance with this provision.	
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.	Review of Facility training documentation showed that there were adequate training curricula on the application and assessment of restraint. This training curriculum for persons who conduct face to face assessments, other than the competency based training described in Provision C.3, was not reviewed in enough detail by the monitoring team to determine if it was competency based. Based on the many areas of improvement needed in BSSLC staff performance, including the direct care professionals responsible for restraining individuals, in the proper use, monitoring, and documentation of restraint, the monitoring team believes the training, even if competency based, has been only marginally effective., as evidenced by the repeated documentation errors. The Facility provided a list of 35 names of staff authorized to perform the duties of a	Noncompliance

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	For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	restraint monitor. The training records of 8 of these 35 staff were selected for review. Based on review of these 8 training records, one staff at the Facility had successfully completed the training to allow them to conduct face-to-face assessment (FFA) of individuals in restraint. Conducting the FFA is one of the primary duties of a restraint monitor. In an interview with the Competency Based Training (CTD) Director the following classes were identified as being required if someone was to act as a restraint monitor, and therefore conduct FFAs. 1. ABU0100 Abuse and Neglect 2. PMA0400 PMAB4: Restraint 3. CPR0100 CPR Basic 4. RES0105 Supporting the Prevention and Safe Use of Restraint 5. UNU0100 Unusual Incidents 6. PBS0100 Positive Behavior Support 7. MEC1000 Application of Mechanical Restraints 8. RCM1000 New Restraint Checklist/Restraint Monitoring 9. RES0115 Restraint: Prevention and Rules for Use at MR Facilities One of the eight training records of restraint monitors showed completion of all nine classes. The other seven training records reviewed contained completion deficiencies in one or more of these classes. In two records the monitoring team did not give credit for RCM class completion as it was last completed in 2004 or earlier and many requirements and forms associated with the restraint checklist and restraint monitoring have changed substantially since the start of the SA. In addition, material was provided to the monitoring team from the Psychology Department in response to a document request asking for curricula for training conducted by the psychology department separate from formal CTD/DADS classes. This material consisted of a description of the duties of a restraint monitor, required CTD/DADS courses and refreshers, various forms a restraint monitor would need to use, sample safety plans, and PMAB course descriptions. The monitoring team asked for, but did not receive, a list of staff who had attended the training put on by the Psychology Department. Therefore, the monitoring team could not validate this training had occurred for the restraint monitors in the sample. Based on a review of 23 non-medical restraint records (Sample #C.1), a face-to-face assessment was conducted in one out of 23 incidents of restraint (4%) by an adequately trained staff member. This was for a restraint of Individual #3 (6/18/10). Two records did not contain documentation of a restraint monitor on the Restraint Checklist. These	

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		were for Individual # 316 (7/19/10 12:35pm) and Individual #9 (10/8/10). The remaining 20 records in the sample identified a restraint monitor. When checking the staff training record for these restraint monitors they were deficient in one or more required classes. Six of 23 (26%) non-medical restraint records in the sample did not include a FFA. This included Individuals #3 (6/18/10 and 11/15/10), #61 (6/19/10), #173 (10/6/10 and 11/22/10, and #399 (11/19/10). Therefore, any data needed from the FFA for the monitoring team to determine partial compliance with the SA is not present in 26% of the sampled restraints. The FFA document includes an entry for "time monitor arrived." The monitoring team views this time as the time the assessment began. For 14 out of 23 instances (61%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included the six records for which an FFA was not provided to the monitoring team: Individuals #3 (6/18/10 and 11/15/10), #61 (6/19/10), #173 (10/6/10 and 11/22/10, and #399 (11/19/10); 2 FFAs for which there was no time arrived entered on the FFA (#3- 8/6/10 and #9- 10/8/10). In 17 instances (74%), the documentation on the FFA showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included the six records for which an FFA was not provided to the monitoring team: Individuals #3 (6/18/10 and 11/15/10), #61 (6/19/10), #173 (10/6/10 and 11/22/10, and #399 (11/19/10). In 17 instances (74%), the documentation on the FFA showed that an assessment was completed of the circumstances of the restraint. Records that did not contain documentation of this included the six records for which an FFA was not provided to the monitoring team: Individuals #3 (6/18/10 and 11/15/10), #61 (6/19/10), #173 (10/6/10 and 11/22/10), and #399 (11/19/10). None of the 23 non-medical restraint records in the sample indicated an alternative physician ordered monitoring schedule. Based on a review of 27 restraint records for restraints that occurred at the Facility (Sample #C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 13 (48 %) of the instances of restraint. Listed below are the individuals and date of each restraint record where this did not occur: o #3 – 7/28/10 o #3 – 8/6/10	

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		o #3 – 11/15/10 An old form was used, SMRF Restraint Checklist (rev. 1/2008). The Facility needs to purge all old Restraint Checklist forms and instruct staff completing Restraint Checklists to use the current form, number 06032010. o #11 – 7/14/10 at 9:32 a.m. o #11 – 7/14/10 at 5:07 p.m. o #493 – 10/22/10 o #488 – 10/14/10 This was a medical restraint for an electrocardiogram. Ativan 1 milligram was administered orally at 7:00 a.m., as ordered by the physician. A note written on the nursing assessment portion of the checklist stated to refer to the Post Treatment Sedation form for monitoring assessment. If the Restraint Checklist is used for monitoring post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist. o #488 – 11/3/10 This was a medical for an electrocardiogram. Valium 5 milligrams was administered orally at 10:00 a.m., as ordered by the physician. A note written by the nurse on the nursing assessment portion of the checklist stated to refer to the Post Treatment Sedation form for monitoring assessment. If the Restraint Checklist is used for monitoring post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist. o #61 – 8/20/10 o #316 – 7/19/10 at 12:35 p.m. This resulted in a two-minute physical hold to the arm because of aggression toward peer and staff. There was documentation that the nurse was notified and present at 12:35 p.m. as the restraint was applied but the nurse failed to document any monitoring assessment on the checklist. o #316 – 7/19/10 at 12:45 p.m. At 12:50 p.m. the code portion of the checklist indicated a code "N" (other) documenting in parentheses, "2 milligrams of Ativan. " However, there was no documentation by a nurse that Ativan was given nor was there monitoring documentation completed on the checklist by the nurse. When chemical restraint is administered there must be monitoring completed by the nurse according to Restraint Policy. o #316 – 7/19/10 at 12:55 p.m.	

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		o #399 – 11/19/10 o #493 – 10/22/10 This was a medical restraint for an eye appointment. Zyprexa 10 milligrams was administered intramuscularly at 6:30 a.m., as ordered by the physician. There was no nursing monitoring documented for medical post treatment sedation nor was there a note to refer to the Post Treatment Sedation form. ▪ Monitored and documented vital signs in 15 (56 %) of the instances of restraint. While 15 Restraint Checklists did have vital signs monitored and documented there were four (27%) of the 15 instances of restraint that failed to have the initial vital signs completed within 30 minutes of the application of restraints and/or interval monitoring and documentation of vital signs was greater than 30 minutes. Records that did not contain documentation of this included: o #11 – 7/14/10 at 9:32 a.m. o #11 – 7/14/10 at 5:07 p.m. o #493 – 10/22/10 o #488 – 10/14/10 This was a medical restraint for an electrocardiogram. Ativan 1 milligram was administered orally at 7:00 a.m., as ordered by the physician. A note written on the nursing assessment portion of the checklist stated to refer to the Post Treatment Sedation form for monitoring assessment. If the Restraint Checklist is used for monitoring post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist. o #488 – 11/3/10 This was a medical restraint for an electrocardiogram. Valium 5 milligrams was administered orally at 10:00 a.m., as ordered by the physician. A note written by the nurse on the nursing assessment portion of the checklist stated to refer to the Post Treatment Sedation form for monitoring assessment. If the Restraint Checklist is used for monitoring post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist. o #61 – 8/20/10 o #316 – 7/19/10 at 12:35 p.m. This resulted in a two minute physical hold to the arm because of aggression toward peer and staff. There was documentation that the nurse was notified and present at 12:35 p.m. as the restraint was applied but the nurse failed to document monitoring assessment on the checklist.	

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		o #316 – 7/19/10 at 12:45 p.m. At 12:50 p.m. the code portion of the checklist indicated a code "N" (other) documenting in parentheses, "2 milligrams of Ativan". However, there was no documentation by a nurse that Ativan was given nor was there monitoring documentation completed on the checklist by the nurse. When chemical restraint is administered there must be monitoring completed by the nurse according to Restraint Policy. o #316 – 7/19/10 at 12:55 p.m. o #399 – 11/19/10 o #493 – 10/22/10 This was a medical restraint for an eye appointment. Zyprexa 10 milligrams was administered intramuscularly at 6:30 a.m., as ordered by the physician. There was no nursing monitoring documented for post treatment sedation nor was there a note to refer to the Post Treatment Sedation form. ▪ Monitored and documented mental status in 14 (52%). Records that did not contain documentation of this included: o #3 – 11/15/10 o #11 – 7/14/10 at 9:32 a.m. o #11 – 7/14/10 at 5:07 p.m. o #493 – 10/22/10 o #488 – 10/14/10 This was a medical restraint for an electrocardiogram. Ativan 1 milligram was administered orally at 7:00 a.m., as ordered by the physician. A note written on the nursing assessment portion of the checklist stated to refer to the Post Treatment Sedation form for monitoring assessment. If the Restraint Checklist is used for monitoring post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist. o #488 – 11/3/10 This was a medical restraint for an electrocardiogram. Valium 5 milligrams was administered orally at 10:00 a.m., as ordered by the physician. A note written by the nurse on the nursing assessment portion of the checklist stated to refer to the Post Treatment Sedation form for monitoring assessment. If the Restraint Checklist is used for monitoring post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist. o #61 – 8/20/10 o #316 – 7/19/10 at 12:35.p.m.	

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		This resulted in a two minute physical hold to the arm because of aggression toward peer and staff. There was documentation that the nurse was notified and present at 12:35 p.m. as the restraint was applied but the nurse failed to document any monitoring assessment on the checklist. o #316 – 7/19/10 at 12:45 p.m. At 12:50 p.m. the code portion of the checklist indicated a code "N" (other) documenting in parentheses, "2 milligrams of Ativan". However, there was no documentation by a nurse that Ativan was given nor was there monitoring documentation completed on the checklist by the nurse. When chemical restraint is administered there must be monitoring completed by the nurse according to Restraint Policy. o #316 – 7/19/10 at 12:55 p.m. o #399 – 11/19/10 o #493 – 10/22/10 This was a medical restraint for an eye appointment. Zyprexa 10 milligrams was administered intramuscularly at 6:30 a.m., as ordered by the physician. There was no nursing monitoring documented for post treatment sedation nor was there a note to refer to the nursing Post Treatment Sedation form. ▪ Based on documentation provided by the Facility, no restraints had occurred off the grounds of the Facility in the last six months. Sample #C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 14 of the individuals for whom medical restraint was used. It included the following individuals: Individuals #2 (7/16/10), #13 (9/10/10), #59 (7/28/10), #81 (8/17/10), #113 (10/11/10), #238 (10/22/10), #332 (11/9/10), #334 (7/15/10), #420 (7/6/10), #488 (9/23/10, 10/14/10, and 11/3/10), and #493 (10/15/10 and 10/22/10). For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. In none of the 14 medical restraints reviewed did the physician specify the schedule and type of monitoring required. Rather, through interview the nursing staff reported they follow a standard protocol of time sequenced checks pre and post procedure unless the physician orders a different monitoring schedule or type of monitoring. None of the 14 medical restraints in the sample indicated an alternative monitoring schedule or type ordered by a physician. The time sequenced intervals for these nursing checks are specified on the Pre Procedure (post medication) and Post Procedure Sedation checklists. There are a 15 and	

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		30 minute check (pre and post) followed by 30 minute checks thereafter until 2 hours post procedure. BSSLC nursing staff use a four page monitoring checklist which includes one page for recording vital signs and other information after sedation has been administered but before treatment, one page for recording vital signs and other information after sedation has been administered but after treatment, one page that provides a nursing assessment when the individual returns home after treatment, and one page that the nursing staff use in providing instructions to direct care staff after the individual returns home. While BSSLC may believe this to be a sound and effective practice it does not meet the requirements of the SA which specifies "in each instance of a medical restraint the physician shall specify the schedule and type of monitoring required." Though the present system for monitoring medical restraint does not meet the requirements of the SA the monitoring felt it useful to review and comment on some examples of medical restraint monitoring. Individual #81 was administered pretreatment sedation at 1:45pm. For reasons not stated in the documentation presented to the monitoring team the treatment did not occur. Pretreatment sedation monitoring checks were done at 15 minute intervals until 3:00pm and 30 minute intervals thereafter until 5:30pm. A final check was done at 7:00pm. Individual #2 was administered pretreatment sedation at 8:12am. Nursing monitoring occurred at 8:30am. Treatment occurred at 9:45am. There is no documentation that any nursing monitoring occurred between 8:30am and 9:45am. The post procedure checklist includes a line to enter vitals at the 15 minute post medication interval. These numbers should match the entries on the pre procedure checklist also labeled 15 minutes post medication. They did not. Individual #238 underwent an eye exam at 8:30am after receiving pretreatment sedation at 7:00am. Post treatment monitoring did not begin until 9:35am, 55 minutes after treatment. Individual #13 was administered pretreatment sedation at 7:30am. Nursing monitoring occurred at 7:45am, 8:00am, and 8:30am. The documentation provided to the monitoring team did not indicate the time of treatment. The individual returned to the home at 9:30am and the post treatment sedation form indicates the 15 minute post procedure check was done at 9:45am, 15 minutes after returning to the home but not necessarily 15 minutes post procedure since the time of the procedure was not recorded on the checklist.	

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		Several post sedation checklists did not include the time the procedure was done. This included Individuals #59, #81, #113, #332, #420, and #488. As a result the monitoring team was unable to measure whether post sedation monitoring commenced within timeframes required by Facility policy.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	A sample (Sample #C.1) of 23 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: 1. In 14 (61%), continuous one-to-one supervision was documented; 2. In 22 (96%), the date and time restraint was begun was documented; 3. In 22 (96%), the location of the restraint was documented; 4. In 23 (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented; 5. In 23 (100%), the interventions taken by staff prior to the use of restraint were documented and are adequate for post restraint review. While information was always checked on the restraint checklist 13 of the 23 (57%) indicated use of only redirection and/or verbal prompts was provided. In most cases subsequent information recorded on the FFA and debriefing did not indicate additional interventions beyond those described on the restraint checklist. Because those in the sample represented some of the most restrained individuals at BSSLC the monitoring team would have expected to see more robust interventions directed towards avoiding restraint. For example, for both Individual #9 (7/1/10) and Individual #61 (8/20/10) reported interventions including a change in environment, moving furniture, implementing the PBSP and Safety Plan, trading out staff, and moving other individuals away. 6. In 23(100%), the specific reasons for the use of the restraint were documented. The monitoring team found that when taken together the information provided on the restraint checklist, the FFA, and the debriefing the specific reasons for the use of restraint was clear, even though one or more of the three documents may have had missing, incomplete, or confusing information. 7. In 12(52%), the method and type (e.g., medical, dental, crisis intervention) of restraint was indicated on the restraint checklist. 8. In 22(96%), the names of staff involved in the restraint episode were indicated on the restraint checklist. 9. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including: o In 23(100%), the observations documented at least every 15	Noncompliance

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		minutes and at release. All restraints in the sample were of short duration. None exceeded 15 minutes; o In 22(96%), the specific behaviors of the individual that required continuing restraint were noted; and o Because of the short duration of all restraint episodes reviewed there was no obvious need for staff to provide, during the restraint, opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. 10. In 21(91%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. 11. In 21 (91%), the date and time the individual was released from restraint was recorded on the restraint checklist. In 3 (13%), the results of assessment by a licensed health care professional were documented as to whether there were any restraint-related injuries or other negative health effects. In a sample of 23 records (Sample #C.1), restraint debriefing forms had been completed for 22 (96%). The restraint debriefing form addresses the following questions: 1. Describe the resident at the time the restraint was used? What was the resident doing that required restraint? What types of emotions were being shown by the resident? 2. Describe what led up to the restraint" What was going on in the environment prior to when the resident displaying challenging behavior? What might have caused the resident to act the way he or she did? 3. When the resident first started showing that he or she was upset, and started displaying the precursors of the challenging behaviors that led to restraint, how did staff try to calm the resident? What interventions were tried prior to restraint, and how did the resident respond? 4. How can we prevent the need for restraining this resident in the future? If a similar situation develops, is there anything we can do instead of restraining the resident? Is there anything we can change in the environment where the restraint occurred that might make it less likely that the resident will again need to be restrained there? 5. Were injuries noted secondary to the restraint? A psychologist prepares the debriefing document after interviewing all staff involved in the restraint and working with the individual prior to the restraint episode. For the most part the content of the debriefing document is sufficiently detailed to be useful to the psychology staff and others in determining future actions that may prevent the need for	

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		restraint. Two of the debriefing documents indicated staff was unavailable for interview. Apparently this document is to accompany the Restraint Checklist that is to be submitted to various people soon after the restraint episode. BSSLC may wish to initiate an additional step calling for an amended debriefing document to reflect the input of all relevant staff. While content in the debriefing document was at least minimally acceptable some were clearly more comprehensive than others with the noticeable variable being the particular psychologist completing the form. BSSLC may wish to engage in some type of peer support or peer learning process to provide for a generalized improvement in the content of the restraint debriefing document. A sample of 14 instances of individuals subject to medical restraint was reviewed (Sample #C.3), and in 5 (36%), there was evidence that the monitoring had been completed as required by the facility policy. The lack of evidence for the rest was primarily because the documentation provided to the monitoring team did not usually record the time treatment occurred, making it impossible to determine if post treatment monitoring occurred 15 minutes after treatment. In these cases it was evident post treatment monitoring occurred at the specified intervals specified on the checklist. There were 4 of the 14 medical restraints where the documentation provided to the monitoring team did not include any pre and post treatment monitoring documentation. These were Individuals #488 (2x) and Individual #493 (2x). Sample #C.4 was selected using the list the Facility provided of individuals who had chemical restraint since the last on-site review. This included the following individuals: Individual #9 (10/8/10) and Individual #61 (8/20/10). This sample of two individuals who were the subject of a chemical restraint was reviewed. In neither case was there any documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Neither documentation file prepared for the monitoring team contained an "Administration of Chemical Restraint Consult" form which, according to policy, is the method by which a psychologist documents findings as to the necessity of chemical restraint.	
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:	During the six-month period prior to the on-site review, a total of three individuals were placed in restraint more than three times in any rolling thirty-day period.. • Individual #61 was restrained six times between 06/17/10 and 06/30/10. The monitoring team requested documentation of the review that was required when more than three episodes of restraint occurred during a 30 day period, but the Facility was unable to locate any documentation for the meeting. Restraint	Noncompliance

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		debriefings conducted after the episodes of restraint included references to ongoing adjustments in the individual's psychotropic medications. Documentation was provided for more recent restraint debriefings from restraint episodes that took place on 7/31 and 08/20 discussed the failure of psychotropic medication to prevent continued difficulties and discussed the possible need for psychiatric hospitalization. PTR notes and the PBSP were reviewed for adequacy of psychiatric symptom monitoring. The individual was diagnosed with schizoaffective disorder and tracking was in place for psychotic statements. • Individual #3 was restrained four times between 07/25/10 and 07/31/10. Restraint debriefings mentioned that anger management and counseling could be helpful in preventing further episodes. The meeting to review the multiple episodes of restraint took place on 08/11/10. The document provided extensive descriptions of the restraints that occurred, reviewed the manner in which the restraints were implemented, the history of past restraint, the need for restraint, and confirmed that the risk of failing to restrain the individual outweighed the risks associated with the restraint. The meeting was attended by a psychiatry assistant but not by the psychiatrist. There was no record of any active clinical discussion and recommendations were for a referral to the psychologist around completion of a PBSP. PTR notes for the latter part of 2010 were reviewed for adequacy of psychiatric symptom monitoring. The individual was diagnosed with bipolar disorder and anxiety was mentioned as a target symptom. The individual was also diagnosed with attention deficit and mood symptoms, racing thoughts, hyperactivity, and marked disturbances in sleep, and the psychiatrist mentioned psychotic behaviors as target symptoms. However, no behavioral tracking was in place for these symptoms. • Individual #399 also had multiple episodes of restraint (although not more than three in 30 days). In that case as well, the individual, had a diagnosis of a mood disorder, but there was no tracking for mood related symptoms. In both cases it is possible that better tracking of these symptoms could have improved treatment and reduced the need for restraint. For both individuals # 399 and #61, the treatment team raised the need for possible psychiatric hospitalization. In order to have the information required to comment on items C7 (a) through (g), the monitoring team asked for complete documentation of restraint episodes for those individuals meeting the 3+/30 day criteria. The Facility did not provide adequate documentation to permit assessment of compliance with this element of this provision. For example, PBSPs initiated or revised as a result of reviews were not provided, and no documents were provided in response to a request for "PST addenda regarding multiple	

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		episodes of restraint" for the relevant individuals.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	
	(b) review possibly contributing environmental conditions;	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	
	(c) review or perform structural assessments of the behavior provoking restraints;	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	
	(d) review or perform functional assessments of the behavior provoking restraints;	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	

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	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		
	(g) as necessary, assess and revise the PBSP.	The Facility did not provide adequate information to permit review of this item. Please refer to C7 above.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The BSSLC process for reviewing each episode of restraint, as reported by staff, begins with a FFA done by the restraint monitor immediately after the restraint episode. This was followed as soon as possible with a restraint debriefing conducted by a psychologist. The restraint episode is reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often consists of verbal reports from staff. It is reviewed that same day by the IMRT, again often based on verbal reports from staff, either the Unit Director, Psychology Manager, or both. The restraint episode is kept on the agenda of both meetings until the restraint checklist, FFA, and debriefing have been completed and each review level has the necessary information to conduct a final review and determine a follow-up course of action which may include a referral to the PST for PSP revisions. Documentation of these reviews is expected to be in IMRT meeting minutes but it is usually quite general, often just noting date and time and that a review occurred. There is also space on the FFA to document that both a unit and IMRT review took place and the date. If a restraint related issue is referred to the PST the results are ordinarily documented in a Personal Support Plan Addendum (PSPA) that becomes part of the permanent record. The Restraint Reduction Committee includes on its agenda a case study each month. This is typically the most difficult behavioral/restraint case at the time of the meeting. The Quality Assurance/Quality Improvement Council also includes restraint use on its agenda although this would not typically include any discussion of an individual restraint. The BSSLC has taken the initiative to implement a new process to improve the restraint documentation by creating a "Restraint Paperwork Tracking Form" managed by the Psychology Managers for each instance of restraint use. As this is implemented it should improve restraint documentation, which should allow review activity to become more substantive, especially around the "circumstances under which restraint was used." Typically, these reviews to determine the circumstances under which restraint was used tend to look for an easy explanation such as "workshop cancelled, " or "mom didn't call"	Noncompliance

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		which may very well be the trigger of a behavior, but often there is a need for a closer examination of "circumstances" such as how staff informed the individual, whether they had alternative preferred activities to offer, whether a preferred staff person engaged the individual, and similar strategies that may have diffused a tense situation. A sample of documentation related to 23 incidents of non-medical restraint was reviewed (Sample #C.1). The facility was asked to prepare a file for each of these restraint episodes that included all documentation associated with the restraint episode including review activity. No files contained any meeting minutes/notes from unit daily meetings or daily IMRT meetings. The documents provided in these 23 files which could have validated that a review occurred were the FFA which includes data on reviews, specifically date of unit review and date of IMRT review, and a dated Restraint Debriefing Form. None of the files contained Unit or IMRT minutes to document administrative review of the restraint episode. None of the FFAs included an entry for date of IMRT review and only 2 included an entry for date of unit review. All the files contained a Restraint Debriefing Form although none were dated so it was impossible to validate the review took place within 3 days. The Restraint Debriefing Form addresses the following questions: 1. Describe the resident at the time the restraint was used? What was the resident doing that required restraint? What types of emotions were being shown by the resident? 2. Describe what led up to the restraint" What was going on in the environment prior to when the resident displaying challenging behavior? What might have caused the resident to act the way he or she did? 3. When the resident first started showing that he or she was upset, and started displaying the precursors of the challenging behaviors that led to restraint, how did staff try to calm the resident? What interventions were tried prior to restraint, and how did the resident respond? 4. How can we prevent the need for restraining this resident in the future? If a similar situation develops, is there anything we can do instead of restraining the resident? Is there anything we can change in the environment where the restraint occurred that might make it less likely that the resident will again need to be restrained there? 5. Were injuries noted secondary to the restraint? A psychologist prepares the debriefing document after interviewing all staff involved in the restraint and working with the individual prior to the restraint episode. For the most part the content of the debriefing document is sufficiently detailed to be useful to the psychology staff and others in determining future actions that may prevent the need for restraint. Two of the debriefing documents indicated staff was unavailable for interview.	

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		Apparently this document is to accompany the Restraint Checklist, which is to be submitted to various people soon after the restraint episode. BSSLC may wish to initiate an additional step calling for an amended debriefing document to reflect the input of all relevant staff. While content in the debriefing document was at least minimally acceptable some were clearly more comprehensive than others with the noticeable variable being the particular psychologist completing the form. BSSLC may wish to engage in some type of peer support or peer learning process to provide for a generalized improvement in the content of the restraint debriefing document. In summary, in no case was restraint review noted to have occurred within three days of the restraint episode. This is based on the documentation provided for the sample of 23 facility prepared documentation files. Nevertheless, through interview and observation it was evident to the monitoring team that individual restraint use is reviewed daily at the Unit meetings and at the facility IMRT meetings. It is unlikely any restraint use at BSSLC would not be reviewed within this 3 day requirement; however, the documentation provided by BSSLC for the compliance visit was insufficient to make this determination.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Formalize the Restraint Reduction Committee's review of restraint trends and use this committee to analyze data and develop action steps to further reduce the use of medical and dental restraints at the facility. Ensure Trend Reports include rolling 12 month data presentation for all data.
2. All restraints should be documented in accordance with state policies.
3. All restraints should be monitored according to guidelines in state policies.
4. Train all staff to recognize when an individual is no longer a risk and may be released from restraints. Although general training might be provided on what indicates individuals are no longer a danger to themselves or others, training should also be provided relevant to specific individuals (including those on safety plans) on the criteria for identifying when an individual is no longer a danger to himself/herself or others.
5. Train restraint monitors to identify and intervene in appropriate restraint procedures.
6. Develop behavior support plans that provide support staff with concrete strategies for deescalating behavioral incidents specific to each individual.
7. Ensure that staff knows restraints should only be used as a last resort measure for crisis intervention.
8. Revise behavior support plans if they are not effective tools for direct support staff responsible for implementation of the plan.
9. Identify in policy the training expectations (class names and corresponding number) for someone to be considered adequately trained in restraint, and adequately trained as a restraint monitor.
10. Purge all old unused Restraint Checklist forms and instruct staff completing Restraint Checklists to use the current form issued on 6/3/10,
11. If the Restraint Checklist is used for monitoring pre and post treatment sedation the monitoring assessment needs to be documented on the checklist to meet compliance with completing the Restraint Checklist.

The following are offered as additional suggestions to the Facility:

1. BSSLC may wish to initiate an additional step calling for an amended debriefing document to reflect the input of all relevant staff.
2. BSSLC may wish to engage in some type of peer support or peer learning process to provide for a generalized improvement in the content of the restraint debriefing document.

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:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management approved 12/20/10 2. List of approved BSSLC policies 12/20/10 3. List of incidents by individual 12/2/09 to 12/2/10 4. Unusual Incident Reports (UIRs) 10-187, 10-207, 11-001, 11-024, 11-042, 11-046, 11-044, 11-077, and 11-079 5. Form 1020 (and similar documents) for 98 employees 6. Your Rights and Zero Tolerance posters 7. Training curriculum used for Abuse/Neglect 6/06 8. Abuse/Neglect/Exploitation Competency Exam (undated) 9. Sexual Incident Competency Reporting Exam (undated) 10. Incident Management Check Sheet 7/5/04 11. Log of Department of Family and Protective Services (DFPS) case dispositions 7/1/10 to 12/2/10 12. DFPS investigation reports 10-182, 10-197, 11-007, 11-027, 11-033, 11-037, 11-041, and 11-045 13. Minutes of 12/10/10 meeting between DFPS/OIG/BSSLC staff 14. Log of law enforcement referrals 1/12/11 15. Office of Inspector General (OIG) Case 06115-11 and 05959-11 16. List of abuse/neglect investigations from 1/1/10 to 1/11/11 17. Incident Management Team meeting minutes 11/29/10, 12/6/10, 12/13/10, 12/20/10, 1/10/11, and 1/11/11 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 11/30/10 21. BSSLC Plan of Improvement (POI), dated 5/17/10 22. Hospital Bed Inventory Inspection Report 12/2/10 23. Bedrail Safety training material and training roster (undated) 24. List of employees who self-reported arrests 7/1/10 -12/31/10 25. Psychiatric Treatment Reviews (PTR) and other information as identified in Section K, Documents Reviewed item #3 for Individual #12 **Interviews with**: 1. Robert Ham, Facility Director 2. Kim Littleton, Assistant Director of Programs 3. Susie Johnson, Settlement Agreement Coordinator 4. Debra Kollman, Incident Management Coordinator 5. Caitlin Connor, Program Compliance Auditor 6. Susan Aguilar, Independent Ombudsman

	7. 10 Direct Care Professionals (DCPs) 8. Six individuals living at BSSLC **Meetings Attended/Observations**: 1. Facility Incident Management Team 1/10/11 2. Quality Assurance/Quality Improvement Council 1/12/11 3. Restraint Reduction Committee 1/13/11
	Facility Self-Assessment: The BSSLC Plan of Improvement reported substantial compliance with four of the five provisions of the Settlement Agreement (SA). The monitoring team determined substantial compliance with one provision (D.5) This provision addresses background checks of employees and volunteers who work regularly with individuals. The BSSLC Plan of Improvement reported substantial compliance with 16 components of SA provisions. The monitoring team found BSSLC to be in substantial compliance with 12 components of SA provisions, although not necessarily the same components as the BSSLC felt it was in compliance with. This is indicative of the progress towards substantial compliance demonstrated by the BSSLC.
	Summary of Monitor's Assessment: BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date12/20/10), was the policy presented to the monitoring team as governing all essential components of this section of the Settlement Agreement. There are several requirements of the SA that were not addressed in this policy. These are described in the appropriate section of this report. Most elements of the policy satisfactorily address SA requirements. There is a significant concern that the cornerstone principle in a client protection system (reporting abuse/neglect) was not being implemented according to policy and does not, therefore, meet the requirements of the SA. BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management states, appropriately, that staff is required to report abuse, neglect, and exploitation to DFPS within one hour by calling the DFPS 1-800 number. This was not the actual practice at BSSLC as demonstrated by staff knowledge and monitoring/training material used by the BSSLC. The monitoring team is concerned with staff knowledge about reporting procedures and the continued training and competency checks staff receive. It appears most staff believe they are to report abuse to the Incident Management Coordinator during regular business hours and the Duty Officer in the off hours; and, then get direction from that person as to whether or not what was reported needs to be called in to the DFPS 1-800 number. This was the most common response from the direct care professionals interviewed. This apparent practice is reinforced through the use of a competency exam program auditors and others use in questioning staff as part of an established monitoring process of staff knowledge and competency. One question asked of the staff person is "Who do you report abuse and neglect to?" The answer key indicates the correct answer is "Director designee, during business hours the Incident Management Coordinator, after hours and holidays the duty officer." There is no reference to an expectation they also are to call DFPS. The Facility uses an Abuse and Neglect poster (separate from the rights poster required by the SA) that is displayed prominently throughout the facility. This poster highlights the reporting described

	above but does include the DFPS number on the bottom. One additional type of poster was observed on a bulletin board in a residential building corridor that instructed staff to report abuse and neglect as described above with no DFPS number noted. Administrators stated that screening is not acceptable and all allegations must be reported to DFPS as notice is given to administration; however, there is a perception among at least some staff that administration guides decisions about whether to report an allegation. Administration reported that calls needed to be made first to the Superintendent (or designee), or duty officer, to ensure appropriate and immediate client protection measures have been, or are directed to be, taken place. This was viewed as necessary because when calling the DFPS 1-800 number it is not unusual to be placed on hold by the DFPS automated phone system for a considerable period of time, sometimes 30 minutes or longer.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The Facility's policies and procedures include a commitment that abuse and neglect of individuals will not be tolerated and require that staff report abuse and/or neglect of individuals. According to the BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date12/20/10), staff were required to report abuse, neglect, and exploitation to DFPS within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement. This was not the actual practice at BSSLC as demonstrated by staff knowledge and monitoring/training material used by the BSSLC. The monitoring team is concerned with staff knowledge about reporting procedures and the continued training and competency checks staff receive. It appears most staff believe they are to report abuse to the Incident Management Coordinator during regular business hours and the Duty Officer in the off hours; and, then get direction from that person as to whether or not what was reported needs to be called in to the DFPS 1-800 number. This was the most common response from the direct care professionals interviewed. This apparent practice is reinforced through the use of a competency exam program auditors and others use in questioning staff as part of an established monitoring process of staff knowledge and competency. One question asked of the staff person is "Who do you report abuse and neglect to?" The answer key indicates the correct answer is "Director designee, during business hours the Incident Management Coordinator, after hours and holidays the duty officer." There is no reference to an expectation they also are to call DFPS. The Facility uses an Abuse and Neglect poster (separate from the rights poster required by the SA) that is displayed prominently throughout the facility. This poster highlights the reporting described above but does include the DFPS number on the bottom. One additional type of poster was observed on a bulletin board in the Bowie corridor that instructed staff to report abuse and neglect as described above with no DFPS number.. Administrators stated that screening is not acceptable and all allegations	Noncompliance

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		must be reported to DFPS as notice is given to administration; however, there is a perception among at least some staff that administration guides decisions about whether to report an allegation. Administration reported that calls needed to be made first to the Superintendent (or designee), or duty officer, to ensure appropriate and immediate client protection measures have been, or are directed to be, taken place. This was viewed as necessary because when calling the DFPS 1-800 number it is not unusual to be placed on hold by the DFPS automated phone system for a considerable period of time, sometimes 30 minutes or longer.	
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:	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA.	Noncompliance
	(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.	According to the BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date12/20/10), staff were required to report abuse, neglect, and exploitation to DFPS within one hour by calling the DFPS 1-800 number. This was consistent with the requirements of the Settlement Agreement. This was not the actual practice at BSSLC as demonstrated by staff knowledge and monitoring/training material used by the BSSLC. The monitoring team is concerned with staff knowledge about reporting procedures and the continued training and competency checks staff receive. It appears most staff believe they are to report abuse to the Incident Management Coordinator during regular business hours and the Duty Officer in the off hours; and, then get direction from that person as to whether or not what was reported needs to be called in to the DFPS 1-800 number. This was the most common response from the direct care professionals interviewed. This apparent practice is reinforced through the use of a competency exam program auditors and others use in questioning staff as part of an established monitoring process of staff knowledge and competency. One question asked of the staff person is "Who do you report abuse and neglect to?" The answer key indicates the correct answer is "Director designee, during business hours the Incident Management Coordinator, after hours and holidays the duty officer." There is no reference to an expectation they also are to call DFPS. The Facility uses an Abuse and Neglect poster (separate from the rights poster required by the SA) that is displayed prominently throughout the facility. This poster highlights the reporting described above but does include the DFPS number on	Noncompliance

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		the bottom. One additional type of poster was observed on a bulletin board in the Bowie corridor that instructed staff to report abuse and neglect as described above with no DFPS number. Administrators stated that screening is not acceptable and all allegations must be reported to DFPS as notice is given to administration; however, there is a perception among at least some staff that administration guides decisions about whether to report an allegation. Administration reported that calls needed to be made first to the Superintendent (or designee), or duty officer, to ensure appropriate and immediate client protection measures have been, or are directed to be, taken place. This was viewed as necessary because when calling the DFPS 1-800 number it is not unusual to be placed on hold by the DFPS automated phone system for a considerable period of time, sometimes 30 minutes or longer. With regard to serious incidents, the BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date12/20/10), does not provide instruction specific to the reporting of serious incidents and the monitoring team was not provided any other policy which included such instructions. According to Facility data provided in the Trend Report entitled Allegations of Physical Abuse, the following represents the numbers of allegations that occurred at the Facility from January 1, 2010 to 11/30/10: Total abuse allegations – 81 The disposition of these 81 cases included 2 administrative referrals back to the facility by DFPS, 12 confirmed abuse, 3 were noted as DFPS extended, 2 were determined inconclusive, 1 was referred for outside investigation, 5 were unfounded, and 56 were unconfirmed. According to Facility data provided in the document entitled Allegations of Neglect, the following represents the numbers of allegations that occurred at the Facility from January 1, 2010 to 11/30/10: Total neglect allegations – 27 The disposition of these 27 cases included 12 administrative referrals back to the facility by DFPS, 4 confirmed cases, 2 found to be inconclusive, 8 unconfirmed cases, and one pending. The pending case is 10-183, dated 7/14/10. BSSLC needs to inquire as to the status of this case. After the visit, the Facility reported that this case was an entry error.	

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		It was referred back to the Facility for investigation. A facility investigation was completed, and the entry in the database has been corrected. According to Facility data provided in the document entitled Allegations not Physical and Not Neglect, the following represents the numbers of allegations that occurred at the Facility from January 1, 2010 to 11/30/10: Exploitation – 2 Both cases resulted in an administrative referral back to the facility by DFPS. It should be noted that an administrative referral by DFPS back to the facility occurs when an allegation is reviewed and, in the opinion of DFPS, the allegation, if proven to be true, would not meet the statutory requirements to be considered abuse, neglect, or exploitation. Such allegations are referred back to the facility for administrative review and follow-up by the facility. Based on an interview of 10 staff responsible for the provision of supports to individuals, only one (10%) was able to correctly describe the complete reporting procedures for abuse, neglect, and/or exploitation. Based on an interview of 10 staff responsible for the provision of supports to individuals, 7 (70%) were able to describe the reporting procedures for other serious incidents. BSSLC provided a report entitled Incidents by Individual Since 12/2/09. From this report the monitoring team was able to determine the BSSLC had 29 serious injuries between 7/1/10 and the date of the report, 12/2/10. From this six were selected for sample D.2 – all serious injuries. Two samples of investigations were selected for review. These included: ▪ Sample #D.1 included a sample of DFPS investigations of abuse, neglect, and/or exploitation between 7/1/10 and 12/2/10. This sample included the following DFPS investigation reports 10-182, 10-197, 11-007, 11-027, 11-033, 11-037, 11-041, and 11-045. ▪ Sample #D.2 included a sample of Facility investigations between 7/1/10 and 12/2/10. Some of these were investigations that had been referred to the Facility by DFPS, while others were investigations the Facility completed related to serious incidents. This sample included the following investigations: 10-187, 10-207, 11-001, 11-024, 11-042, and 11-044.	

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		Based on a review of the 14 investigation reports included in both Sample #D.1 and Sample #D.2, six (43%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. The 8 that did not include: ▪ DFPS cases 10-197 and 11-037. Case 10-197 was reported to DFPS on 8/13/10 at 4:14pm. The date of the alleged incidents on this report were 8/12/10 and 8/9/10; the 8/9/10 incident was not reported timely. DFPS case 11-037 was reported to DFPS on 11/9/10. The date of the alleged incident was 10/30/10. ▪ The monitoring team could not validate reporting timeframes for the Facility UIR investigations (those in which abuse or neglect was not alleged or suspected) because the UIR form did not clearly display the date and time the alleged incident occurred from which a reporting time frame could be established. Data in the "intake Information" section may be intended to represent the date and time the alleged incident occurred. This is probably not a correct interpretation. For example, in UIR10-207 intake information stated the incident occurred at 7:05pm on 8/28/10. The injury was treated by medical staff earlier in the day, so this probably was not the time the alleged incident occurred. It was sometimes possible to determine the date and approximate time the incident occurred by reading through the detailed notes in section 7 of the UIR - Chronology of the Incident/Injury. For example, in UIR10-207 there was a long entry at 4:25pm describing a series of events involving the individual and peers. There was an entry at 4:45pm indicating a nurse was called to assess the injury, so a conclusion can be drawn that the injury occurred between 4:25pm and 4:45pm. This is not specific enough to enable the monitoring team to determine if reporting timeframes were met. The monitoring team believes the UIR document needs to have a clear entry to indicate the date and time of an alleged incident. ▪ Fourteen investigation reports (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. The Facility had a standardized reporting format which meets generally accepted standards with sufficient information necessary for adequate follow-up, as well as tracking and trending of incidents. Based on a review of 14 investigation reports included in Sample #D.1 and Sample #D.2, 14 (100%) contained a copy of the report utilizing the required standardized format. In reviewing clinical documentation during preparation of this report after the	

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		compliance visit, the Monitoring Team found one example in which reporting of an allegation of abuse was not done. Psychiatric Treatment Reviews for Individual #12 of 11/3/10 and 12/1/10 reported an incident described by the Individual who alleged that a staff "yelled" and "cussed" at him. This was not reported as an allegation of abuse by a consulting psychiatrist or by a staff psychologist who described this incident in their reports. When this was brought to the attention of Facility administration, they immediately ensured that it was reported for investigation.	
	(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.	According to BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date12/20/10), the facility staff are instructed to: 1. Take the necessary action to stop the Abuse, neglect, or exploitation and the action to remove the alleged perpetrator from contact with individuals. 2. Seek medical treatment (or assessment) for the victim as needed, comfort and reassure the victim. 3. Alert the Center Director, or designee, of the details of the incident. 4. Report the incident to DFPS within 1 hour and then record the details of the situation in writing including documenting on the Client Injury Report form (nursing staff). 5. Take appropriate steps to preserve and/or secure physical evidence related to an allegation if any (i.e. Take precautionary measure to prevent physical evidence from being destroyed, stolen, tampered with, etc.) Based on a review of 14 investigation reports included in Sample D.1 and Sample D.2, in every instance where an alleged perpetrator (AP) was known the AP was immediately placed in no contact status. In one neglect allegation, the staff involved in an accidental injury to an individual was immediately retrained to ensure proper use of an Arjo lift. Review of 14 investigation files included in Sample #D.1 and Sample #D.2, showed there were no instances where staff that had been removed from direct contact and subsequently reinstated after a well-supported preliminary assessment posed a risk to individuals or the integrity of the investigation. Based on a review of the 14 investigation files, it was documented that adequate additional action was taken to protect individuals in each case. For example: nursing assessments were done and treatment rendered as appropriate, alleged perpetrators were put in NDC (No Direct Care) status, retraining, and environmental conditions that could have created a safety hazard for other individuals were corrected.	Substantial Compliance
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10), requires that all staff complete class ABU0100 Abuse and Neglect, and UNU0100 Unusual Incidents at least yearly. These two classes are	Noncompliance

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	potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	sufficient to demonstrate compliance with the SA. A review of the training curricula related to abuse and neglect was carried out for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows: In relation to the requirement that training is competency-based, the material reviewed includes provisions for trainees to demonstrate their understanding of what constitutes abuse, neglect, and exploitation and how to report observations or suspicion of abuse, neglect, or exploitation. The material also includes adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. Review of 25 staff records (Sample #C.2), showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect and unusual incidents prior to working directly with individuals. Five staff (of the 25) were not current (within one year) with UNU0100 Unusual Incidents. Based on interviews with 10 staff: ▪ Four (40%) were able to list signs and symptoms of abuse, neglect, and/or exploitation with sufficient depth to demonstrate competency of understanding; and ▪ One (10%) was able to describe the complete reporting procedures for abuse, neglect, and/or exploitation. Refer also to the training related issues described in D.1 regarding reporting procedures.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10), does not include specific requirements associated with this component of the SA and the monitoring team was not provided any other policy which included such information. Copies were requested of the forms for staff hired during the two full months prior to the on-site review. Based on a review of those forms, 66 of 73 (90%) of staff hired during this time period had signed the DADS required acknowledgement form 1020. This is the form required by DADS policy to document compliance with this component of the SA. The Facility was able to present a similar document for the other 7 staff, either a memorandum from the Facility Director entitled "Abuse/Neglect/Exploitation Reporting	Substantial Compliance

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	Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	Obligations in which the employee attested to understanding their responsibilities, or a copy of policy directive 07-008 Dismissal for Abuse or Neglect, again requiring the employee acknowledgement signature, or a memorandum from the Facility Director entitled "Zero Tolerance Work Behavior Policy" which, like the others, required an employee acknowledgement. Nevertheless, this was not the document required by policy. The monitoring team cannot make a determination that alternative forms of documentation meet policy requirements. Therefore, the Monitoring Team finds Substantial Compliance but cautions the Facility to use the forms required by policy or provide evidence that alternative forms have ben approved. A sample of 25 staff (Sample #C.2) was randomly selected to determine if annual acknowledgements had been signed. Of the 25, 18 (72%) had signed annual acknowledgments form 1020. The other seven had one of the alternative documents described in the previous paragraph. It was reported to the monitoring team that the acknowledgment form 1020 (which the monitoring team considers as the approved documentation to comply with this element of the SA) was not kept on file at the facility but was sent to central office. The monitoring team did not, through interview and document review, find any instances of failure to report in the prior 6 months.	
	(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.	BSSLC engages in very limited activity directed at this component of the SA. Materials are provided to LARs prior to each individuals PSP meeting. Monitoring Team members attended numerous PSP meetings, which are identified in several Sections of this report. None of these meetings included any discussion of abuse, neglect or other reportable incidents. In interviewing a sample of six individuals, each were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. No serious incidents had been identified as being reported by an individual, their LAR, or others who were significantly involved in their lives.	Noncompliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10), does not include specific requirements associated with this element of the SA and the monitoring team was not provided any other policy which included such information.	Substantial Compliance

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	exercise such rights and how to report violations of such rights.	A review was completed of the posting the Facility used. It included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. Observations by the Monitoring Team of living units and day programs on campus showed that all of those reviewed had postings of individuals' rights in an area to which individuals regularly had access.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10), includes specific requirements associated with this element of the SA. These are found in section IV.F of the policy. Based on a review of eight allegation investigations completed by DFPS (Sample #D.1) DFPS had made law enforcement referrals in each case. Based on a review of six investigations completed by the Facility (Sample #D.2), law enforcement referral was not necessary or appropriate given the nature of the incident being investigated and the facts discovered during the course of the BSSLC investigation.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10), includes specific requirements associated with this element of the SA. These are found in section V of the policy. Based on interviews with the Facility Director and the Incident Management Coordinator it was clear retaliation would not be tolerated and this was reinforced in training and during the course of individual investigations. The monitoring team was provided with an instance of perceived retaliation investigated by the Office of Inspector General which documented appropriate reporting, investigation, and follow-up on the part of facility administration. Based on interviews with six individuals served by the Facility, all reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Sample #D.1 and Sample #D.2), there were no concerns noted related to potential retaliation. The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. The facility indicated it did not have such a list because the only incident of perceived retaliation was that noted	Substantial Compliance

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		above by the monitoring team.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Facility staff reported they have not as yet developed a process to work towards compliance with this component of the SA.	Noncompliance
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:	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA.	Noncompliance
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. The monitoring team review of this policy found it did describe in a comprehensive fashion the conduct of all such investigations; did require that investigators be qualified but did not specify any specific requirements that would cause an investigator to be deemed qualified such as successful completion of certain CTD or Labor Relations Alternatives classes; did require that investigators have training in working with people with developmental disabilities, including persons with mental retardation; and did require that investigators be outside of the direct line of supervision of the alleged perpetrator. The monitoring team did not review curricula used by DFPS in training its investigators and cannot comment on its content and whether or not it is competency based. Because DFPS case investigations reviewed by the monitoring team are generally thorough and comprehensive and case reports are generally well written the monitoring team believes, at least for now, the training DFPS investigators receives is achieving the desired results. BSSLC reported that Facility Investigator training is to consist of the following classes: ABU0100 Abuse and Neglect, UNU0100 Unusual Incidents, CIT0100 Comprehensive Investigator Training, and MEN0300 People with Mental Retardation. Staff designated as principal investigators also are required to complete the LRA training Conducting	Noncompliance

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		Serious Investigations and Root Cause Analysis. The monitoring team believes this training, if completed as described, should be adequate for the conduct of investigations at BSSLC. DFPS reports its investigators are to have completed APS Facility BSD 1 & 2, or MH &MR Investigations ILSD and ILASD depending on their date of hire. While not required it appears most investigators also take a class titled "MH&MR Overview – APS Investigator Role". Completion of this class would demonstrate training in working with people with developmental disabilities. DFPS has two investigators assigned to work BSSLC cases. The training records for these investigators were reviewed. Both completed the requirements for investigations training, including the MH/MR overview. BSSLC has two staff designated as principal investigators. The training records for these investigators were reviewed. Both have completed the required training with the exception of Root Cause Analysis (RCA). RCA was offered at Brenham in June, 2010 and, from the training roster reviewed by the monitoring team neither investigator attended. BSSLC has an additional 8 staff identified as investigators, primarily campus coordinators and program auditors. The monitoring team reviewed their training records. Four of the eight (50%) had not completed course CIT0100 Comprehensive Investigator Training. One of the eight (13%) was not current in UNU0100 Unusual Incidents. Five of the eight (63%) had not completed Root Cause Analysis. None of the staff designated as investigators have supervisory responsibilities and therefore are not in the direct line of supervision of anyone subject to investigation.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. This policy includes language directed at this element of the SA including the following language in section IV.A.3.e, f, and g: e. The director or designee shall require employees and agents to cooperate with DFPS investigators so that they are afforded immediate access to all records and evidence as necessary to conduct an investigation in a timely manner. f. The director or designee shall assist in whatever way possible to make employees and agents who are relevant to the investigation available in an expeditious manner. g. Employees who fail to cooperate with an investigation are subject to disciplinary	Substantial Compliance

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		action. As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Sample #D.1 and Sample #D.2, which consisted of DFPS investigations, and Facility investigations, respectively. ▪ Review of the investigation files in Sample #D.1 showed that in 8 out of 8 investigations (100%), Facility staff cooperated with DFPS investigators.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Eight of the 8 (100%) investigation records from DFPS (Sample #D.1). There was no evidence of interference by one agency or the other in any of these 8 case files. ▪ Of the six investigation records from the Facility (Sample #D.2), none had been referred to law enforcement agencies. All were serious injuries where there was no suspicion of abuse or neglect, and therefore would not be reported to DFPS or law enforcement.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence as well as three pieces of stored evidence secured in a locked file cabinet in the locked office of the Incident Manager's office. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2) any evidence that needed to be safeguarded was.	Substantial Compliance

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	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	The monitoring team was not provided with any policies directed at this element of the SA beyond the BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10). The monitoring team was provided with a list of approved BSSLC policies which did not include any policies directed at serious incidents in general, or injury reporting. The Protection from Harm policy did require that investigations commence within 24 hours or sooner, if necessary and be completed within 10 calendar days of the incident. The policy did not require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed outside of the 10-day period. The policy also references that time extensions are only to be considered under extraordinary circumstances. Policy also required that an investigation is to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: o Four of eight (50%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. The following were the investigations for which adequate investigatory process did not occur within the first 24 hours or sooner: Investigation 10-182: this is an allegation that was referred back to the facility as an administrative and clinical issue. The referral form notes the allegation having been reported on 7/10/10 at 4:05pm and the referral form being signed by the investigator on 7/12/10 (no time noted). It is not possible for the monitoring team to determine when this investigation (which resulted in a decision to refer the case back to BSSLC) began. Investigation 10-197 was reported to DFPS at 4:14pm on 8/13/10. The initial face-to-face with the alleged victim did not occur until 8/16/10 at 11:05am. Interviews of staff did not begin until 8/17/10. No additional documentation of other investigatory	Noncompliance

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		activities occurring within 24 hours of the report was provided. Investigation 11-027 was reported to DFPS at 3:00pm on 10/21/10. The initial face-to-face with the alleged victim was on 10/22/10 at 9:00am. The alleged victim was uncooperative, so no relevant information could be gathered. Staff interviews did not begin until 10/27/10. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided. Investigation 11-041 was reported to DFPS at 4:30pm on 11/11/10. The initial face-to-face with the alleged victim was on 11/12/10 at 2:10pm. The alleged victim was nonverbal and unable to provide information; therefore, no information to begin an investigation was gathered. Staff interviews did not begin until 11/23/10. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided. Six out of eight (75%) were completed within 10 calendar days of the incident. ▪ For the two that were not completed within 10 days, the Monitoring Team was not provided during the visit with documentation of approval of an extension by the Adult Protective Services Supervisor, and there was no documentation of the extraordinary circumstances that necessitated the extension. It is possible that such approval existed but the Monitoring Team could not confirm that. ▪ Eight (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In three of the investigations reviewed, recommendations for corrective action were included. In all three the recommendations were adequate to address the findings of the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ Six of six (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified of the serious incident.	

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		▪ Six of six (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. ▪ Six of six (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In all six of the investigations reviewed, recommendations for corrective action were included. In all six of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. The contents of the investigation reports reviewed were sufficient to provide a clear basis for its conclusion and the reports utilized a standardized format that sets forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o 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; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations:	Substantial Compliance

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	investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	▪ In eight of eight investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		
		▪ The report utilized a standardized format that set forth explicitly and separately
		o In eight (100%), each serious incident or allegations of wrongdoing;
		o In eight (100%), the name(s) of all witnesses;
		o In eight (100%), the name(s) of all alleged victims and perpetrators;
		o In eight (100%), the names of all persons interviewed during the investigation;
		o In eight (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In eight (100%), all documents reviewed during the investigation;
		o In eight (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;
		o In eight (100%), the investigator's findings; and
		o In eight (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of Facility investigations:
		
		▪ In six of six investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		
		▪ The report utilized a standardized format that set forth explicitly and separately
		o In six (100%), each serious incident or allegations of wrongdoing;
		o In six (100%), the name(s) of all witnesses;
		o In six (100%), the name(s) of all alleged victims and perpetrators;
		o In six (100%), the names of all persons interviewed during the investigation;
		o In six (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In six (100%), all documents reviewed during the investigation;
		o In six (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency
		o In six (100%), the investigator's findings; and
		o In six (100%), the investigator's reasons for his/her conclusions.	

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	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. Based on review of this policy it does require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent. The policy also requires that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ None of the eight case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. ▪ In all eight case files, there was evidence that the BSSLC Incident Manager Coordinator had conducted a review of the investigation report and that any concerns had been reported back to DFPS to correct deficiencies or complete further inquiry. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In all six investigation files reviewed there was evidence that the supervisor had conducted a review of the investigation report. ▪ In all six, there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry.	Noncompliance
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	BSSLC creates a report titled "A/N/E Committee Report" that documents review of each DFPS investigation report, any issues they may have with the report and follow-up action with DFPS, and concerns either DFPS had identified in the report, or the review group identifies, that require follow-up action on by the facility. This report becomes part of the official file for the particular incident. Standing members of this review group consisted of the Facility Director, the Incident Management Coordinator, and the Assistant Director of Programs. Other executive staff participate as needed.	Substantial Compliance

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	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. This policy requires disciplinary or programmatic action necessary to correct a situation and/or prevent recurrence to be taken promptly and thoroughly The Facility had a relatively effective mechanism for tracking and documenting such actions and the corresponding outcomes. Much of this occurs through the incident management review process that is supported primarily by daily unit meetings and the facility-wide daily IMRT meetings. IMRT agendas and minutes generally record and track intended actions until their completion and the expected outcome occurs.	Substantial Compliance
	(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 BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (approval date 12/20/10) is intended to address this provision of the SA. This policy requires the maintenance of investigation files to be easily accessible and to enable an investigator to quickly identify individuals and staff who have been the subject of prior investigations. A database is maintained to facilitate this process and file storage in the IMC's office is organized and up-to-date. The monitoring team did not probe whether DFPS has a similar process by which it can quickly access prior history of alleged perpetrators and alleged victims and will need to do so in the next review..	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	BSSLC produces a monthly Trend Report. The Abuse/Neglect Exploitation section of this report displays the number and type of abuse, neglect, and exploitation allegations for each month going back to state fiscal year 2009. This includes the number of cases referred to DFPS. Total allegations are trended for a rolling 12 months. The rolling 12 month data is also delineated by unit and by living area within each unit. Current month data also identifies alleged perpetrators and individuals involved in allegations. This data is trended for the past 3 rolling months. The monitoring team believes for this report to substantiate compliance with the SA all data should trended for the last 12 rolling months. Current month data on the report includes identification 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 investigations. This provides a good snapshot of the current month; however, these data are not trended over time, such as a rolling 12 month period. The monitoring team believes they must be in order to achieve compliance with this provision of the SA. The BSSLC produces a similar report tracking and trending injuries to individuals and Unusual Incident Reports. As with the ANE report both of these reports should be	Noncompliance

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		expanded to present rolling 12 month data for many data items presented for the current month only. The BSSLC recently established a Quality Assurance/Quality Improvement Council. The monitoring team observed a meeting of this group during the review. The Trend Report was presented but there was little discussion directed at interpreting the data in a meaningful manner that would cause substantive change in policy or practice. In fairness to the BSSLC this process for review had just started. The monitoring team suggests that trend reports be reviewed by QA/QI members before the meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantive discussion.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed with the Facility Director. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of October, 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that 11 employees had self-reported arrests since 7/22/10 and the facility had, or is in the process of, taking appropriate action.	Substantial Compliance

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		In an interview with the Facility Director, his decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, his decisions were based on the facts and were mindful of his responsibility to safeguard the individuals and staff of the Facility	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Abuse/neglect reporting procedures, and all training of staff associated with reporting procedures, must be in accordance with state policy.
2. State and BSSLC should define what training (specific classes) is required for Facility investigators to be considered sufficiently trained.
3. The UIR document should have a defined entry to display the date and time of an alleged incident that would enable SA monitoring of reporting timeframes to be properly measured.
4. The BSSLC policy on abuse/neglect/incident management should be expanded to cover each required element of the SA.
5. Investigatory activity should meet all timeframes required by policy and the SA.
6. Investigation reports should include all content, review, and approval elements required by policy and the SA.
7. Trend reports should display all data over a rolling 12 month period.
8. A policy and procedure should be developed to address section D.2.i of the SA.
9. BSSLC should expand competency checks of staff knowledge in order to demonstrate that training has produced competency in terms of staff knowledge and ability to implement what has been taught.

The following are offered as additional suggestions to the Facility:

1. The monitoring team suggests that trend reports be reviewed by QA/QI members before the meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantive discussion.

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. BSSLC Policy Quality Assurance Process - approval date11/22/10 2. BSSLC Policy Quality Assurance/Quality Improvement Council (QA/QI) - approval date 10/5/10 3. BSSLC Nursing Peer Review Policy – approval date 12/10/10. 4. BSSLC FY2010 Quality Enhancement Plan 5. BSSLC Program Improvement Council meeting minutes from 7/26/10 and 8/30/10 6. Initial training agenda for QA/QI Council 10/21/10 7. QA/QI meeting minutes 11/10/10 8. QA/QI meeting agenda and meeting handouts 1/11/11 9. Facility Trend Reports 11/30/10 10. Twenty-six monitoring tools currently in use by the QA department 11. BSSLC Plan of Improvement (POI) 12/29/10 12. DADS Regulatory reports (CMS 2567's) from 7/1/10 to date **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs 2. Susie Johnson, Settlement Agreement Coordinator 3. Debra Kollman, Incident Management Coordinator 4. Caitlin Connor, Program Compliance Auditor 5. Susan Aguilar, Independent Ombudsman 6. Jill Quimby, QE Nurse 7. Debbie Williams, Chief Nurse Executive 8. Shawn Cureton, M.S. Psychology Manager 9. Kathleen Williamson, M.Ed., Psychology Manager 10. 10 Direct Care Professionals (DCPs) **Meetings Attended/Observations**: 1. Facility Incident Management Team 1/10/11 2. Quality Assurance/Quality Improvement Council 1/12/11 3. Restraint Reduction Committee 1/13/11
	Facility Self-Assessment: The self-assessment provided by the BSSLC in its POI reported it was not in compliance with any of the provisions of this section of the SA. The monitoring team concurs. Significant positive steps have been taken since the first compliance review such as the development of several important policies that are in the process of being implemented. These include the BSSLC Policy Quality Assurance Process (11/22/10), the BSSLC Policy Quality Assurance/Quality Improvement Council (10/5/10), and the BSSLC Nursing Peer Review Policy (12/10/10). These are important steps but they have not, as yet, resulted in a cohesive organized system of reliable data collection, data analysis, and subsequent decision-making.

	Summary of Monitor's Assessment: The BSSLC has taken several important steps in Quality Assurance since the first compliance review. Three important policies have been developed, been approved by facility management, and are in the process of being implemented: BSSLC Policy Quality Assurance Process (11/22/10), BSSLC Policy Quality Assurance/Quality Improvement Council (10/5/10), and BSSLC Nursing Peer Review Policy (12/10/10). The Facility had created an organized methodology for use of monitoring tools and displays this is in a document (undated) titled FY2010 Quality Enhancement Plan. This identifies the monitoring tools in use, the frequency in which they are to be used, sample sizes, frequency of monitoring, and the person responsible to do the monitoring or see that it gets done. This process has been used long enough to be producing considerable summery data available for management review, although the reliability of these data needs review. The Facility had also initiated a process for staff competency checks. Program Auditors, on a regularly scheduled basis, test staff knowledge by interviewing staff at their worksite, using a standard set of questions that include an answer key from which the program auditor records whether the staff person gave a correct response. So far, staff competency checks are in place for: 1. Abuse/Neglect, and Exploitation 2. Aspiration 3. Restraint 4. Enteral Feeding 5. Sexual Incidents This process supplements a more formal monitoring process that includes use of monitoring tools for observation of actual staff performance (as opposed to just staff knowledge). This can be a good process to increase staff knowledge (and presumably staff performance) but a word of caution is in order. Summary data provided to the monitoring team indicated extremely high rates of correct answers. For example, mealtime monitoring showed compliance rates of 97%+. Active treatment monitoring showed similar positive performance. The observations made by the monitoring team during the review week, and the monitoring teams review of DADS Regulatory reports, suggests these data are not reflective of actual staff performance. This calls into question the reliability of these data and can cause the Facility to believe it does not have systemic issues to deal with or may be putting corrective plans in place that are not targeted at the actual problems the facility needs to address. Competency checks will only be useful if they are accurate and identify errors to be corrected and systemic errors needing process improvement. Finally, it should be noted that at the time of review the position of QA Director was vacant. The facility is in the process of filling this very important position.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. BSSLC produces a monthly Trend Report. The component sections of the monthly trend report include: 1. Allegations of Abuse/Neglect/Exploitation Trend Report 2. Facility Restraint Trend Report 3. Allegations of Abuse/Neglect/Exploitation Trend Report 4. Facility Injury Trend Report 5. Facility UIR Monthly Trend Report The Abuse/Neglect /Exploitation report displays the number and type of abuse, neglect, and exploitation allegations for each month going back to state fiscal year 2009. This includes the number of cases referred to DFPS. Total allegations are trended for a rolling 12 months. The rolling 12-month data is also delineated by unit and by living area within each unit. Current month data also identifies alleged perpetrators and individuals involved in allegations. These data are trended for the past 3 rolling months. The monitoring team believes for this trend report to substantiate compliance with the SA all data should trended for the last 12 rolling months. Current month data on the abuse/neglect trend report includes identification 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 investigations. This provides a good snapshot of the current month; however, these data are not trended over time, such as a rolling 12-month period. The monitoring team believes they should be in order to achieve compliance with this provision of the SA. The other trend reports generated by the BSSLC are similarly deficient in presenting rolling 12-month data which limits their usefulness in fully analyzing trends and targeting administrative actions which may be needed to address particular issues, especially systemic issues, in particular locations, at particular times, or with particular staff and individuals.	Noncompliance
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	The BSSLC recently established a Quality Assurance/Quality Improvement Council. Presumably this would be the deliberative body that would analyze data and initiate corrective action planning. The monitoring team observed a meeting of this group during the review. The Trend Report was presented but there was little discussion directed at interpreting data in a meaningful manner that would cause substantive change in policy or practice. In fairness to the BSSLC this process for review had just started. The monitoring team suggests that trend reports be reviewed by QA/QI members before the	Noncompliance

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	need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantives discussion. The limitations of the trend data discussed in E1 also need to be addressed to enable this group to engage in meaningful analytical activity. There was no evidence produced for the monitoring team to suggest analysis of data was leading to action plans to address systemic or reoccurring issues. This was evident from observation of the QA/QI Council meeting. Additionally, the POI indicated that Corrective Action Plans, and tracking corrective actions, are not yet in place and in the process of being developed. This was further validated through interviews with administrative staff. The QA/QI Council, as observed by the Monitoring Team and confirmed by review of the minutes, was primarily a forum for presenting information, including actions that had been taken. There were no new actions planned at this meeting that were identified through observation or in the minutes.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. The POI indicated that Corrective Action Plans, and tracking corrective actions, were not yet in place and in the process of being developed. This was further validated through interviews with administrative staff.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. The POI indicated that Corrective Action Plans, and tracking corrective actions, were not yet in place and in the process of being developed. This was further validated through interviews with administrative staff. This is true not only for corrective action plans developed through the QA/QI Council but also for corrective actions required in response to other audits. For example, no process was in place to verify that corrective actions arising out of audits of active records were completed.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. The POI indicated that Corrective Action Plans, and tracking corrective actions, were not yet in place and in the process of being developed. This was further validated through interviews with administrative staff.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility: 1. Continue to develop and implement the quality assurance plan making modifications to ensure it is producing reliable data. 2. Determine how to make the QA/QI Council more of a deliberative body identifying systemic issues and setting corrective action planning in motion, rather than merely receiving reports. 3. Establish a corrective action planning process that meets State policy. 4. Trend reports should be reviewed by QA/QI members before the meeting (rather than have them essentially read at the meeting) so that meeting time can be devoted to more substantives discussion.	**Recommenda**

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. BSSLC Policy Personal Support Plan Process approval date 12/10/10 2. PSPs and related documents for Individuals #1,, #9, #19, #33, #38, #53, #54, #81, #151, #246, #249, #273, #305, #332, #386, #358, #399, #407, # 427, #465, #475, #492, , #513, #556, and #573 3. Personal Focus Assessments (PFA) for four individuals: #20, #151, #294, #513, #457, #490 4. BSSLC Plan of Improvement (POI), 12/19/10 5. Personal Support Plan Meeting/Documentation Checklist (9/1/10) for Individuals #4, #237,#358, #379, and# 566 6. Report titled "Individuals and PSP Dates" 12/8/10 7. PBSPs and related documents for Individuals #7, #51, #261, #337, and #399 **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs 2. Juanita Taylor, QMRP Coordinator 3. Susie Johnson, Settlement Agreement Coordinator 4. Susan Aguilar, Independent Ombudsman 5. Shawn Cureton, M.S. Psychology Manager 6. 10 Direct Care Professionals (DCPs) **Meetings Attended/Observations**: 1. Quality Assurance/Quality Improvement Council 1/12/11 2. PSP Meeting for Individuals #19, #20, #294, #427, and #457 3. Personal Focus Assessment meeting for Individual #411 4. PST 30 day staffing for Individual #490 5. PST risk assessment meeting for Individual #5
	Facility Self-Assessment: The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. The facility recently (12/10/10) completed its policy on PSP planning and is beginning to improve some aspects of the PSP process although much of what was noted by the monitoring team as an improved practice was situational and not observed in enough instances to conclude that a generalized improvement throughout the facility had occurred.
	Summary of Monitor's Assessment: 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, much of the discussion is multidisciplinary, and decisions about treatment are often made in the absence of team discussion. The new PSP planning process had been initiated, and most staff had received training. For the most part, PST members were having difficulty understanding the concept of providing integrated services and the need for a comprehensive PSP that describes the individual's strengths and abilities, and then translating this understanding to a functional and meaningful program of services and supports. PSTs do attempt to discover and meet the preferences and needs of individuals; however, they seldom use a fully interdisciplinary process that results in an integrated approach to life planning with the individual. Staff who were needed because of specific areas of concern or support for individuals were not always present at planning meetings. As a way to identify preferences, the Facility had begun to implement the new PFA in December 2010. The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. 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. The new PSP planning process had been initiated, and most staff had received training. Implementation was at a very early stage.	Noncompliance
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	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. Each PSP planning session was facilitated by one person, the Qualified Mental Retardation Professional (QMRP). This is the position in the Facility organization who is responsible for ensuring the PSP is developed, monitored, and revised as needed. The	Noncompliance

	supports.	Facility had re-organized how this responsibility was carried out. In the past, the Facility had used facilitator positions, separate and apart from the individuals' QMRPs, to facilitate the annual planning meetings. The meetings were now facilitated by the QMRP, while the facilitators had been re-designated as Lead QMRPs. These latter staff currently served as QMRP for a small group of individuals, but had a primary role of assisting and coaching the QMRPs. This was a commendable concept, as the evidence described in other sections of this report, particularly in F2a and T1b, indicated the QMRPs often failed to guide the teams to develop well thought-out, integrated plans for treatments, services and supports at the PSP and PFA meetings observed during this site visit. The Lead QMRP observed did provide some assistance, but did not demonstrate sufficient competency in the process to be an effective coach as of yet. The Lead QMRPs had received 40 hours of training on the Supporting Visions curriculum and have been certified as instructors to teach the classes at BSSLC, but much additional training will be required. For this provision to be in compliance, not only does this need to be facilitated by one person, but also team members must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year. This did not always occur., as indicated by the following examples: • Provision F1b notes that physicians and psychiatrists often did not attend PSP planning sessions or participate fully. • Provision K5 reports that intellectual and adaptive behavior assessments were not routinely provided as needed. • Provision R1 reports many records that indicated no participation by the SLP in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP. This provision also provides examples in which supports designed to improve or augment existing language were not provided.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. The teams ordinarily consisted of the individual and/or LAR or a family member who does not have guardianship, clinicians representing specific services, and direct care staff. The Facility had begun to implement the new Personal Focus Assessment (PFA) in December 2010, which was intended to ensure the PSP would be centered on the needs, preferences and personal goals of the individual. For the only PFA held during the week of the site, both the individual and the individual's parents attended the PFA meeting. The monitoring team also requested an additional sample of PFAs to review, but it was not possible to assess the quality and level of participation as often the signature sheets were not included.	Noncompliance

		There did not appear to be an expectation of direct involvement from other significant disciplines at the PSP meeting. A physician and psychiatrist did not always attend the PSP meeting. The monitoring team identified three instances of the presence of a physician at a PSP meeting during the site visit. For one of the three, the physician displayed a lack of familiarity with the process by a stated uncertainty as to whether or at what point living options would be discussed, and by a lack of knowledge as to what "SSO" (Staff Service Objective) stood for. For Individual #294, who had numerous medical conditions on the active problem list, a physician was not present at the annual PSP meeting. The PST was unaware of several of the medical conditions, including a history of intestinal parasites that could be related to rectal digging. Without the presence of the physician or recognition of the potential contribution of parasites to rectal digging, a PBSP for that behavior was initiated. 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 facilitate quality discussion and for good decision making. PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff. In 0 of 19 records reviewed (0%), 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 #427's PSP where recommendations were read with no discussion provided by the PST. Examples of where individual PNMPs were not developed with input from the IDT included: o There was no evidence of staff participation during the development of PNMPs for Individuals #33, #54, #81 and #305 o No discussion of PNMPs by the PST; refer to discussion of Individual #427 above. In 21 of 21 records reviewed (100%), there was documentation that the PNMPs were reviewed annually at the PSP meeting but as mentioned above, there was no active discussion of the plan. SLPs did not actively participate in all facets of care in which communication was relevant. For example:	

		• 15 of 23 records indicated no participation by the SLP in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP. An example is Individual #475 team discontinued the communication dictionary without the presence of the SLP.	
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.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. As a way to identify preferences, the Facility had begun to implement the new PFA in December 2010. Prior to that time, the Facility used the Personal Focus Worksheet to obtain information regarding personal goals and preferences to be used to develop a person-centered plan. The goal of this new process was to ensure that individuals' preferences formed the basis for the goals, objectives, anticipated outcomes, services, supports, and treatments of the individual's own PSP. The PFA is completed at the time of the third quarterly review. A review of four PFAs and attendance at a portion of the single PFA meeting held during the week of the site visit indicated the process was not yet conducted with sufficient quality to reliably identify the individual's strengths, preferences and needs. Four of the four PFAs were incomplete, with many questions and even whole sections left blank. For the one PFA meeting attended during this site visit, for Individual #411, the QMRP and the rest of the team were clearly not yet comfortable with the process nor proficient at eliciting preference information from individuals who are not verbally fluent. In many instances, the QMRP simply asked the question written on the PFA form, regardless of whether the question was meaningful to or understandable by the person. This was particularly true for questions such as whether the individual had "any goals we can help you achieve." When there was no response to this question, the team simply moved on to the next question. The PSTs need to receive substantially more training in how to use the PFA as a tool to guide a conversation, rather than as a rote completion of a checklist of questions. With that said as the overall impression of the PFA meeting, the monitoring team appreciated that the PST for Individual #411 did use the process effectively to have a thoughtful discussion about the individual's diet texture preferences and how the team might support her to attempt an upgraded texture. Some assessments are scheduled routinely, such as DISCUS and MOSES assessments of medication side effects. Others are scheduled annually as part of the PSP process. Others, such as formal preference assessments and functional analyses, are done intermittently or on an as needed basis. Assessments must be done not only as scheduled but also in response to what might be significant changes in an individual's life. Refer to Provision H1 for examples. In general, scheduled assessments were done timely; annual assessments were, for the most part, completed, MOSES/DISCUS	Noncompliance

		assessments were nearly all done as scheduled, and quarterly nursing assessments routinely meet timelines. However, as noted in several Sections of this report, not all assessments met current, generally accepted standards or the requirements of the SA. Some assessments were either not done or were not timely; for example, many individuals receiving psychiatric services did not have psychiatric assessments, and intellectual and adaptive behavior assessments were not within accepted timelines. The schedule for completing Communication assessments is far too delayed. Furthermore, there were examples of assessments that should have been done but were not routinely scheduled or were not done as the individual's status changed. Several of these related to Physical and Nutritional Management (PNM). For example: • Based on the review of 16 individual records, 16 of 16 who were enterally nourished revealed these individuals did not receive an annual assessment that addressed potential pathways to oral by mouth (PO) status. Examples of individuals who received enteral nutrition and did not receive an appropriate annual assessment: Individuals #26, #79, #305, #83, #453, #343, #413, #570, and #461 received an assessment but no discussion or plan for possible pathways to PO intake or increased PO intake. • While the PNM status is scheduled to be regularly reviewed during the PST quarterly meetings, there was no clear indicator that status is reviewed by the team in the event of a change in status. For more detail, please refer to Provision O.1. • Two of seven individuals reviewed for having increased or decreased BMI did not have nutritional assessments. Examples of individuals who did not have their nutrition adequately assessed: o Individual #9 has a BMI greater than 40 but had no formal nutritional assessment. o Individual #61 has a BMI greater than 35 but does not have an assessment. There were several examples of change in acute health care status that were treated symptomatically, but in which the changes in status did not trigger further assessment. These are described in Provisions L2 and M1. Based on a review of 8 individual records, documentation supported that the PNMT 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. For example: • Individual # 305 had aspiration pneumonia on 10-17-10 and 12-28-10 with no evidence of discussion by the PNMT. • Individual #81 had aspiration pneumonia on 11-17-10 with no evidence of discussion by the PNMT.	

		• Individual #78 had aspiration pneumonia on 10-20-10, 11-1-10, and 11-7-10 with no evidence of discussion by the PNMT.	
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.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs Examples can be found in several provisions of this report in which assessments were not completed according to current, generally accepted standards, or in which the services and supports in the PSP do not match the findings of the assessment. • There should be concordance between diagnosis, relevant behavioral symptoms and psychotropic medications. Provision J13 provides examples in which the diagnosis did not match the behavioral symptoms being monitored (that is, the behavioral symptoms did not match criteria for the diagnosis that was the basis of medication selection). • As noted in Provision K5, adaptive assessments results included only the provision of scores without interpretation or identification of strengths and limitations. • Most, but not all, communication assessments showed improvement in comprehensiveness. However, the plan to complete assessments would include significant delays, so that these assessments would not be available to provide information for the PSP in the near future.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. While DADS policy and the SA explicitly state that the decision of the LAR regarding community placement is to be honored, the ADA and Olmstead decision call for a person to be served in the most integrated setting appropriate to their needs as determined by qualified professionals unless the individual (or LAR) specifically objects. The monitoring team attended five PSPs and reviewed 13 PSPs completed since the new process began in 10/10, as measures of how this new process may have impacted the PSTs' implementation of this requirement of the SA. For five of five PSPs observed during the monitoring visit, and for 10 of 13 PSPs reviewed, the PST failed to adequately consider and provide an assessment, by qualified professionals, of the most integrated setting appropriate for the person. The PSTs largely deferred their own assessment of the most integrated setting appropriate for the individual in light of the guardians' or family's opposition to community placement or preference for the individual to remain living at the Facility. Examples include: • Individual #19, when asked where he would like to live, identified a church he had attended with his family member, the LAR. The LAR stated that she would not be able to care for him if he moved to her home and that she felt he was best	Noncompliance

		served at BSSLC. No further discussion of other living alternatives was held. Several barriers to movement to a more integrated environment were discussed, including his advancing dementia, which the PST indicated would mean he could not be served in a community setting. There was no discussion of investigating the availability specialized dementia services. • Individual #20, a teenager with a guardian, stated several times throughout the PSP meeting the desire to live in a group home or family foster home. The parents were opposed. PST did not have any discussion with the individual about why this living environment was preferred, nor discuss the potential living options or Permanency Plan with the parents. The PST did not identify any obstacles, yet agreed that BSSLC was the least restrictive environment. Even in the case of objection by the parents, the professionals on the PST are required to assess and make recommendations on movement to a more integrated environment; this was not done. • For Individual #513, another teenager with a guardian, the PST found there were no obstacles to community placement, but noted the parent/guardian preferred the individual remain at BSSLC. The PST then determined the most integrated setting at the current time was that the individual should remain at BSSLC at the request of the guardian. Even in the case of objection by the parents, the professionals on the PST are required to assess and make recommendations on movement to a more integrated environment; this was not done, even though, in this case, only a preference to remain (not a specific objection to referral) was stated. • For Individual # 492, the PST appeared to define the individual's Optimistic Living Vision as BSSLC, based upon the individual's response to the CLOIP review of living options, which was to walk away, as well as the family's stated preference that the individual remain at BSSLC. The team then noted there were no obstacles keeping the individual from this optimistic vision. The team did not provide any information regarding their determination of the most integrated setting even though, elsewhere in the PSP, the team documented the individual had been on visits to two group homes during the past year and was very excited by them, and that the sister had requested to visit a group home with the individual. It is recommended that PSTs receive additional instruction as to their responsibilities to complete a professional assessment of the most integrated setting appropriate for each individual as well as additional training in how to implement those responsibilities.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and	The self-assessment provided by the BSSLC in its POI reported it was in compliance with this provision of the SA. The monitoring team does not concur. The self-assessment provided by the BSSLC in its POI reported it was not in compliance with each component	Noncompliance

	procedures that provide for the development of integrated ISPs for each individual as set forth below:	of this provision. Consequently, it cannot be in compliance with the provision.	
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 self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs.	Noncompliance
	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;	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. For three of three PSPs attended by one member of the monitoring team, the PST did not sufficiently address barriers to community living, as detailed in section T1b, nor was community participation sufficiently encouraged, For example, Individual #20, a teenager, stated during the PFP that she would like to go to visit some of her friends from school in their homes. The team's response was that (1) the individual would have to wait to be asked, and (2) that the individual could not ask the friend to invite her. Notwithstanding that this was an expectation that was inconsistent with normal teenager social behavior, the team also failed to suggest any alternatives to a visit to a friend's home, such as suggesting that a friend might be asked to meet the individual at the mall or for a meal or some other community activity.	Noncompliance
	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;	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. For three of three PSPs attended by one member of the monitoring team, the PSTs failed to adequately develop individualized goals and action plans. Although there was a new PSP process in place, the PSTs observed developed plans for the coming year that had essentially the same action plans as the year before. In some instances the PSTs did not exhibit an awareness of what was included in the current plan. Examples include: • Individual #20 is a teenager whom the monitoring team has observed over the course of the past year. Considerable progress in the areas of appropriate social behavior and communication was evident during this year's meeting. The individual expressed a number of desires and preferences during the PSP meeting which the team did not adequately address. The individual expressed a desire to attend the Boys and Girls Club. The team agreed later in the meeting to look into it. No member of the team expressed any awareness that this was discussed and included in last year's PSP as an Action Plan. A review of the individual's record later revealed no action taken other than a single note that a	Noncompliance

		referral to Program Services had been made on 1/22/10. Similarly, the PST discussed whether swimming might be of interest to the individual and suggested it would obtain a swimming assessment. The team expressed no awareness that a water safety assessment had been completed in 12/09. A review of the record also revealed the individual went swimming at the aquatic center with peers and staff on 8/10/10. The eventual outcome of this PSP was that most of the action plans were the same or a slight variation of the past year's plan. • For Individual #294, the action plans developed were nearly identical to those from the past year, including manipulation of musical instruments, an SSO for community outings, pulling his pants up, bathing, putting clothes in a hamper, toothbrushing and engaging in a preferred activity. The PST also recommended continuing a Positive Behavior Support Plan for rectal digging, which included the wearing of a jumpsuit garment at night. As described above, the PST was not aware of a medical history that might be indicative of a need for medical treatment as opposed to behavioral intervention. Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. For example, Individual #20 expressed a desire on several occasions during her PSP meeting to move to a community setting. In light of the parent's opposition, the PST chose not to have any meaningful discussion with the individual about this desire or what criteria might lead to the possibility of such a move at some point in the future. The PST did not discuss nor develop any action plans around the barriers to the individual's expressed desire to live in a group home or family home in the community.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. There were numerous examples in which services and supports were not coordinated and integrated with other services and supports. Some examples include the following: • Individual #294 had numerous medical conditions on the active problem list. One of those was a history of intestinal parasites. The individual also engaged in rectal digging. With no discussion of the potential relationship of intestinal parasites to rectal digging, a PBSP for that behavior was initiated. • PSPs contained reference or a brief statement of an individual's communication skills but did not provide integration of the utilized devices or strategies into existing action plans resulting in a decreased opportunity for generalization and/or acquisition of skills. • The Facility did not routinely integrate the special education services that children living at BSSLC receive with the Facility PSP. For 3 of 3 PSP meetings	Noncompliance

		held, and for 3 of 3 PSPs reviewed during the site visit for individuals under the age of 22, there was no information available regarding the goals, objectives and services found in the IEP, nor any coordination with such. Examples include: o For Individual #20, there was no discussion in her PSP meeting of the IEP or the specific goals and objectives, nor was there a representative from the school present. The IEP in the individual's BSSLC record indicated objectives in the areas of, and that the individual has attained considerable skills in, areas such as: keeps area neat, has good social skills; follows directions; cares for materials; attends to task for periods of 10 minutes; adds and subtracts with a calculator; reads aloud and answers questions about story; writes in complete sentences; and has personal interests and hobbies. These skills and goals and objectives were not reinforced at all in the PSP developed for this individual. The team did not ask the individual directly what she was working on or learning in school. At one point the individual stated she would like to attend a certain university, but no one on the team responded to this assertion. Toward the conclusion of the PSP meeting, the parents were asked if there were any other things they would like the individual to work on, and the mother suggested some of the things being worked on at school, such as reading a menu. The PST did not provide any further discussion nor develop any action plans in this regard, o For Individual # 490, there was no IEP information available at the 30-Day meeting. It was reported that a new IEP was to be developed in the near future, but there was neither team discussion as to the individual's previous experience in school, nor any input as to recommendations for the upcoming IEP. No member of the team asked the individual about her educational or vocational goals. o For Individual #513, there was no mention of the IEP or the individual's experiences at school, other than one mention that the individual did not like to make her bed before leaving for school. o For Individual #427, the team members, other than the direct contact employee who routinely works with the individual, were grossly unaware of the individual's use of spoken language while at school and the communication programs implemented at the school. Furthermore, although the Individual was to complete school within 5 months, the team members had not included post-education plans into the assessments or training programs. BSSLC should ensure that the PSP and the IEP are fully integrated and that goals and objectives are developed to reinforce the learning opportunities in both settings. Whenever possible, BSSLC should hold PSP meetings at times that school representatives	

		can attend, and should ensure that a representative who is familiar with the individual attend IEP meetings.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. For example, at the time of the site visit, DADS had not finalized how assessments for skill acquisition programming, such as a CFA or task analysis, were to be conducted at the State Supported Living Centers. Without guidance on approved assessment instruments and strategies, the Facility was unable to go forward with revisions to the actual skill acquisition plans, including teaching procedures, time frames and responsible staff. Five PBSPs reflecting the latest practices of the Behavior Services department were reviewed. These PBSPs and Structural and Functional Assessments (SFAs) involved Individual #7, #51, #261, #337 and #399. • Zero of 5 PBSPs (0%) included strategies addressing setting event and motivating operation issues. In several of the PBSPs, there were included general guidelines for preventing or avoiding the undesired behavior. The difficulty here was that the SFAs did not involve specific procedures for identifying motivating operations, setting events or antecedents. Without the inclusion of these elements in the assessment, any prevented steps in the PBSP were based upon guesses and were unlikely to provide meaningful benefit. • Zero of 5 PBSPs (0%) included strategies addressing antecedent issues. • Four of 5 PBSPs (80%) included strategies that involved the teaching of desired replacement behaviors. • Zero of 5 PBSPs (0%) included strategies to weaken undesired behavior. The strengthening of replacement behaviors can, if a true functional relation exists, weaken the undesired behavior. It most scenarios, however, it is essential to involve complementary procedures for strengthening desired behavior and weakening undesired behavior in the same intervention plan. This increases the probability of success and increases the efficiency of the behavior change process. None of the PBSPs reviewed at BSSLC included such procedures. • Zero of 5 PBSPs (0%) included a specific description of data collection procedures. • Five of 5 PBSPs (100%) included treatment expectations and timeframes written in objective, observable, and measureable terms. It was not clear, however, upon what data such comparisons were to be based. • Five of 5 PBSPs (100%) included clear, simple, precise interventions for responding to the behavior when it occurs.	Noncompliance

	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. For Individual #20, the PST agreed in the PSP to continue a money management program to identify items that could be purchased that would equal $3.00, but to modify it by increasing the number of verbal prompts provided from three to six. The team did not consider whether the training program itself might not be effective. A review of the record revealed that this program was to have been implemented at least weekly throughout the year. The data collection sheets for the months of 1/10-10/10 revealed the individual was only offered training for a total of ten times during this period. It was unlikely that adequate learning of the skill could occur in those circumstances, regardless of the number of verbal prompts offered. Of particular concern was the PBSP for Individual #337. The target behavior for this individual was inappropriate sexual touch. Throughout the SFA, the predatory and covert aspects of the Individual's behavior were used as a reason not to carry out an actual functional assessment. No effort to identify specific motivating operations, setting events or antecedents was described in the SFA, although the narrative described potential factors that were worthy of further investigation. Of special interest was the statement that, if data are correct, the behavior has occurred only twice in 7 years, but staff reported that this might be happening more often; the Facility did not attempt to develop observation protocols to identify whether there were additional instances. No functions for the behavior were identified, and it remained unclear whether the behavior was reinforced by sexual pleasure, aggression, or a health condition. Due to the stated lack of assessment information, the behavior intervention consisted of blocking and redirecting the behavior. Furthermore, no assessments specific to sexual offending and its treatment were carried out; there were no assessments of risk of re-offense or of factors that can direct treatment such as such as social skills, triggers for sexual excitement, and stimuli or conditions that can serve as establishing operations/motivating operations/setting events that increase likelihood of inappropriate sexual behavior and must be addressed in treatment.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. • Zero of 5 PBSPs (0%) included a specific description of data collection procedures. • One of 5 PBSPs (20%) included baseline or comparison data. Although historical data were included in several PBSPs, it is important to recall that baseline data are data collected under specific conditions that provide for specific pre- and post-treatment comparisons. Too often data selected from an arbitrary point in time or that reflect an ideal treatment outcome are labeled as baseline data. Such	Noncompliance

	person(s) responsible for the data review.	practices obscure rather than reveal treatment effects.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. Although the new PSP process had led to greater interdisciplinary discussion during planning meetings, the PSPs developed at those meetings were not substantially different from those developed in prior years. Several examples of lack of integration are described in Provision F2 item a.3. These include initiation of a PBSP for a behavior that might be related to a medical condition, without consideration of the medical condition; and lack of integration of communication skills into other services such as PBSPs and vocational goals, even when communication goals are found in an IEP,	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. Seven of ten direct care professionals indicated the PSP was written in a manner that was understandable to them and they found the document useful in knowing what their responsibilities were with respect to individuals under their care. The other three staff indicated the PSP was written in a manner that was understandable to them but were unable to provide any examples of how the document was of assistance to them in understanding things about the individual and carrying out their daily responsibilities. Staff were able to find PSPs and necessary information in the Active Record and individual notebook. Nevertheless, staff were, at times, not familiar with the contents of the PSP. For example: • DCPs interviewed were not knowledgeable of the communication programs. • As noted in Provision P3, staff did not implement PSPs accurately. • As reported in Provision S3, observations documented little activity in both homes and day programs. There was no evidence that the PSPs guided staff actions to engage individuals.	Noncompliance
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. For the most part, PST members responsible for each service or support documented review monthly. There were instances in which either that documentation was not available or there was no change in the service or support although documentation indicated lack of progress over an extended time without action being taken by the PST. • For Individual #502, the 2010 PSP included a SSO for the individual to be provided with opportunities to go on an outing at least weekly and to practice	Noncompliance

	interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	money management skills if he chooses to do so. The monitoring team requested documentation of these activities. The evidence provided consisted of the Quarterly reviews, which indicated the service was provided, a copy of the SSO, which indicated the method of documentation was to be the Program Data Sheets, and a single blank Program Data Sheet for the SSO. • For Individual #20, the PST did not take action as needed when the individual's money management training program failed to progress as an apparent result of a lack of consistent implementation. It also remained unclear, based upon provided information, that available data were used to identify the need for enhanced assessment or revised PBSPs. Records reflect that behavior data graphs were reviewed on a monthly basis in some context. It was not clear, however, that the interdisciplinary team was involved in this review process, or that the review produced meaningful changes in intervention strategies or behavior. This lack of a data-based process for treatment decisions is reflected in the examples below. • In 2 of 20 "best work" examples provided by the Behavior Services staff (10%), substantial increases in targeted behaviors did not result in revised behavioral intervention plans. • Individual #196 was diagnosed with autism and was prescribed Risperdal, Tenex and Ativan targeted at aggression and self-injury. Reports from the psychologist indicated that the majority of aggressive and self-injurious behaviors were associated with a lack of meaningful activities and other environmental factors. Due to elevated prolactin levels, an effort was made to supplant Risperdal with Seroquel. When withdrawal dyskinesia and aggression spiked after the discontinuation of the Risperdal, the decision was made to add a third antipsychotic medication without further exploration of environmental factors. • Individual #12 was diagnosed with Organic Mental Syndrome Secondary to Fetal Cocaine Exposure and was prescribed Pexeva, Benadryl, Seroquel, Risperdal and Tenex to address aggression, depression and hyperactivity. Narrative documentation provided by the psychologist described episodes of staff "confronting" and "yelling at" the Individual, followed by aggression and self-injury by the Individual. The record reflected no effort to formally assess the role of staff actions in the displays of undesired behavior by the Individual.	
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	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. To be in compliance with this component the facility must demonstrate that the initial training provided to new employees, and refreshers at 12 month intervals, is competency	Noncompliance

	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.	based, and that every employee has completed the training. The Facility had begun to provide training on a new PSP process for staff responsible for the development of individuals' PSPs. According to the Report to Monitors provided at the entrance meeting, 352 staff had been trained in the new process. The training curriculum was reviewed. There was not a competency evaluation component. Additionally, the facility must also be able to demonstrate that individual staff members responsible for working with a particular individual have received competency based training on the implementation of that specific individual's program plan, and additional competency based training whenever that plan is revised. The definition of competency-based training in the SA reads "…the provision of knowledge and skills sufficient to enable the trained person to meet specified standards of performance as validated through the persons' demonstration that he or she can use such knowledge or skills effectively in the circumstances for which they are required." The monitoring team believes that competent staff performance, on the job, is the critical variable in determining compliance with this component of the SA. There are numerous examples throughout this monitoring report of staff not adhering to policy, not engaging individuals (active treatment), not intervening appropriately in behavioral issues, and not intervening appropriately at mealtime which suggests much improvement is needed in training curricula, training delivery, or competency testing, or, all three.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. From a report generated by the Facility and provided to the monitoring team in a document request, the monitoring team identified 18 of 329(6%) individuals for whom a PSP was not put in place within 30 days of its preparation. For this analysis the monitoring team viewed preparation of the PSP as taking place on the day of the meeting with the expectation that the plan be initiated within 30 days of the date of the PSP meeting. While some of these 18 were only a few days in excess of 30 days for 10 of the 18 the time period between plan preparation and implementation exceeded 45 days. These were individuals #160, #404, #475, #101, #316, #238, #32, #273, #35, and #46. For two of these individuals it was nearly 2 full months between the PSP meeting and PSP implementation.	Noncompliance
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this component of the SA. The monitoring team concurs. The Facility used the Personal Support Plan Meeting/Documentation Checklist as a	Noncompliance

	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.	quality assurance tool to identify and remediate problems to ensure PSPs are developed and implemented consistent with the provisions of section F of the SA. The completed checklists reviewed by the monitoring team, and summary reports prepared by the QA Department did not reveal the scope or number of issues the monitoring team observed in PSP meetings attended. This suggests more rigorous training of monitors, and more rigorous monitoring, is needed to achieve compliance with this component of the SA.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Fully Implement DADS policy on PSP planning.
2. Consider criteria and methods by which to include necessary professional clinicians in PSP meetings where such attendance is important to future planning for the individual.
3. Improve methods for data collection, tabulation, and use for all program plans.
4. Review the assessment process to ensure individuals receive necessary assessments and reassessments as their circumstances change.
5. PSTs should receive additional instruction as to their responsibilities to complete a professional assessment of the most integrated setting appropriate to each individual per the ADA and the Olmstead decision, and additional training in how to implement those responsibilities.
6. The PSTs need to receive substantially more training in how to use the PFA as a tool to guide a conversation, rather than as a rote completion of a checklist of questions.
7. BSSLC should ensure that the PSP and the IEP are fully integrated and that goals and objectives are developed o reinforce the learning opportunities in both settings. Whenever possible, BSSLC should hold PSP meetings at times that school representatives can attend, and should ensure that a representative who is familiar with the individual attend IEP meetings.

The following are offered as additional suggestions to the Facility:

1. In implementing the new policy consider some type of peer review process to facilitate good learning across teams.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Plan of Improvement updated 12/29/2010 2. BSSLC Outline of Section's (sic) Presentations dated 01-10-2010 3. BSSLC Policy Personal Support Plan Process revised 11-22-2010 4. BSSLC Policy Physician Procedures and Best Practice Guidelines approved 10-18-2010 5. Active Record for Individual #19 6. PSPs, CLDPs, and other documents reviewed by members of the monitoring team 7. Consultation reports for individuals #12, #26, #29, #59, #95, #138, #160, #187, #403, #428, #475, #499, #570, and #576 **People Interviewed:** 1. Bret Hood, MD, Director of Medical Services 2. Interviews with various discipline staff by the members of the monitoring team **Meetings Attended/Observations:** 1. PSP meeting for Individual #19
	Facility Self-Assessment: The Facility reported that it was not in compliance with either provision of this section. The Facility reported that committees have been established to integrate services. The Monitoring Team concurs that these committees had begun to function. The Facility reported implementation in December 2010 of a communication form for physicians to document action plans following review of consultation reports. The Monitoring Team did not find any of these in its sample, probably due to the recent implementation. The Facility should be aware that Provision G1 is not limited to physician review but requires "the appropriate clinician" to review recommendations from non-Facility clinicians.
	Summary of Monitor's Assessment: BSSLC had implemented a number of steps to begin integration of clinical services. New interdisciplinary committees were established to integrate planning on drug utilization, physical and nutritional management, and oversight of psychoactive medication. Although the Facility reported new procedures for review of recommendations from non-Facility clinicians, no documentation based on this new procedure was available in the consultation reports reviewed by the Monitoring Team. Documentation of review and of consideration of the recommendations was variable.

#	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.	Efforts had been made to improve integration of clinical services, but there remains a need for significant action to continue this improvement process. Improvements included the initiation of new committees to bring together various disciplines for decision-making and action around specific issues. • The Drug Utilization Evaluation (DUE) Committee had been implemented. Under drug utilization review, the Clinical Pharmacist has provided high quality educational venues on three select medications. The result of this venue has been well received by physician services and has had a positive impact on prescribing practices at the Facility. • BSSLC had developed a Physical and Nutritional Management Team (PNMT). The team consists of an Occupational Therapist (OT), Physical Therapist (PT), Speech-Language Pathologist (SLP), Physician (MD), Nurse (RN) and Dietitian (RD). The PNMT held meetings weekly (10 total) and as of this review had completed and reviewed five comprehensive assessments for five individuals. • The Facility organized a Psychoactive Medication Oversight Committee (PMOC) and monthly meetings began on 11/29/10. Participation in PMOC included key staff and disciplines, such as medicine, psychiatry, psychology, pharmacy, and nursing. This committee had already contributed to coordinated care, and its reviews of polypharmacy had produced changes in prescribing. The new PSP Planning policy had been implemented. Although at early stages of implementation, with much improvement needed, it has the potential to provide opportunity for increased integration of services. The PNMT had reviewed five individuals and the assessments reviewed were comprehensive and demonstrated active collaboration through multiple disciplines. Dr. Hood reported that physicians are now responsible for specific sections of the SA. This was seen as a way to make them more aware of the requirements and the need for integrated planning. Physicians are expected to attend more PSP meetings, Psychiatric Treatment Review (PTR) meetings, and neurology clinics. In addition to the review of polypharmacy, other integrated clinical activities had begun. For example, procedures for the use of dental pre-treatment sedation were clarified in policy, and the responsibilities of various disciplines were established for coordinated care and safety. In addition, the Dental Office had collaborated with other disciplines to implement suction toothbrushing as one action to reduce aspiration pneumonia. Also, OT/PT assessments routinely showed collaboration between the disciplines and included signatures and date of both OT and PT.	Noncompliance

#	Provision	Assessment of Status	Compliance
		In collaboration with physician and nursing services, Pharmacy Services developed a process and provided training that had essentially eliminated the writing of scripts, dispensing and administering of medications to persons with documented allergies. Another very impressive improvement is, under the direction of Pharmacy Services, and in collaboration with physicians, a methodical and clinically appropriate process was developed to review and provide on-going review of all persons on select classes of medications with the result of a significant reduction in the number of less desirable medication being prescribed. Nevertheless, integration of clinical services had not yet become regular practice. Per discussion under provision J8, combined case and assessment and formulations between the various behavioral health disciplines (psychology, psychiatry and others such as occupational therapy) were not in place. PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff. **N**one of the records reviewed documented that PNMPs were clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). PNMPs were included in PSPs and were reviewed at PSP planning meetings, but there was no evidence of integrated discussion. This was evident during PSP planning meetings where recommendations were read with no discussion or input provided by the PST. BSSLC Policy Physician Procedures and Best Practice Guidelines paragraph under Physician Documentation Requirements requires that "Specific medical orders will be written detailing the monitoring that the physician expects from the nursing staff for ongoing assessment of the acute problem." As identified in Provision L1, there were examples in which the physician did not write specific detail about monitoring. For example, for Individual #294, there was no written order to monitor signs of dehydration; note that this example occurred before the policy was implemented. The requirement to write details of monitoring is important; if implemented as required, it will help ensure timely action when the status of an acute health condition changes. In this policy, under Meeting Requirements for Physicians, there are requirements for the physicians to "provide medical assistance/information to the PSPs" but no requirement for attendance or participation at PSP planning meetings.. As reported in Provision F1b, physicians were not always present at these meetings and, when present, did not always participate fully. The Hospital Liaison Nurse continued to visit individuals in the hospital and/or	

#	Provision	Assessment of Status	Compliance
		maintained regular contact with hospital personnel, and kept the other integrated team members informed of hospitalized individuals' health status. SLPs did not actively participate in all facets of care in which communication relevant. For example: • 15 of 23 records indicated no participation by the SLP in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP. An example is Individual #475 team discontinued the communication dictionary without the presence of the SLP. Additionally, five of six individuals who experienced potential aspiration indicators noted during monitoring were not consistently shared with nursing or Habilitation Therapies. For example: • Individuals #50, #57, #403, #449, and #475 experienced multiple coughing events during a meal but there was no evidence of nursing or habilitation therapy notification.	
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.	This Provision was not in compliance because documentation of review and of consideration of the recommendations was variable and showed no involvement of the PST in accepting or rejecting recommendations or integrating them into the plan for services and supports for individuals. Consultations were reviewed in the Medical records for 14 individuals. These consultations covered a range of medical disciplines. For 11 of 14 individuals (79%), the consultations reviewed showed documentation of review by the Facility clinician. Of the consultations that included such documentation, six of 11 (55%) documented agreement with the recommendation, none documented rejection of the recommendation, and five (45%) did not document acceptance or rejection (in most cases, documentation for these was simply initial and date by the clinician, signifying review). One consultation did not document review by the Facility clinician but did document referral to the PST (however, the PST did not meet to review the recommendation). Per discussion under provision J1 there are now monthly telephone conferences with clinicians from other DADS facilities. However, there were currently no arrangements for non-Facility clinician to provide consultations with recommendations.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Involve physicians, including psychiatrists, more actively in PSP planning meetings when indicated by the preferences and needs of individuals served.
2. Develop or revise Facility policy to specify expectations and procedures for integrated services. Ensure that each policy related to treatment planning reflects the need for integration across disciplines.
3. Establish a process and guidelines for referral of recommendations from non-Facility clinicians to the PST.
4. Develop and implement procedures for review and decisions regarding recommendations from non-Facility clinicians.
5. 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.

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Plan of Improvement updated 12/29/2010 2. BSSLC Outline of Section's (sic) Presentations dated 01-10-2010 3. BSSLC Policy Personal Support Plan Process revised 11-22-2010 4. BSSLC Policy Physician Procedures and Best Practice Guidelines approved 10-18-2010 5. PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in sections below **People Interviewed:** 1. Bret Hood, MD, Director of Medical Services 2. Interviews with various discipline staff by the members of the monitoring team **Meetings Attended/Observations:**
	Facility Self-Assessment: The Facility reported compliance with Provision H2 and noncompliance with the other provisions. The Facility also provided information on actions that had been implemented or were in process. For Provision H1, the Facility reported that psychiatric assessments are being done for new admissions, Reiss Screens are being done, and the PNMT is meeting regularly. These are positive steps but do not yet address the issue of performing assessments as behavioral and health status of individuals changes. For Provision H2, the Facility reported development of a policy that addresses diagnosis. This appears to be the same policy described below for Provision H7. Based on this, the Facility assessed that it was in compliance. The Monitoring Team disagrees. The prevalence of "NOS" psychiatric diagnoses does not meet the required standards yet. Psychiatric diagnoses otherwise did show progress toward generally meeting the standard. For Provision H7, the Facility reported that a policy on integrated clinical services had been developed and implemented. The Monitoring Team requested the policy; the relevant policy that was provided was titled Physician Procedures and Best Practice Guidelines. Although this policy does provide guidance to physicians, it does not provide guidance on integrated clinical services to all disciplines, nor does it establish requirements for interdisciplinary interaction between physicians and other clinicians beyond providing information and assistance to PSPs.
	Summary of Monitor's Assessment: There was a great deal of variability across disciplines regarding completion of assessments. Some disciplines generally completed assessments timely and some scheduled assessments were done as scheduled, others were not.

	Furthermore, changes in behavioral and health status did not routinely trigger assessments and evaluations. Interventions were not always implemented or revised as clinical indicators showed a change in status. A new behavioral data system was a significant step toward having and using indicators of behavior change to identify efficacy of interventions and to trigger new evaluation and revision of those interventions. A new policy provides guidance to physicians on standards for care and monitoring and addresses integrated planning. The policy does not provide guidance on integrated clinical services to all disciplines, nor does it require interdisciplinary interaction beyond providing information and assistance to PSPs.

#	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.	The Facility was not in compliance with this provision. Although many assessments were performed on an appropriate and regular basis (for example, Comprehensive Nursing Assessments and MOSES/DISCUS assessments), others were not performed regularly (for example, intellectual and adaptive behavior assessments). Some assessments are scheduled routinely, such as DISCUS and MOSES assessments of medication side effects. Others are scheduled annually as part of the PSP process. Others, such as formal preference assessments and functional analyses, are done intermittently or on an as needed basis. Assessments must be done not only as scheduled but also in response to what might be significant changes in an individual's life. In general, scheduled assessments were done timely; annual assessments were, for the most part, completed, MOSES/DISCUS assessments were nearly all done as scheduled, and quarterly nursing assessments routinely meet timelines. However, as noted in several Sections of this report, not all assessments met current, generally accepted standards or the requirements of the SA. Some assessments were either not done or were not timely; for example, many individuals receiving psychiatric services did not have psychiatric assessments, and intellectual and adaptive behavior assessments were not within accepted timelines. The schedule for completing Communication assessments is far too delayed. Based on review of OT/PT tracking spreadsheet, all individuals had received an OT/PT assessment and/or screening. This was validated via review of 12 records for completed OT/PT assessment/screening. There were numerous examples in which assessments were not done in response to changes in an individual's status. For example: • Provision M1 documents symptomatic treatment in the absence of further	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment of health status for Individuals #344 and #505. • As reported in Provision P1, record review of individuals who had experienced a change in health or physical status found that five of eight individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. • Based on a review of 8 individual records, documentation supported that the PNMT 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. For example: o Individual # 305 had aspiration pneumonia on 10-17-10 and 12-28-10 with no evidence of discussion by the PNMT. o Individual #81 had aspiration pneumonia on 11-17-10 with no evidence of discussion by the PNMT. o Individual #78 had aspiration pneumonia on 10-20-10, 11-1-10, and 11-7-10 with no evidence of discussion by the PNMT. Psychiatric (re) assessments continued to be done at PTR's and annual Psychiatric Medication Reviews. Updated information on the individual's response to psychiatric treatment was not included in the PBSP medication section. Section XI of the Comprehensive Nursing Assessment (Nursing Summary) primarily consisted of raw clinical data, statements to continue Health Maintenance Plans, and lists of recommendations and goals as opposed to stating whether individuals' health status were progressing, maintaining, or regressing in relation to their established goals. The summary section of the nursing assessment should provide a clinical analysis of the raw data from the previous sections. To determine individual's health status, data should be compared to the previous quarter's assessment regarding the individual's progress related to their health and behavioral goals.	
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	The Facility reported compliance with this provision. The Monitoring Team finds that the Facility does not yet comply. Psychiatric diagnoses were consistent with the Diagnostic and Statistical Manual of Mental Disorders. " For example the Facility updated a diagnosis for individual #12 from "organic mental disorder secondary to (named substance) exposure," to "mood disorder secondary to (name substance) exposure." The change made the diagnosis consistent with DSM IV. However, the use of "Not otherwise Specified" diagnoses was still unacceptably high. Comprehensive Nursing Assessments did not contain nursing problems written in the	Noncompliance

#	Provision	Assessment of Status	Compliance
	Related Health Problems.	North America Nursing Diagnosis Association (NANDA) format. They did not consistently contain nursing diagnoses for Health Risk Scores greater that one, or include nursing diagnoses for stable but chronic conditions listed on the Medical Active Problem List for which they were receiving medical interventions	
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.	Although many interventions were provided timely, there were examples in which treatments and interventions were delayed or were not changed when the individual's health or behavioral status changed. Furthermore, the lack of appropriate assessments made judgments on clinical appropriateness difficult for both the Facility and the Monitoring Team. For example, although an improved procedure for Structural and Functional Assessments had been put into place, most PBSPs were not based on adequate functional assessments. As an example of timely intervention, OT/PT plans were developed within 30 days of the date of the assessment/update. Examples in which intervention was not timely include: • For individuals who were restrained for behavior issues more than three times in a rolling 30-day period, the Facility did not provide documentation that treatments and interventions had been revised. • Fourteen out of 16 records reviewed indicated individuals with identified language difficulties were not receiving active Speech Treatment or participating in a Speech program. Examples of Individuals with identified Speech or language difficulties not receiving services included: o Individuals #160, #86, #434, and #473 had severe language disorders, had not received a comprehensive evaluation and did not have communication goals. o Individual #390 has decreased communication. The QMRP stated that another assessment would be requested since the last Speech Assessment was conducted in 1992. There is no evidence that this was provided. • As exemplified by the reports in Provision M1 for Individuals #334 and #505, nursing staff and physicians failed to recognize and appreciate acute changes in health status and provide or seek aggressive and timely medical intervention..	Noncompliance
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and	The Facility reported it does not comply with this provision. Actions that have been taken include collaboration between psychiatry and psychology to track through the PBSP symptoms of diagnoses. The Facility reported other efforts continue. Nevertheless, for many individuals, symptom monitoring, needed for assessment of	Noncompliance

#	Provision	Assessment of Status	Compliance
	interventions shall be determined in a clinically justified manner.	treatment efficacy, was not in place (please refer to section J, provisions J3, J6, and J13 for detail). BSSLC had implemented substantial changes to the behavioral data collection and monitoring process. A new data collection form and process had been implemented facility-wide in October 2010. The data collection form was redesigned. The new form used partial-interval data collection rather than narrative reporting, which presented the potential for increased data reliability. While the move from narrative to interval data collection was a step in the desired direction, the Facility needs to continue to develop data collection tools. In other areas, there had been less progress in identifying and tracking clinical indicators of efficacy. For example, while PNMPs are reviewed when there is an identified problem, a significant change in status, or at the PSP, there was not a system in place that clearly monitored the effectiveness of the plan by tracking the occurrence or absence of triggers associated with physical and nutritional decline. A new process was beginning to be implemented that would allow for the tracking of triggers as well as subsequent review. This process was just starting and as of this review only two had been completed. This process will be reviewed again at the next visit.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Collaborative reviews by both psychiatry and psychology took place at psychiatric treatment reviews. Clinical data from behavioral ratings was often absent (please refer to section J, provisions J3, J6 and J13 for detail). A policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted did not exist at RSSLC. The newly developed Physician Procedures and Best Practice Guidelines provides guidance to physicians, but standards need to be broadened to all health disciplines. While the PNMP monitoring system was designed to address mealtimes and have multiple professionals involved, a policy or process was not fully developed that included: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Identification of monitors and their roles and responsibilities, o Monitors are re-validated on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms are correct and consistent among various individuals conducting the monitor, and	Noncompliance

#	Provision	Assessment of Status	Compliance
		o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	A new behavioral data system and pilot of a database for entry and review of data reflected progress toward meeting the requirements of the SA. At the time of the site visit, however, the database remained in the pilot phase. Furthermore, many objectives included a variety of behaviors for which a single data measure was taken. Because the same interventions might have varying effects on different behaviors that are in different functional classes, grouping the target behaviors into one aggregate data point may mask the effects of the intervention. The new database system did not reflect a process for focusing upon specific treatment targets or functional classes of behavior. Without useful data to evaluate efficacy of interventions, it is difficult to assess when they should be modified. The examples of lack of response to changes in health status for Individuals #334 and #505, as described in Provision M1, indicate that there are failures to modify treatments and interventions in response to changes in clinical indicators.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The Facility had established two policies that could be considered relevant to this Provision. The PSP Process policy established procedures to develop an integrated PSP. As reported in Sections F and T, implementation had begun but significant improvement was needed to ensure full clinical participation in decision-making done in an integrated manner. The Facility reported in the POI that a policy on integrated clinical services had been developed and implemented. The Monitoring Team requested the policy; the relevant policy that was provided was titled Physician Procedures and Best Practice Guidelines. Although this policy does provide guidance and sets standards for physicians in a number of areas, it does not provide guidance on integrated clinical services to all disciplines, nor does it establish requirements for interdisciplinary interaction between physicians and other clinicians beyond providing information and assistance to PSPs. For example: • In the section on Aspiration Pneumonia, the policy points out that oral hygiene and positioning are factors which protect people from aspiration pneumonia but does not give guidance to the physician on how to work with other disciplines to include these in an integrated health plan to minimize risk of aspiration pneumonia. • In the section on Prevention, the policy mentions "holistic approaches to wellness" that "integrate all aspects of the human experience" and that	Noncompliance

#	Provision	Assessment of Status	Compliance
		"healthcare professionals and other IDT members should promote high-level wellness" but does not give guidance on process to integrate that planning.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Develop quality assurance procedures to assess whether changes in health or behavioral status are addressed promptly by assessment and, as appropriate, change in treatments or interventions.
2. Revise the new physician practice policy to increase emphasis on interdisciplinary interaction and planning.
3. Each discipline should identify clinical indicators that can be selected by clinicians and PSTs.
4. Monitoring should be put in place to determine whether clinical indicators are discussed at PSP planning meetings and other clinical review meetings.

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. DADS Policy 006 At Risk Individuals 12/29/10 2. BSSLC Plan of Improvement (POI) 12/29/10 3. Integrated Risk Rating Form for Individuals #59 and #138 (both dated 1/5/11) 4. PSP for Individual #19 **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs 2. Kori Kelm, Director of Habilitation Therapies 3. Susie Johnson, Settlement Agreement Coordinator 4. Susan Aguilar, Independent Ombudsman **Meetings Attended/Observations**: 1. PST risk assessment meeting for Individual #5 2. Facility Incident Management Team 1/10/11 3. Quality Assurance/Quality Improvement Council 1/12/11 4. Restraint Reduction Committee 1/13/11 5. PST 30 day staffing for Individual #490
	Facility Self-Assessment: The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this section of the SA. The monitoring team concurs. The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. The monitoring team had an opportunity to review the first two risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the BSSLC.
	Summary of Monitor's Assessment: The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. The monitoring team had an opportunity to review the first two risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the BSSLC. The risk assessment system used prior to implementation of the new policy continued to inaccurately assess risk levels for individuals. This was the operative policy for nearly all of the time period for this compliance review, A concern with the new procedure is that the risk guidelines provided to QMRPs were based primarily on the history of the indicator occurring and not on indicators that lead to an increased risk. Guidelines need to be expanded to promote proactive review of risk. The monitoring team looks forward to a review of the implementation of the new policy at its next review.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. The state established a new at risk policy dated 12/29/10 to be effective 1/1/11. The monitoring team had an opportunity to review the first two risk rating assessments completed under the new policy and believes the new process is much more likely than the old process to accurately reflect risk levels for individuals living at the BSSLC The risk assessment system used prior to implementation of the new policy continued to inaccurately assess risk levels for individuals. This was the operative policy for nearly all of the time period for this compliance review, Individuals who are at an increased risk of physical and/or nutritional decline remained not accurately identified. The system that was in place incorrectly identified individuals who are at an increased risk. Examples of individuals not being appropriately identified include: • Individual #97 had a choking incident on 9/2/10 but was listed as being at a low risk. • Individual #33 had aspiration pneumonia three times over the past year but was listed as being at a medium risk of aspiration. • Individual # 305 had aspiration pneumonia on 10/17/10 and 12/28/10 but was listed as being at a medium risk of aspiration. • Individual #576 had seven falls occurring from 10/1/10 to 12/26/10 but was listed as being at a medium risk of injury. BSSLC did have a new risk process but the risk process and its accuracy in identifying those individuals who are at an increased risk could not be fully assessed at this time as the risk process had just been implemented at BSSLC; therefore, the first opportunity for a thorough review of the new process to determine if compliance has been established will come at the next visit. The monitoring team did have the opportunity to observe a risk meeting as well as review two individuals who had undergone the new risk process. Records were reviewed for individuals #59 and #138 along with risk levels and two of two accurately identified the level of risk. The meeting observed contained active collaboration and brainstorming regarding factors that affect the level of risk and is a significant improvement over the previous format. There was no physician at the meeting; therefore, medical issues could not be discussed, which was a significant portion of the agenda.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Another concern of the monitoring team was the risk guidelines that were supplied to the QMRPs. The risk guidelines were based primarily on the history of the indicator occurring and not on indicators that lead to an increased risk. For example; in order to be listed as being aspiration high risk, the individual must have experienced aspiration in the last year. No indicators such as COPD, constipation or being dependent for oral feeding that are known to increase the risk are represented in the guidelines. It is a concern that as time progresses, the team will begin to rely solely on the written guidelines rather than include clinical judgment in ensuring appropriate determination of risk level. Guidelines need to be expanded to promote proactive review of risk.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. Based on a review of 8 individual records, documentation supported that the PNMT 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. For example: • Individual # 305 had aspiration pneumonia on 10-17-10 and 12-28-10 with no evidence of discussion by the PNMT. • Individual #81 had aspiration pneumonia on 11-17-10 with no evidence of discussion by the PNMT. • Individual #78 had aspiration pneumonia on 10-20-10, 11-1-10, and 11-7-10 with no evidence of discussion by the PNMT.	Noncompliance
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, 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	The self-assessment provided by the BSSLC in its POI reported it was not in compliance with this provision of the SA. The monitoring team concurs. The at risk policy in place until 1/1/11 failed to accurately assess an individual's risk status. The policy in place as of 1/1/11, based on initial review by the monitoring team, is more likely to make an accurate assessment. The State has established an ambitious time schedule for initial implementation of the new policy. This scheduled called for all individuals to be assessed using the new policy by 3/31/11, and, any individual who is believed may be at high risk to be assessed by 1/31/11. Individuals who have had aspiration pneumonia and those receiving enteral nutrition will be assessed by 1/31/11.	Noncompliance

#	Provision	Assessment of Status	Compliance
	plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.		

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Implement DADS Policy 006 – At Risk Individuals.
2. Develop a BSSLC policy that operationalizes the DADS at Risk policy.
3. Ensure that appropriate assessment and revision of the PSP is done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented.
4. As the new At-Risk process evolves, assessment guidelines should promote proactive review of risk as well as addressing risk indicator events that have already occurred.

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. BSSLC Plan of Improvement (POI) 12/29/10 2. For the following individuals:. #1, #3, #9, #061, #50 #058, #061#009, , #112, #173, #316, #399, #427, #488, #493, #173, #488, #493, #3, #399, #502, and #058, #427, #112, #538, #1, and #50: Comprehensive reviews of Social History Evaluations, Individual Problem Lists (active and inactive), Personal Support Plans (PSP) and PSP addenda, Specific Program Objectives (SPO) with related progress notes, Positive Behavior Support Plans (PBSP), Positive Behavior Support Committee (PBSC) and Human Rights Committee (HRC) reviews of PBSPs / psychoactive medications, Psychiatry section of the chart, Pharmacy Annual Evaluation, the three most recent Quarterly Drug Regimen Reviews (QDRR), most recent Annual Physician Summary, Health Risk Assessments, Hospital Risk Assessments, Hospital Admission section of the chart, any pre-treatment sedation assessments, MOSES/DISCUS side effect screens for last nine months, the Neurology section of the chart 3. Psychiatry evaluations for the following individuals: #1, #3, #9, #11, #12, #13, #19, #20, #23, #33, #35, #39, #52, #58, #62, #65, #66, #67, #75, #76, #88, #112, #127, #139, #144, #163, #167, #173, #181, #185, #191, #196, #207, #221, #229, #230, #246, #255, #264, #305, #312, #342, #349, #358, #370, #377, #390, #398, #399, #400, #407, #417, #425, #427, #467, #471, #484, #490, #492, #493, #502, #513, #528, #536, #538, #543, #547, #556, #568, and #589 4. A list from the dental clinic of all individuals who received oral pre-treatment sedation (oral or intravenous) or total intravenous anesthesia (TIVA) during 2010 5. A list of all current medical and dental desensitization plans Medical and dental desensitization plans for the following individuals: #30, #33, #45, #50, #51, #113, #120, #140, #141, #283, #294, #330, #332, #370, #398, #562, #594, and #598 6. A list of all individuals screened with the Reiss screen Reiss screens for the following individuals: #8, #34, #54, #89, #93, #206, #283, #294, #337, #339, #428, #445, #508, #574, #548, and #595 7. A list of all individuals treated with Reglan 8. A list of all individuals screened for tardive dyskinesia (TD) 9. A list of all individuals diagnosed with tardive dyskinesia 10. PTR, PBSP, and PBSC/HRC reviews for new medications for the following individuals: #2, #50, #112, #173, #184, #196 (two medications), #397, #425, and #538 11. PSP addenda regarding review of multiple episodes of restraint for individuals #3, #61, and #399 12. Written descriptions of the new Psychoactive Medication Oversight Committee (PMOC) and minutes of meetings for the last three months 13. Written descriptions of Facility Integrated Review of Medication (FIRM) from September 2010 14. Minutes, Pharmacy and Therapeutics Committee (P&TC) 15. Curricula vitae, medical licensure and professional credentials, all Facility psychiatrists 16. Lists of all individuals treated with interclass or intraclass polypharmacy, with medication names and

	doses. 17. BSSLC Policy and Procedure: Medical and Dental Restraint 18. BSSLC Form: *Consent for Use of Psychoactive Medication for Behavior Support.* **People Interviewed:** 1. Terry Hancock Ph.D., Chief Psychologist 2. Sergio Luna, MD, Staff Psychiatrist 3. Brenda McCarty, RN, Staff Nurse 4. Victoria Morgan, MD, Lead Psychiatrist 5. Julie Weidemann, Dental Hygienist 6. Linda Wellman, RN, Staff Nurse 7. Debra Williams, RN, CNE **Meetings Attended/Observations:** 1. PSP meetings, individuals #502, #102, and #457 2. Quality Assurance/ Quality Improvement (QA/QI) meeting (1/11/2011) 3. PMOC meeting (1/12/2011)
	Facility Self-Assessment: The Facility reported that it complied with the provisions of SA provisions J1 (qualified professionals). The monitoring team concurred, and found that the Facility was in substantial compliance. The Facility reported compliance with provision, J2 (evaluation and diagnosis by a psychiatrist prior to psychotropic medication prescription). In the comments on status section, the Facility noted the current staffing level of two full time equivalent (FTE) psychiatrists. However, the monitoring team found that many individuals did not have the needed evaluations and concluded that the Facility was not yet in compliance. The Facility reported compliance with provision J5 (sufficient number of psychiatrists to ensure the provision of services). In the comments on status section, the Facility noted that the vacant position for psychiatry has now been filled. However, the monitoring team found that the Facility had not demonstrated its capacity to ensure the provision of needed services, and the team concluded that the Facility was not yet in compliance. The Facility reported compliance with provision J14 (informed consent). In the comments on status section, the Facility clarified that the Psychiatry Department had revised and implemented a new consent form for psychotropic medications. However, the monitoring team found that the procedures in place were not yet fully compliant with the requirement of the provision, and concluded that the Facility was not yet in compliance. The Facility reported that progress was made in the areas of Reiss screen administration (provision J7), integration of psychology and psychiatry, (provision J9) polypharmacy oversight (provision J11), medication treatment plans (provision J13), and coordination of care between neurology and psychiatry (Provision J15). The Facility did not self assess compliance in these areas. The monitoring team concurred

	that progress has been made in these areas. Following review, the monitoring team found the Facility had achieved substantial compliance for Provisions J11, J12, and J15.
	Summary of Monitor's Assessment: **For provision J1:** The provision was determined to be in substantial compliance: The Facility had hired a third qualified psychiatrist. This brought the psychiatry group up to staffing at a combined effort level of two full time equivalents (FTE). Psychiatrists actively and appropriately participated in the interdisciplinary process, except that they had not yet begun routinely to participate in the annual PSP meetings, which they plan to begin doing. **For provision J2:** The provision was determined to be not in compliance. The Facility reached a staffing level that that ensured that evaluation and diagnosis could be done in a clinically justifiable manner, but many individuals do not have an evaluation in place. The facility had taken initial steps to establish a process of review and improvement for psychiatric assessments. **For provision J3:** The provision was determined to be not in compliance. All individuals who were prescribed psychotropic medication had treatment plans, all had working psychiatric diagnoses, and there was no evidence that medications were used for the convenience of staff or for punishment. Additionally, monitoring team observations of meetings showed that there was active member participation. However, in many cases the medical record did not document a rationale for the use of psychotropic medications, and in many cases there was no concordance between diagnoses, relevant behavioral symptoms, and psychotropic medications. **For provision J4:** The provision was determined to be not in compliance. The Facility had developed needed procedures for medical and dental pre-treatment sedation. The procedures outlined measures taken to assure safety during the period of sedation, and measures taken to minimize or eliminate the need for the pre-treatment. However, the monitoring team was not able to confirm that all individuals who received pre-treatment sedation had the required plans in place, the team found that the plans that were in place were often very general, and the team found that there was no process in place to evaluate the effectiveness of the plans. The new procedures required that data on pre-treatment sedation rates would be reviewed at the Restraint Reduction Committee, but such reviews had not yet started. **For provision J5:** The provision was determined to be not in compliance. The new psychiatrist had just started, and it was not possible to determine whether or not the Facility has sufficient staff to ensure the services needed to fulfill the requirements of the SA. **For provision J6:** The provision was determined to be not in compliance. The Facility started to use the Appendix B format for psychiatric assessment diagnosis and case formulation, but only six evaluations had been completed. **For provision J7:** The provision was determined to be not in compliance. Reiss screens were

	administered to all individuals who required them and no individuals from this group were identified to meet criteria for psychiatric assessment. Of the individuals currently treated by psychiatrists, psychiatric assessments meeting the requirements of Appendix B were not yet in place for many individuals. **For provision J8:** The provision was determined to be not in compliance. The monitoring team confirmed that behavioral data were considered in decisions regarding pharmacological treatments. However, a process was not in place to provide integrated behavioral care through combined assessment and case formulation. **For provision J9:** The provision was determined to be not in compliance. The absence of integrated case formulations was exacerbated by the fact that no process was in place to determine which behavioral treatments were most likely to be most effective for an individual. **For provision J10:** The provision was determined to be not in compliance. The Facility planned to have PSTs--including primary care physicians ((PCPs), psychiatrists, and nurses--assess risks and benefits of proposed medications, and consider treatment alternatives. However, such meetings were not in place at the time of the tour. **For provision J11:** The provision was determined to be in substantial compliance. The Facility had established a psychoactive medication oversight committee, and that committee had started to meet. The group monitored polypharmacy practices, including sufficiency of documentation of rationale. The committee will monitor the reduction and elimination of psychotropics that are not clinically justified. **For provision J12:** The provision was determined to be in substantial compliance. The Facility had established a process for facility-wide monitoring of side effects, in conjunction with the psychoactive medication oversight committee. **For provision J13:** The provision was determined to be not in compliance. The Facility had started a new system for psychotropic medication treatment plans. However, these plans reviewed lacked clear rationales for the proposed treatments, and did not identify appropriate behavioral symptoms for treatment monitoring. **For provision J14:** The provision was determined to be not in compliance. The Facility started a new process for psychotropic medications consent, but not all parts of the process were in place. **For provision J15:** The provision was determined to be in substantial compliance. The Lead Psychiatrist attended neurology clinics, review and oversight of medications prescribed by both neurology and psychiatry were in place, and a process was being developed, to allow the contract neurologist to collaborate with the consulting neurologist.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The Facility employed three psychiatrists. In December 2010, Dr. Sergio Luna joined the Facility as a full time staff psychiatrist. Dr. Luna had been oriented to the psychiatric service and had assumed an active caseload. Dr. Morgan assumed responsibility for Facility-wide oversight of psychiatric services, and was active in setting up monitoring in the areas of polypharmacy and medication side effects. She also helped organize monthly conferences with psychiatrists in other DADS facilities. These conferences were part of a required review and improvement process for psychiatric evaluations. Dr. Chacko continued her part time work as a contract psychiatrist. Dr. Chacko has been employed by the Facility for many years. The credentials of all three psychiatrists met the requirements of the Settlement Agreement (SA). The psychiatrists participated in the IDT process through Personal Support Team (PST) meetings, participated in meetings of the Medical Department, and they participated in various facility committee meetings. The Facility planned for the psychiatrists to participate in annual PSP meetings but they did not yet do so.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	Psychiatric services were provided to 168 individuals. The Department of Psychiatry provided the monitoring team with copies of all psychiatric evaluations done in recent years. There were seventy such evaluations, and all were reviewed by the monitoring team. Most of the evaluations were completed in 2008 or later, and a few were completed earlier. The monitoring team determined that fifty-eight of these evaluations were sufficiently detailed to be the basis of clinically justifiable diagnoses. The Facility has now started to do psychiatric evaluations in the format required by Settlement Agreement (SA) Appendix B, and to date has completed six such evaluations. . The SA requires that a process of review and improvement should be in place, to ensure that evaluations and diagnoses were carried out in a clinically justifiable manner. Dr Morgan helped assure that monthly telephonic conferences were in place. These conferences were attended by psychiatrists from the various DADS facilities, and informal case conferences were part of the format for the discussions. Although significant progress was made in the area of psychiatric diagnosis and assessment, the monitoring team found that the Facility was not in compliance, due to the large number of individuals who did not have psychiatric evaluations.	Noncompliance
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	The medical records of the 15 individuals selected for comprehensive review were examined. All individuals reviewed received psychotropic medications, and all had working psychiatric diagnoses. There were no indications that medications were prescribed for the convenience of the staff, or as punishment. Medical records were examined, to determine whether clinical rationales were provided,	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>for each of the psychotropic medications given to the individual. Documents examined included PBSPs, psychiatric evaluations, psychiatric treatment review (PTR) notes, and PBSC/HRC Reviews. None of the forms used at the Facility required the psychiatrist to provide a clinical rationale. PTR notes (although not PBSPs) contained tables that indicated the psychiatric diagnosis that was linked to the psychotropic medication. Sometimes, that information was all that was needed to understand why the medication was prescribed/proposed. Examples were prescriptions of antidepressants for individuals diagnosed with depression, or prescriptions of hypnotics for individuals diagnosed with insomnia. Other times, however, the name of the medication and the diagnosis did not provide sufficient information, to understand why the medication was proposed. Examples included prescriptions of antipsychotics or mood stabilizers for individuals diagnosed with Pervasive Developmental Disorder (PDD). Most often, the best way to understand why psychiatrists chose particular medications was to read the psychiatrist's comments in the integrated progress notes (IPN) or in the dictations they made during PTRs.

The table that follows summarizes the monitoring team's assessment as to whether the rationale for the use of psychotropic medication could be deduced from information contained in the various sources discussed above. The listing of medications and associated diagnoses follows the tables contained in PTR notes.

<table>
<tr><th>Individual</th><th>Diagnosis</th><th>Medication</th><th>Rationale (*)</th><th>Monitoring team comments</th></tr>
<tr><td>#538</td><td>Anxiety Not Otherwise Specified (NOS), PDD NOS</td><td>Zoloft</td><td>I</td><td rowspan="2">NOS diagnoses needed re-evaluation and/or clarification</td></tr>
<tr><td></td><td></td><td>Trazadone</td><td>I</td></tr>
<tr><td>#1</td><td>Autism
ADHD
Impulse NOS</td><td>Depakote</td><td>N</td><td rowspan="5">The reason for the use of the NOS diagnosis and the relationship of aggression to autism should be clarified.</td></tr>
<tr><td></td><td></td><td>Clonidine</td><td>I</td></tr>
<tr><td></td><td></td><td>Ritalin</td><td>I</td></tr>
<tr><td></td><td></td><td>Lunesta</td><td>I</td></tr>
<tr><td></td><td></td><td>Risperdal</td><td>I</td></tr>
<tr><td>#61</td><td>Schizoaffective</td><td>Seroquel</td><td>I</td><td>The reason that two</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status					Compliance
						statements." Clarification about the relationship of depression to the symptom of "refusal" is needed.	
		#502	Autism	Risperdal	I		
		#9	Bipolar NOS PTSD	Geodon	N	NOS diagnoses need re-evaluation and/or clarification. Explanation of the differential use of two atypicals for different symptoms (per PTR) is needed	
				Zyprexa	N		
				Topamax	N		
				Depakote	I		
		#316	Mood related to developmental syndrome	Risperdal	N	The developmental syndrome has a known behavioral phenotype from which the use of (only) two medications can be inferred. The choices of the particular medication should be explained, and the use of atypical polypharmacy justified	
				Quetiapine	N		
				Gabatril	I		
				Lexapro	I		
		#399	Bipolar Disorder NOS, OCD, PDD, PTSD	Seroquel	N	There was no tracking of mood in the setting of mood disorder diagnosis	
				Prozac	I		
				Naltrexone		The basis for the diagnosis of Obsessive Compulsive Disorder (OCD) and its relationship to self injurious behavior (SIB) should be clarified	
		#173	PDD	Zyprexa (Invega pending)	N	The relationship of aggression and SIB to PDD was not articulated, and the use of Depakote for aggression needed explanation.	
				Depakote			
		#427	Autism	Trazadone	I	The relationship of tracking	

#	Provision	Assessment of Status					Compliance
				Risperdal	I	should be put into writing	
				Clonidine	I		
				Adderall	I		
		#488	Intermittent Explosive Disorder (IED)	Risperdal	N	For DSM IV, the key to the diagnosis of IED is that aggressiveness is out of proportion to any precipitating event. The key adaptation for the use of IED for individuals with ID is that level of ID should be taken into consideration. The diagnosis is easier to make in individuals with milder disabilities, where the discontinuity between stress and aggressive behavior can more easily be judged. As with other impulse disorders, objective measures of impulsivity are helpful for measuring treatment response.	
				Zoloft	I		
		#488	Bipolar I	Lithium	I	While the relationship of the medications to the diagnosis is clear, tracking is limited to aggression and self injury. Symptoms that are more directly related to the diagnosis should be identified and tracked	
				Tegretol	I		
				Zyprexa	I		
		#493	Psychosis NOS	Seroquel	N	Not otherwise specified (NOS) diagnoses needed re-evaluation and/or clarification	
		#3	Bipolar I Disorder, ADHD	Clonidine	I	Per recent psychiatric evaluation, diagnoses are under re-evaluation. The use of Lamictal for aggression requires clarification.	
				Depakote	I		
				Lamictal	N		
				Concerta	I		

#	Provision	Assessment of Status	Compliance

#112	PDD	Seroquel	N	PTR notes clearly document improvement. But symptoms mentioned in the PTR are not tracked, only SIB and sleep.
		Abilify	N	
#50	Depression NOS	Remeron	I	Not clear why an NOS diagnosis is needed or why symptoms of depression are not tracked, only "refusal."

(*) Y – Rationale was clear
I - Rationale was not clear but could be inferred from the available clinical material
N – Rationale was not clear.

As described in the above table, the monitoring team was able to reconstruct the rationale for the use of the medications. To understand the thinking that led to the selection of a particular medication, the monitoring team often needed to examine medical record progress notes. Progress note information, however, was often not transferred to a more enduring form of documentations such as the PBSP, in which information was carried forward over time. Information contained only in progress notes was eventually thinned from the medical record. Unless transferred elsewhere, such information was often not retained by the clinical team.

The SA required that there should be a master problem list that identified the problems that were the focus of treatment. The 15 charts were examined to see if they included the required list. With the exception of individual #50, annual medical assessments of all individuals contained a problem list. Problem lists were also included in many PBSPs. Ten of the 15 PBSPs reviewed listed Diagnostic and Statistical Manual (DSM) diagnoses as a section of the PBSP. Each of the ten listed at least axis I of the diagnoses, many included axis II, one included axis III, and one included axis IV. In two cases (individuals # 502 and #58)) the psychiatric diagnoses were mentioned only in the text that introduced the plan. In three PBSPs (individuals #1, #427, and #488), psychiatric diagnoses were not mentioned. Diagnoses were listed in all PTR notes.

The following table compares the problems/diagnoses listed in the different sections of the medical record. In some cases, there was inconsistency across sections in the diagnoses listed.

Individual	Active Medical Problem List	PBSP Diagnoses	PTR diagnosis

#	Provision	Assessment of Status				Compliance
		#58	Intermittent Explosive Disorder	Intermittent Explosive Disorder (*)	Intermittent Explosive Disorder Obsessive Compulsive Disorder	
		#488	Bipolar Disorder Impulse Control Disorder	None	Bipolar Disorder	
		#502	Autism Fragile X Syndrome	Autism (*)	Autism	
		#427	Autism ADHD Depression Insomnia	None	Autism	
		#538	PDD Anxiety Disorder	PDD Anxiety Disorder	PDD Anxiety Disorder	
		#112	Psychotic Disorder	PDD	PDD	
		#399	Major Depressive Disorder Bipolar Disorder Obsessive Compulsive Disorder Oppositional Defiant Disorder PTSD PDD	 Bipolar Disorder Obsessive Compulsive Disorder PTSD PDD	 Bipolar Disorder Obsessive Compulsive Disorder PTSD PDD	
		#1	Autism Intermittent Explosive Disorder Mood instability Inappropriate Sexual Behavior ADHD Insomnia	None	Autism Impulse Disorder NOS ADHD	
		#316	Mood Disorder secondary to (named developmental disorder) **	Mood Disorder secondary to (named developmental disorder) *	Mood Disorder secondary to (named developmental disorder) *	
		#3	Bipolar Disorder ADHD	Bipolar Disorder ADHD	Bipolar Disorder ADHD	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>#493</td><td>None listed</td><td>Psychosis, NOS
Stereotypic Movement Disorder w/ SIB</td><td>Psychosis, NOS
Stereotypic Movement Disorder w/ SIB</td></tr>
<tr><td>#173</td><td>PDD</td><td>PDD</td><td>PDD</td></tr>
<tr><td>#50</td><td>None Listed</td><td>Depression NOS
Disruptive Behavior NOS</td><td>Depression NOS
Disruptive Behavior NOS</td></tr>
<tr><td>#9</td><td>Bipolar Disorder
PTSD</td><td>Bipolar Disorder
PTSD</td><td>Not located</td></tr>
<tr><td>#61</td><td>Schizoaffective Disorder, bipolar type</td><td>Schizoaffective Disorder, bipolar type</td><td>Schizoaffective Disorder, bipolar type</td></tr>
</table>
(*) Mentioned only in text – not in list
(**) the syndrome is named in the documents

During the next tour, the monitoring team will review with the Facility which of the lists is the Facility's master problem list, and review with the Facility how changes in information, for example changes in diagnoses, are incorporated into the ongoing clinical record.
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<tr><td>J4</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.</td><td>As part of the pre-tour document request, the monitoring team asked for a list of individuals who during the past six months had received pre-treatment sedation medication for medical or dental procedures, and the date, medication, dosage, and route of administration of the medication. The Facility clarified that it had just started tracking medical and dental pre-treatment sedation with the AVATAR electronic record system. The Facility noted that the AVATAR system is not set up to report the medication, dose and route of administration. The Facility provided a list (acknowledged to be incomplete) of 99 individuals who had received either dental or medical pre-treatment sedation during the second half of 2010. During the tour the monitoring team requested and received from the dental clinic the names and dates of all dental clinic appointments in 2010 for which individuals received oral or intravenous sedation. Oral pre-treatment and TIVA administrations were recorded on separate lists. Information on oral pre-treatment sedation was provided for all of 2010, information on TIVA was provided for the second half of 2010. The lists were taken from the dental clinic appointment book. In a meeting with the monitoring team, a dental clinic staff member clarified that it was possible that the appointment book did not have the names of all individuals who were seen in the dental clinic. The staff member explained that it was possible that individuals were to the clinic added at the last minute. The staff member did not think that this</td><td>Noncompliance</td></tr>
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		happened often but was not able to be more specific. Dental records provided to the monitoring team showed that for the period of July through December 2010, oral pre-treatment sedation was given 11 times to 10 different individuals. During the same period, intravenous sedation (TIVA) was given 34 times to 33 different individuals. Five individuals received both oral pretreatment sedation and TIVA. Steps taken to assure safety during sedation were reviewed. BSSLC procedures for medical and dental restraint/sedation were approved on 12-10-2010, as *Medical and Dental Restraint (Client Services – Behavioral Services*.) These procedures were in place at the time of the tour and were reviewed in a meeting with Debra Williams CNE, and two members of her staff. This meeting clarified that at the time of the tour, orders for oral pre-treatment sedation were written by the primary care physician. Nurse monitoring for safety included vital signs, O2 saturation, lung sounds, and general physical evaluation. The results were documented in *Pre Procedure Sedation and Post Procedure Sedation* Checklists. Since pre-treatment sedation was considered a medical restraint, the nurses also completed a restraint checklist that included 15 minute vital sign checks. Individuals were transported to the health center dental area via wheelchair. Nurses were stationed in the health clinic and were available to assist in the dental clinic area on an as-needed basis. The individual was transported by wheelchair back to the residential unit after completion of the procedure, and nurses completed a post sedation checklist. Monitoring continued for 120 minutes post procedure, and longer if necessary. In the case of intravenous sedation, nurses used the SSLC Nurse Protocol *Post Anesthesia Care.* Monitoring continued until the individual was stable, per protocol guidelines. The Facility conducted periodic chart reviews to confirm that pretreatment sedation monitoring for safety was taking place as required. The monitoring team examined reviews for individuals #65, #93, #120, #238, #332, #392, #424, #457, and #559. The reviews covered oral pre-treatment sedation for dental and medical procedures as well as intravenous sedation in the dental clinic. The oral agents most commonly used were Ativan and Valium. Nurse monitoring for safety was documented in all cases. Efforts to minimize the need for pre-treatment sedation were reviewed. Guidance on BSSLC procedure was provided by the document: Me*thods to Develop Cooperation for Medical and Dental Procedures and to Decrease the Need for Restraint and Sedation (Rev 06/04/09).* The need to have pre-treatment sedation was often based on difficulties encountered during attempts to conduct routine clinic procedures without sedation. The monitoring team met with a member of the dental clinic staff to review the manner in which individuals were determined to have difficulty that necessitated pre-treatment sedation. . Each time the individual experienced behavioral difficulty that required postponement of the needed dental care, the behavioral difficulties were documented in the dental care section of individual's chart. After three failed attempts to complete the dental appointment, dental staff notified the QMRP about the difficulty a PST meeting	

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		was then scheduled, and a Specific Program Objective (SPO) for the a plan for desensitization was developed and was reviewed by the HRC. The new procedures call for this to be done after one failed attempt at treatment without sedation. Medical and dental desensitization plans were reviewed for 15 individuals. Several examples of desensitization plans follow: ITP: Sit in dental chair\ for 5 minutes (For Individual #538). Instructional Strategies: 1. Staff will accompany (the individual) to the dental clinic on Tuesday after he gets home from PBS. 2. At the dental clinic Staff will explain to (the individual) what he/she is learning. 3. Staff will then ask (the individual) to sit in the dental chair. 4. If (the individual) sits in the dental chair for three minutes a (+) sign will be recorded. If (the individual) does not sit in the chair or does not stay seated for 5 minutes, then a (-) sign will be recorded. SPO: Dental desensitization: (For Individual #221). Instructional Strategies: 1. Staff will inform (the individual) that he/she is going to practice getting ready for a dental visit. 2. Staff will swab (the individual's) teeth with a lemon flavored swab as though brushing his/her teeth. 3. Staff will talk to (the individual) about what happens on a dental visit. 4. Staff will comment on how nice his/her teeth look after he/she visits the dentist. SPO: Objective Tolerate light (Desensitization program for Dental and Eye exams) (for Individual #598). Instructional Strategies: 1. Monitor will explain to (the individual) that this is a training program to assist (the individual) with dental and eye exams and that you will be shining a light, quickly near his/her eyes. 2. Monitor will then sweep a pen light or small light going from one side of (the individual's) face to the other (3 second sweep). 3. If (the individual) tolerates this task with no more that 5 verbal prompts, make a + pm the data sheet. 4. If (the individual) needs more assistance, provide assistance as needed to complete the task and mark the type of assistance. 5. Please praise the individual throughout the training.	

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		6. Please let the QMRP know if (the individual) seems to have difficulty with this. SPO: Visits with Dental Staff (For Individual #330) Instructional Strategies: 1. The monitor will take (the individual) and his CD player and 2 CD's to the dental center while the dental staffs (sic) are still there. 2. The monitor will play one of (the individual's) CD while in the office with the dental staff. 3. Smile and clap, to encourage (the individual) to enjoy the music along with the dental staff. 4. The interaction should last long enough for at least one song. 5. Thank the dental staff and return home or to PS. 6. Record the amount of time (the individual) interacted with the dental staff in minutes. Overall, the monitoring team found that there was considerable variation between plans. Some were quite general in their approach, while others were more specific. The monitoring team reviewed a list of all individuals who had medical or dental desensitization plans. The Facility reported that such medical and dental support plans were in place for 88 individuals. This list was compared to the list of 43 individuals who had received pre-treatment sedation. The names of 20 of the individuals appeared on the list of individuals who had plans. The names of the other 23 did not. On the basis of the information provided above, the monitoring team was not able to confirm that all individuals who received pre-treatment sedation had treatment plans in place to reduce the need for such sedation. The monitoring team requested a description of any current process by which individuals receiving pre-treatment sedation were evaluated for any needed mental health services, beyond desensitization protocols. The Facility clarified that there is no formal process in place other than the PST meeting process, Reiss screening, and psychiatric evaluation. The new Brenham State Support Living Center (BSSLC) procedure for medical and dental restraint and sedation stated that a monthly trend analysis will be reviewed at the Restraint Reduction Committee Meetings. The January meeting of the committee did not yet have such data. In summary, since the last tour the Facility has revised and improved procedures for	

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		safety monitoring during sedation, and had developed a policy and procedure for medical and dental sedation. The monitoring team found that safety monitoring procedures were adequate, and reviewed internal BSSLC audits that documented that procedures were followed. The monitoring team also reviewed records for required treatment plans to reduce the need for pre-treatment sedation. In many cases the monitoring team could not confirm that required desensitization plans were in place. Many of the plans that were in place were very general. Quality assurance measures such as trend analyses for the use of sedation were not yet in place.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	The Facility was approved for two FTE positions in psychiatry. With the employment of Dr. Luna in December 2010, both FTE positions have now been filled. Dr. Luna was employed as a staff psychiatrist on a full time basis, Dr Morgan was employed as a staff psychiatrist on an 80% basis, and Dr Chacko was employed on a 20% basis. For the two years prior to Dr. Luna's employment, psychiatric staffing at the Facility was at a single FTE level. Prior to Dr Morgan's employment in 2008, Dr Chacko was the sole psychiatrist at the facility. Even with the addition of Dr. Luna, the overall caseload of the psychiatrists at the Facility was high. At the time of the tour there were 168 individuals at the Facility who received psychiatric services. This translated to an overall caseload of 84 individuals per FTE psychiatrist. This overall caseload was higher that at some similar DADS facilities. BSSLC psychiatrists face many pending and pressing clinical and clinical/ administrative tasks. Although Drs. Chacko and Morgan are highly qualified and hard working psychiatrists, many tasks were unavoidably left unattended, due to the staffing shortages. For example, at the time of the tour the Facility did not have psychiatric evaluations in place for close to 100 individuals who received services. In addition to the need to catch up on the backlog of work, Facility psychiatrists also need to respond to specific requirements of the SA, some of which are very time consuming. For example, Facility psychiatrists need to implement psychiatric evaluations per appendix B (J6) across the campus, they need to work with psychologists and others on joint case formulations (J8), and they need to participate in the effort to expand behavioral tracking for psychiatric symptoms, (J3 and J13). Additional psychiatric time may be needed to fulfill requirements for informed consent (J14) and to assist with the broader needs for restraint reduction (see recommendations). Time is also needed for the psychiatrists' joint activities with other medical professionals (J10 and J15), and time is needed for required facility wide clinical monitoring (J11 and J12). This must all be done at a time when Dr. Luna is not only new to the Facility; he is also new to the field of intellectual disability psychiatry. With the above in mind, it remains to be seen if the Facility will be able to accomplish the	Noncompliance

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		needed tasks, with the current level of staffing. At this point the monitoring team cannot state that the Facility has a sufficient number of FTE psychiatrists, to ensure the provision of required services.	
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.	Since the last tour of the monitoring team, BSSLC started to use the Appendix B format for psychiatric evaluations. Six evaluations were completed in the Appendix B format; the monitoring team reviewed each. All three psychiatrists completed at least one of the evaluations, so that review of the six cases gave some measure of current psychiatric practices for the psychiatric department as a whole. Comments on specific evaluations follow: • Individual #513: The psychiatrist stated that although the individual experienced mood lability, a history of clear cut mania or clear cut depression has not been noted, and that the individual would be monitored. The psychiatrist demonstrated that many element of a disorder of attention. The use of the NOS diagnosis as a provisional diagnosis was understandable, but it should be time limited. Plans for medication management were detailed, involving Thorazine, Trileptal, Clonidine, Ritalin and DDAVP. Each of the medications was accompanied by a list of possible side effects. Rationales for the use of several medication (Trileptal, Clonidine, and Ritalin) were provided, but not for Thorazine. • Individual #490: Key diagnostic issues that faced the psychiatrist were the issues of whether or not what the individual called "hearing the devil "were auditory hallucinations. Additionally, the psychiatrist needed to determine whether or not the individual's thinking was disorganized to the point of ongoing psychosis. It was also possible that the individual's thinking simply fragmented when the individual was under stress. The psychiatrist evaluated these issues, diagnosed mood and psychotic disorders, both NOS, and formulated plans for treatment. the focus for medication was to be mood stabilization, for (presumed) auditory hallucinations and aggression. This should have prompted the psychology department to track relevant symptoms even before medication trials, in order to establish baseline measures. • Individual #255: The psychiatrist identified the DSM diagnostic criteria upon which the diagnosis of autism was made. The "discussion" section was specific and focused, and offered a good working understanding for at treatment plan. The psychiatrist was clear in her discussion of why impulsive, hyperactive and physically intrusive behavior were related to the diagnosis of a developmental disorder and did not warrant additional diagnoses.	Noncompliance

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		• Individual #417: The psychiatrist was clear that diagnoses of psychotic disorder NOS and mood disorder NOS were to be used while more information was gathered to make a more specific diagnosis. The psychiatrist mentioned that Seroquel would be ordered for treatment of target behaviors related to the axis I disorders and lists that the tracking in the interim behavior plan would be for SIB, aggression, allegations of abuse/neglect, inappropriate sexual behavior and psychotic statements/behavior. The treatment recommendations and plan were direct and thoughtful. There were unresolved diagnostic issues, the request for records from the inpatient hospital records was a good way to try and resolve these issues. The plan for medication was direct and mentioned target symptoms, and the mention of behavioral tracking to be done at BSSLC (per the citation of the interim behavior plan) was helpful. However, while the list of symptoms to be monitored by psychology included psychotic statements/behaviors, it did not include any measures of mood (hypersexuality, if related, was at best a secondary measure). • Individual #399: In the discussion, the psychiatrist reviewed in detail how the behavioral symptoms the individual displayed could be understood as both/either learned behaviors and psychopathology. This individual also required multiple episodes of restraint. This individual would have benefitted from a joint evaluation by a behavior analyst and psychiatrist. One focus of such an evaluation would be to determine the relative roles of psychology and psychiatric factors; such a determination could have led to the establishment of a joint treatment plan. • Individual #196: The diagnostic formulation outlined in detail the basis for the diagnosis of autism. The psychiatrist was clear about the medication to be used, although it would be better to have more clearly stated the manner in which the target symptoms were related to the diagnosis. Common side effects were provided. It was not necessary to outline uncommon side effects (unless the individual had a predisposition to the side effect in question), as these would be given in educational monographs provided to the LAR. The psychiatrist indicated that (presumed) anxiety was a target related to the use of Ativan, and that Tenex was provided to treat hyperactivity and impulsivity. Issues that were noted in several evaluations were as follows: 1. NOS diagnoses were used frequently. Such diagnoses should be used only on a temporary basis while more information is being gathered, or when there is no	

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		viable clinical alternative. An exception is PDD NOS – a diagnosis for which the DSM does not yet have good alternatives. 2. Rationales for proposed medication treatment were not always included. 3. Target symptoms to be monitored for treatment were not always included. The Facility was not found to be in compliance with the provision, since the deployment of the appendix B evaluations has just started.	
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.	The psychology department reported that it had completed Reiss screens for all individuals who lived at BSSLC, with the exception of individuals who received psychiatric services. A list of the names of all individuals who had the Reiss Screen was provided. The monitoring team selected sixteen names from the list and requested to see the Reiss screens of those individuals; each tenth name was selected from the list that was provided. The individuals that were chosen were #8, #34, #54, #89, #93, #206, #283, #294, #337, #339, #423, #428, #445, #508, #548, and #595.#93, #428, #508, #283, #574, #54, #8, #294, #89, #339, #548, #595, #337, #445, #34, and #206. The monitoring team reviewed the Reiss screens for these individuals, and confirmed that they were done properly. In addition to the requirements for the Reiss screen, the provision also required that all individuals who have a psychiatric diagnosis or receive psychotropic medication should have a psychiatric evaluation. The Facility provided a list of new admissions since 01/01/10. The names of ten individuals were provided. One individual, #21, was not followed by a psychiatrist; she had a Reiss screen. Nine individuals, (#417, #399, #377, #400, #139, #425, #196, #255, and #513) were followed by psychiatry. Five of the nine (#196, #255, #513, #417, and #399) were evaluated with a psychiatric evaluation per SA Attachment B. The four remaining individuals (#377, #400, #139, and #425) were evaluated prior to the use of the Appendix B evaluations. The evaluations for three of those individuals (#377, #400, and #139) were found by the monitoring team to have provided a clinically justifiable evaluation and diagnoses. The evaluation provided to the monitoring team for individual #425 was not complete. In addition to the requirements for the Reiss screen, the provision also required that all individuals who have a psychiatric diagnosis or receive psychotropic medication should have a psychiatric evaluation. As reviewed under provisions J2 and J6, many individuals who live at BSSLC and receive psychiatric treatment had not yet been evaluated.	Noncompliance
J8	Commencing within six months of the Effective Date hereof and with	The system used at BSSLC to integrate pharmacological and behavioral interventions through combined assessment and case formulation was reviewed. BSSLC provided	Noncompliance

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	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.	several settings where psychologists and psychiatrists worked side-by-side. These included PTRs and other PST team functions. Recently, the Lead Psychiatrist started to attend the PBRC. In addition, the facility planned to start weekly FIRM meetings. During the first compliance tour (June 2010) the monitoring team learned about initial plans to use that meeting as a campus wide resource, available to teams from all psychiatric clinics/PTRs for discussion of key treatment issues/decisions. In the Plan of Improvement (POI) for the current tour, the Facility stated that the process has been outlined and team members have been selected. Per the POI, the team will review the psychiatrist's recommendations to start a new psychotropic medication, before the medication trial begins. The monitoring team examined medical record documents of the 15 individuals selected for comprehensive review in order to determine whether they contained combined assessments and case formulation for individuals. Documents examined in order to make that determination included PBSPs, psychiatric evaluations, PTR notes, and PBSC and HRC Reviews. The monitoring team found that no form used at the Facility required documentation of such combined analyses. Statements that contained at least some degree of a combined case formulation were located for only two of the 15 cases reviewed. In both cases, the statement was found at the beginning of the PBSP: For individual #488: "*Based on staff report and informal observations, it appears that (the individual) engages in challenging behaviors when he is denied access to preferred items (i.e. being outside, following a set routine). (The individual) also appears to engage in challenging behaviors in order to escape from non-preferred activities (certain tasks and medical/dental procedures). All of his challenging behaviors may currently be exacerbated due to a loss in appropriate requesting/refusal skills due to an increase the symptoms of his psychiatric disorder.* " Put differently, the document stated that the psychologist was able to determine the functional purpose for the individual's challenging behaviors, and the psychiatrist had determined that the individual had a psychiatric disorder (bipolar disorder). An increase in the challenging behaviors could be due to an exacerbation of the underlying psychiatric disorder. For individual # 502 *"The individual exhibits many stereotypical behaviors that are characteristic …of someone diagnosed with Autistic Disorder… He tends to pace constantly around, smelling or spinning items. When he gets upset frustrated or doesn't get his way, he will grab others and not let go easily. He requires an established routine and will become upset if his routine is changed.*	

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		Intervention strategies for staff to use would be positive requests instead of demand and keep his routine consistent. Let (the individual) keep a preferred item with at all times (it is a comforting device). " In other words, the combined analysis was that behaviors of concern that were the focus of the work of the psychologist were linked to symptoms of the Autistic Disorder. PTR notes stated that the individual was given a medication for targets that included aggressive behavior that was linked to the diagnosis of autism. The formulation would have been stronger, had there been more elaboration on how autism and aggression were linked (Is it simple frustration? Lack of flexibility" Rigidity? Is there a relationship to stereotypy? What is the connection to routine, and so forth) . Overall, the monitoring team found that information was indeed forwarded from psychology to psychiatry. But there were few examples of statements that expressed combined case analyses. The monitoring team also found few places in the work structure at the Facility that encouraged psychologists, psychiatrists, and others involved in behavioral health care to work in an interdisciplinary, rather than multidisciplinary fashion. PTRs were the place that joint conversations about cases typically took place. However, the pace of the reviews at routine PTRs was simply too fast to allow for interdisciplinary case formulations for new cases and/or complex clinical circumstances. It is possible that PTRs can be the place for the needed case conference discussions. But if so, adequate time needs to be set aside and/or additional meetings scheduled. Extended case conferences were needed for new admissions and for reviews of more complicated clinical circumstances, for example when individuals were involved in multiple episodes of restraint. Such in-depth reviews were notably absent. Related comments are provided under provision C7, for individuals #399 and #061 (included in the 15 detailed chart reviews), and for individual #3. In summary, in the POI response to this provision, the Facility stated: "Psychology provides behavioral data to the psychiatry department which allows for a psychiatric assessment and case formulation based on relevant data analysis. Nevertheless, combined assessments and case formulations were rarely noted, either in the clinical process that was observed by the monitoring team, or in the documents that were generated by Facility clinicians.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented,	The provision requires the PST and the psychiatrist to evaluate possible modalities of treatment (medication, behavior treatment, or other intervention), and to decide which treatment or combination of treatments would best serve the individual. The provision requires that this should be done before a PBSP is implemented. The monitoring team examined the manner in which the process took place for three recent admissions to the Facility.	Noncompliance

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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.	Individual #399 was admitted to the facility in June 2010 as a transfer from another facility. Although a minor, the individual had a long treatment history and was taking three psychotropic medications, as well as two other medications that were prescribed for neurological reasons (but also had psychiatric effects). At the time of admission these medications were continued, per documentation of the admitting physician in the annual medical assessment (completed ten days after admission). A full psychiatric evaluation was completed in late 2010. In that evaluation the psychiatrist recommended "the individual should be continued on her psychiatric medications at the current doses, and changes will be made if necessitated by behavioral or neurological changes." HRC review (interim approval on 10/14/2010, full approval on 01/06/2011) stated "less intrusive approaches previously attempted: Providing (the individual) with choices, social reinforcement, interpositioning, redirection, verbal prompting, verbal praise, teaching replacement behaviors. "A PBSP was developed on 11/30/2010. The plan included the following language: "Determination by Personal Support Team: The team has met and determined that the risk of her challenging behaviors threatens (the individual's) life, health and happiness, while limiting her ability to be successful in the community." The PBSP contained a medication section. It listed the three psychotropic medications with which the individual was treated since admission, along with the psychiatric diagnosis and target behaviors (aggression, suicidal threats, and SIB) associated with medication. A PSP was developed on July 14, 2010, and quarterly review of the plan for the following three months listed her medications. Individual #425 was admitted in March 2010. Initial psychiatric assessment was done in April 2010. The assessment reviewed the individual's history of past treatment with five psychiatric medications. The psychiatrist commented that side effects outweighed the benefits for all five and the medications were discontinued. The psychiatrist commented on the individual's many challenging behaviors, including aggression and self-injury. Monthly psychiatric reviews (PTRs) followed. These were attended by the psychiatrist, the psychologist and other PST members. In September 2010 the psychiatrist chose a psychotropic medication for mood stabilization, to target hyperactivity, agitation and self injury. The medication was reviewed by the Human Rights Committee on 09/20/10 (interim) and 09-23-10 (full review). The plan stated: "less intrusive approaches previously attempted: Environmental change, positive reinforcement, verbal requests, interpositioning, stimulus change." The individual had a Positive Behavior Planning Guide which was completed shortly after admission. The Planning Guide listed the individual's challenging behaviors, and recommended behavioral interventions. The individual was not taking medications at the time it was written. Individual #196 was admitted in August 2010 from another DADS facility. The individual was treated with psychotropic medications at the other facility and these were continued	

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		at BSSLC. A psychiatric evaluation was done on 11/24/10. The evaluation provided a psychiatric diagnosis, commented on current medications, and proposed some changes in the medication. The psychiatrist commented that data from the psychologist should be reviewed. The new medication, Seroquel, was reviewed by the HRC on 11-18-10. The form contained the following language: "Less intrusive approaches previously attempted noncontingent reinforcement, differential reinforcement, prompting, interpositioning, extinction." A PBSP for this individual was developed in October 2010. It contained the following language: "Determination by Personal Support Team: The team decided that the use of a Positive Behavior Support Plan is necessary to improve the quality of (the individual's) life, to provide supervision and instructions for staff and to provide a procedure for review, and comparison of data for professional support staff." The three cases reviewed above were all of recent admissions to BSSLC Each individual was evaluated by qualified professionals from both psychology and psychiatry, and the professionals provided good description of the care they then provided. Also, professionals from psychology attended the psychiatric clinics, and this contributed to coordinated care. But the focus of provision J9 was that the psychiatrist and the rest of the IDT needed to deliberate on the kinds of treatment available, weigh the advantages and disadvantages of each, and decide on a recommended course of action. After review of the documents, the monitoring team could not tell where or whether or these discussions took place, what the decisions were, and on what basis they were made. Although documents were generated that provided an appearance that treatment planning had taken place, the monitoring team could see no clear process guiding key decisions about what kind of behavioral treatment would most helpful to the individual. Not surprisingly, documents that appeared to discuss these matters were written in language that was so broad, the documents could have applied to almost any clinical case. Given the process in place at the Facility, it was not clear to the monitoring team where the clinical meetings needed to decide what treatment would be used could have taken place. Perhaps the PTR setting would have been used if an extended block of time was set aside during the clinic and the team assembled for an informal case conference, but there is no suggestion that this happened. Similarly, it is possible that the needed discussions about overall directions for care could take place in the setting of the facility wide FIRM. However, FIRM meetings had not started at the time of the review. In summary, the monitoring team found major deficiencies in the flow of clinical information, in particular regarding decisions about treatment selection. Although individual clinicians made assessments, it was not clear to the monitoring team how or if facility clinicians decided whether as individual would be best served through	

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		behavioral, pharmacological, or other interventions, in combination or alone.	
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.	Provision J10 required that before non-emergency psychotropic treatments were started, the interdisciplinary team (the Personal Support Team or PST), including the psychiatrist, nurse and primary care physician, needed to have considered treatment alternatives, and needed to have conducted a risk benefit analysis of the proposed medication treatment. At the time of the tour the deliberations required by the provision took place during the psychiatric clinics (PTR meetings). New medications were also discussed at PBRC and HRC. Relevant documentation was provided on PTR notes, PBSP documents, and PBRC/HRC review forms. To review Facility compliance with the requirements, the monitoring team requested relevant documents from PTR, PBSP, PBRC, and HRC for the last 10 newly prescribed psychotropic medications. These were identified by the Facility as medications prescribed for individuals #1, #50, #112, #173, #184, #196 (two medications, Seroquel and Ativan), #397, #425, and #538 Full sets of needed documents were received for six of the requested medications, for individuals #1, #112, #196, #397, #425, and #538.# 538, #1, #112, #425, #397, and #196 (Seroquel). Those plans were reviewed. The monitoring group confirmed that HRC Review forms documented treatments alternatives that had been tried, and also risk vs. risk considerations. However, the monitoring team was not able to verify that members of the required disciplines participated in the deliberations, as required by the provision. This was understandable, since PCPs do not attend all PTRs. Additional comments about problems noted in the HRC Review forms are included under provision J14. The monitoring team learned from the POI and from documents shared with the monitoring team during the tour that the Facility planned to start Facility Integrated Review of Medication (FIRM) meetings. As outlined in the POI, these will be a once per week meetings that will focus on new medication treatments. FIRM will be attended by essential team members, including representatives from medicine, nursing and psychiatry. If the future FIRM meetings include deliberations on the items listed under provision J10, then the requirements for participation of medicine, nursing and psychiatry will be met. However, during the tour, the monitoring team was provided with diagrams that suggested that the FIRM meetings will focus on the items included under provision J9, and the FIRM meetings were listed in the POI under J9, not J10. Similarly, flow charts provided to the monitoring team that outlined the new consent process (see provision J14), described a team meeting with medical personnel that appeared to focus on items listed in J9, not J10.	Noncompliance

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		During the next tour, the monitoring team will seek clarification on how the Facility plans to assure that items in this provision are reviewed by the PCP, psychiatrist and nurse.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	The Facility organized a Psychoactive Medication Oversight Committee (PMOC) and monthly meetings began on 11/29/10. Participation in PMOC included key staff and disciplines, such as medicine, psychiatry, psychology, pharmacy, and nursing. PMOC will: 1. Identify individuals treated with psychoactive medications that constituted polypharmacy. 2. Review identified high risk individuals for psychoactive medication–related side effects. In the November meeting, PMOC determined that the pharmacy was responsible for tracking facility-wide polypharmacy (two psychotropic medications from the same class or three or more psychotropic medications, regardless of class). The pharmacy will disseminate this information to the various other departments. In response to the monitoring team's request for information on facility-wide polypharmacy, information was provided that clarified there were 30 individuals who were prescribed three psychoactive medications, 22 who were prescribed four psychoactive medications, seven who were prescribed five medications, and one individual who was prescribed six psychoactive medications. In response to the monitoring team's request, the Facility stated that 24 individuals were treated with intraclass polypharmacy. The Facility informed the monitoring team who the individuals were, the names of medications in question, and the start dates for each medication. Minutes of the December 2010 PMOC meeting were provided to the monitoring team. The January PMOC meeting took place during the tour and was attended by the monitoring team. During the December meeting 10 individuals who received intraclass antipsychotic polypharmacy were reviewed, to ensure the use of medications was clinically justified. Information provided to the committee included information about screening results for tardive dyskinesia. Specific recommendations were made about each individual, for consideration by the treating psychiatrist. In one case the committee suggested that the psychiatrist should consider an attempt at medication reduction, to minimize exposure to side effect risks. During the January meeting, all individuals on campus who received intraclass mood stabilizer polypharmacy were reviewed. The PMOC process for oversight of polypharmacy is well constructed, and it has appropriate representation from several departments. Its work has been productive and	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		it is already contributing to coordinated care. The Facility plans to continue to improve and refine the process.	
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.	During the tour the monitoring team met with Debra Williams, RN, CNE, Linda Wellman, RN and Brenda McCarty, RN. The meeting clarified that nurse case managers tracked medications taken by individuals under their care, so as to know which side effects screens were needed, and when. The nurse case managers also administered the DISCUS and MOSES screens, per guidelines for the tool. Ratings were done before a medication was started, and DISCUS screenings were continued for three months after medication discontinuation, per the tool guidelines. The 15 clinical records selected for comprehensive review were examined to verify that MOSES and DISCUS forms were administered, as required and rated by the psychiatrists. Review of MOSES and DISCUS forms showed that they were done correctly, and that they were reviewed in a timely manner. Overall, the monitoring team found that the process of DISCUS and MOSES administration by nursing staff was satisfactory. This does not mean that the process was flawless: On some occasions DISCUS forms were not signed (individual # 9) or the signature for the DISCUS was by the PCP, not the psychiatrist (DISCUS for individual #58 done on 03/01/2010). On occasion the monitoring team was not able to confirm that ratings were completed, since they were not provided to the monitoring team (individual #173). Nonetheless, on the whole the ratings were done regularly and completely. During the first compliance tour, the monitoring team had suggested that the facility should maintain a list of the names of all individuals screened for tardive dyskinesia (TD). In particular, the monitoring team commented that it was important to know the names of all individuals who were diagnosed with dyskinesia. Prior to the current tour, the monitoring team was provided with a list that showed both who was screened and who was diagnosed with dyskinesia. Comparison of medication lists and dyskinesia showed a number of individuals (#5, #30, #335, and #453) who had dyskinesia, but who nonetheless required treatment with atypicals. The presence of dyskinesia does not, per se, mean such treatment was unjustified. But the level of scrutiny must be higher and risk benefit analyses must be considered carefully. The monitoring team was informed that these individuals would be reviewed, as part of work of the polypharmacy committee At the request of the monitoring team, the facility provided a list of individuals treated with Reglan. These individuals were included in the list of individuals monitored for TD. The review of the monitoring team demonstrated that a process is in place for monitoring side effects, and that a new system is in place for facility level monitoring for tardive dyskinesia.	Substantial Compliance

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<tr><td>J13</td><td>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 necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.</td><td>As described under provision J14, the Facility started to use a new format for informed consent. The new consent form contained a Medication Response Profile (MRP) that contained information on several of the items required by the provision. The Facility also provided the monitoring team information on Facility Integrated Review of Medications. Although FIRM meetings had not started the materials made clear that document prepared for a new medication would include revised PBSP for the new medication.

The monitoring team examined the clinical records provided by the Facility for the last 10 newly prescribed psychotropic medications. Materials reviewed included:
(a) PTR/integrated progress notes (IPN)documenting the rationale for choosing that medication,
(b) signed consent form,
(c) PBSP, and
(d) HRC documentation.

The required materials were provided by the Facility for eight of the new medications. The medications were prescribed to individuals #1, #112, #173, #196 (two medications), #397, #425, and #538. These documents were examined for the presence of the various elements of a treatment plan for psychotropic medication. The results are reviewed in the paragraphs that follow, organized according to the required elements that are outlined in the language of the provision.

• <u>The clinically justifiable diagnosis or specific behavioral-pharmacological hypothesis and the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy:</u>

Guidelines for Provision J3 (Psychotropic medication use is appropriate) clarified that there should be concordance between diagnosis, relevant behavioral symptoms and psychotropic medications. The following table lists these items for each of the eight new medication plans. The table shows that there was concordance between the diagnosis and target symptoms in only two cases (#397 and #538). In the other cases, the target symptoms were not part of the diagnostic criteria for psychiatric disorder.

<table><tr><td>Individual</td><td>Diagnosis</td><td>Target symptoms</td><td>Medication</td></tr><tr><td># 1</td><td>Autism, Impulse NOS</td><td>Physical Assault and Aggression</td><td>Zyprexa</td></tr><tr><td># 112</td><td>PDD</td><td>SIB, sleep</td><td>Seroquel</td></tr></table></td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

		disturbance	
# 173	PDD	Aggression and self injury	Invega
# 196	Autism	Aggression	Seroquel
# 196	Autism	Agitation	Ativan
# 397	Primary Insomnia	Insomnia	Rozerem
# 425	Autism	Aggression, self injury, hyperactivity	Geodon
# 538	Anxiety NOS	Sleep disturbance	Remeron

The monitoring team tried to understand the frequent lack of concordance between the diagnosis and the symptoms used to track psychiatric response. To do so, the monitoring team looked closely at the progress notes written by psychiatrists, to see if symptoms connected to the diagnosis of record were mentioned in those notes. For this analysis, the monitoring team looked both at the new medication plans, and other cases reviewed by the monitoring team as part of the comprehensive chart reviews. The monitoring team found that in some cases, the psychiatrist gave an indication of symptoms that could be assessed, but appropriate tracking did not follow. For example

- In the case of individual #112, (a new medication case) the psychiatrist reported in a PTR note that the medication had helped the individual with affective symptoms. Affective symptoms were not tracked, however. Other examples were also found where the psychiatrist had identified appropriate symptoms, but no data on those symptoms was collected.
- In the case of individual #399 (one of the comprehensive chart reviews) was an individual who repeatedly made suicide threats and was diagnosed with a mood disorder. Nonetheless, there were no ratings for mood.
- In the case of individual #3, (also one of the comprehensive chart reviews) the psychiatrist diagnosed bipolar disorder. In her notes the psychiatrist mentioned that the diagnosis was made on the basis of mood symptoms, racing thoughts, hyperactivity, marked disturbances in sleep and psychotic behaviors. None of these symptoms were tracked.

Overall, the monitoring team found that in many cases there was no concurrence between the diagnosis of record and symptoms monitored for medication treatments connected to that diagnosis. Further examination revealed that more appropriate target symptoms had been identified by the psychiatrist, but tracking was not put in place. The lack of relevant symptom monitoring for individuals #399 and #3 was particularly notable, since they were among the individuals who had the highest levels of restraint at

#	Provision	Assessment of Status	Compliance
		the facility, and for whom monitoring for clinically relevant marker of treatment efficacy was particularly important • Expected time line for the therapeutic effect of the medication to occur. The timeline for treatment response was provided in each case, as part of the MRP format. The document also specified that the response to treatment would be assessed in psychiatric treatment review or as clinically warranted. • By whom, when, and how the monitoring will occur. The details of treatment monitoring were specified in the PBSPs, and the language of the new consent for medication stated that the Medication Response Profile (MRP) was used only as an integral part of individually designed behavior support program (PBSP). The format of the DADS approved PBSPs also contained guidance to the psychiatrists for that document to include "criteria for change" that states what the response might be if (a) the medicine is effective in reducing symptoms and or/target behaviors, or (b) there are no changes (trends) in symptoms and/or target behaviors, or (c) the symptom and/or behaviors increase. As reviewed elsewhere in this report (for example, provision J3) many PBSPs do not contain information that is required for the document, per DADS guidelines. Separately, these items are also required by the SA. • Minimum of quarterly reviews: These are specified in the PBSPs as meeting the requirement of quarterly reviews. BSSLC PTRs take place monthly. The items contained on the newly implemented medication consent form, together with the information contained in the PBSP updates contain the information required by the SA provision for medication treatment plans. However, in many cases the overall rationale for the proposed treatment was not clear. In addition, it was not clear that appropriate behavioral symptoms were selected for treatment monitoring. As a result, the requirement that there should be concordance between the diagnosis, behavioral symptoms monitored for treatment response, and psychotropic medications was not met.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed	In the past several months the form used for informed consent has changed. The new form was titled "*Consent for Use of Psychoactive Medication for Behavior Support.*" It was a two-sided form. The front of the form contained information on the medication and the prescribing physician (check boxes were provided for the staff psychiatrist's name or for	Noncompliance

#	Provision	Assessment of Status	Compliance
	consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	the PCP's name,) followed by the clarification that the PCP was following the recommendation of the (named) BSSLC contract psychiatrist. The back of the form included spaces for the brand and generic names of the medication, psychiatric (axis 1) diagnoses, targeted symptoms, the expected drug response, common side effects, and a medication dose chart (adult or child). The form clarified that a Patient Education Monograph for the medication would have been attached to the consent form. Such monographs provided additional medication information and a more comprehensive list of possible side effects. The consent form was signed by the competent individual or legally authorized representative (LAR). A box was provided for verbal consent, explained below. During the tour, the monitoring team was provided with flow sheets (dated September 2010) that outlined the steps taken to obtain consent for new psychotropic medications. Following the recommendation of the psychiatrist for a new medication, a PSP meeting (attended by psychiatry, psychology, medicine, nursing, pharmacy and QMRP) was held. During the meeting, the PSP team reviewed the medication to determine the least intrusive and most positive interventions to treat the psychiatric and or behavioral condition. The psychiatry department completed the consent form. The consent was then mailed to the LAR and tracked by designated administrative staff. The consent process for urgent psychotropic medications was that the PSP meeting was held on an urgent basis. The new medication order was written and sent to the pharmacy, marked "urgent." The psychiatrist or RN case manager then obtained verbal consent from the LAR. Verbal consent was accompanied by information about a witness or witnesses. A consent form and Patient Education Monograph was mailed to the guardian and tracked by the administrative clerk. The Facility informed the monitoring team that part of the review of new medication also involved PBSC and HRC review. The psychologist submitted a revised PBSP to the PBSC for their review. Medication consents, PBSPs, and PBSC/HRC Review forms were examined by the monitoring team, for eight recently proposed medications. These were medications prescribed to individuals # 538, #1, #112, #425, #397, #173, and #196 (two medications). The information on the consent form was compared to the information listed on the PBSC/HRC reviews. In many cases, the monitoring team found that side effect information presented on the PBRC/HRC Review form was different from side information provided on the consent form. In the cases of individuals #538 and #397, the PBRC/HRC Review form stated that the individual already took several medications and named the new proposed medication, but then provided only a single list of medication side effects. That list was different from the list of side effects of the new medicine presented in the consent form.	

#	Provision	Assessment of Status	Compliance
		In the case of individual #425 a similar problem was noted: The listed side effects of "medicines" on the PBRC/HRC Review form (there was only one medication, the new proposed medication) was nonetheless different from the list of common side effects included in the medication consent forms. In the case of individual #538 the HRC form listed side effects for each of seven medications - six current and the new medicine, Zyprexa. But the list of side effects listed for Zyprexa was again different from the information provided for the same medication on the consent form. The monitoring team also examined the medical record documents of the 15 individuals selected for comprehensive review. In all those cases, *PBRC/HRC Review* form, clarified that consent was obtained from the guardian and the date it was obtained. Actual consent forms were not reviewed. Side effect information was contained on the *PBRC/HRC Review* forms. For several cases, the forms provided a single list of side effects that were said to a grouping of several medications. In other cases side effect information was not provided but a reference was made to the external monograph, and sometimes side effect information was not provided at all, although there was a section that discussed the risk(s) associated with taking the medication.	
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 Lead Psychiatrist continued to attend scheduled clinics of the consulting neurologist. A process to coordinate care between the consultant psychiatrist and neurologist was being developed. The pharmacy and psychiatry departments monitored when anticonvulsant medications were prescribed for seizures, for psychiatric indications, or for both. The polypharmacy review committee provided facility wide reviews for such medications, such as the Jan 2011 review of mood stabilizer polypharmacy. Review of several charts showed integration of psychiatric and neurological care. The monitoring team found that a good process was in place. The Facility planned to continue to improve that process.	Substantial Compliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Departments of Psychiatry and Psychology, with input from other clinical departments, should review and improve the process under which combined assessments and case formulations are generated. Once this is done, the Departments should decide where such formulations should be documented, and a mechanism for periodic review of case formulations should be identified.
2. The Departments of Psychiatry and Psychology, with input from other clinical departments, should improve the manner in which the combined case formulations are used to make recommendations to the PST about which treatment modalities (behavioral, pharmacological, or other interventions) are most likely to benefit the individual.
3. Psychiatrists should verify that in each case a new medication is proposed, the clinical rationale for the medication trial is documented in the medical record.
4. Psychiatrists and psychologists need to verify that in each case a new medication is proposed, there is concordance between the clinical diagnosis

and behavioral symptoms selected for treatment monitoring.
5. Psychiatrists and Psychologists should verify that in each case a new medication is proposed, appropriate behavioral symptoms are monitored.
6. The lists of common side effects cited on the consent for new medications and presented to HRC should be the same.
7. The list of common side effects cited on the consent for new medication should not be too lengthy and uncommon side effects need not be cited – Patient Education Monographs provide fuller information.
8. The process of review of existing clinical diagnoses from the "NOS" category should continue. Such diagnoses should be replaced by more specific diagnoses, whenever it is clinically viable to do so. NOS diagnoses should be used in new evaluations only on a temporary basis, and/or when there is no clinically valid alternative to their use.
9. The section of the PBSP that describes medication treatments should present relevant information for each psychotropic medication (relevant diagnosis, symptoms/behavioral characteristics monitored to assess drug efficacy, the most likely medication side effects). Information about medications should not be presented for a combined list of all psychotropic medications. The practice of including references to a separate Patient Education Monograph for fuller information about additional medication side effects is encouraged, but such references should not replace information in the PBSP about the most likely medication side effects.
10. The process by which individuals' progress on treatments/strategies to minimize pre-treatment sedation is assessed, should be clarified and improved.
11. Psychiatrists should prioritize their participation in the IDT meetings that are held when an individual experiences more than three episodes of restraint in 30 days.

The following are offered as suggestions to the Facility:

1. Psychiatric assessments in the Appendix B format that the psychiatrists have just begun to use do meet the requirements of the SA. However, the evaluations offer an excellent place for the psychiatrists to summarize psychiatric input for a brief formulation of psychiatric input needed for items 1-5 listed above. Elective inclusion of such items should be considered.
2. Items # 3, #4, and #5 above address new medication treatments, but ultimately the issues addressed apply to existing medication as well. During the coming annual review cycles, psychiatrists should consider a process of gradual review of the relevant parameters, so as to bring them into compliance.
3. DADS guidelines for the medication section of the PBSP include a "criteria for change" section, in which the PBSP indicates (possible) medication plans, if the relevant symptoms improve, worsen, or do not change. Such "criteria for change" are not required by the SA. However, the section provides psychiatrists an excellent place to provide periodic/annual updates on care plans. Psychiatrists should consider use of this section; it would partially answer monitoring team concerns (see discussion for provision J3) about failures to carry relevant information forward, from year to year.
4. As a matter of good clinical practice, psychiatrists should consider making the initial contact with LARs, whenever a new medication is recommended. Additionally, the Facility should contact the State Office to enquire whether state regulations require that step.
5. The Facility has indicated that Appendix B evaluations will be put in place during the current annual review cycle. This plan is commendable. However, the plan to do so will consume many hours of work, and the plan to do so must be balanced against the competing needs identified in the above recommendations. Since the clinical charts contain acceptable working diagnoses, priority management of the tasks at hand may require a slower pace for completion of Appendix B evaluation across the campus.
6. The Facility should consider the addition of 0.5 to 1.0 FTE of psychiatric time, needed to fulfill the requirements of the SA (see discussion for provision J5).

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. RSSLC Plan of Improvement (POI) 2. RSSLC Supplemental Plan of Improvement (SPOI) 3. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), structural and functional assessments (SFAs), 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, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #1, #3, #4, #7, #8, #9, #11, #12, #15, #20, #21, #38, #51, #61, #62, #65, #66, #118, #121, #139, #173, #196, #206, #229, #231, #252, #261, #314, #316, #337, #349, #399, #411, #417, #424, #425, #427, #467, #484, #488, #490, #493, #504, #513, #528, #556, #559, and #576. **People Interviewed:** 1. Terry Hancock, PhD – Chief Psychologist 2. Shawn Cureton, MS – Psychology Manager 3. Kathleen Williamson, MEd – Psychology Manager 4. Melissa Waters, MBS – BCBA 5. Kim Littleton – ADOP 6. Tammy Bryant – Residential Director – Childress Terrace 7. Philip Carnagey – Residential Director – Cottage Estates 8. Melissa Abston – Residential Director – Driscoll Gardens 9. Victoria Morgan, MD – Psychiatrist 10. Andrea Miller – Program Services 11. Juanita Taylor – QMRP Coordinator 12. Michael Doebler – Vocational Services 13. Cheryl Powell – HRC 14. Stephanie Tyrone – Active Treatment Monitor 15. Shanitra Dennis - Active Treatment Monitor 16. Direct Care Professionals **Meetings Attended/Observations:** 1. Psychology Peer Review Committee 2. PTR – Bowie 3. PSP – Individual #427 (Fannin) (1/11/2010) 4. Human Rights Committee (1/13/2011) 5. Observed training at the Adult Activity Center and off-campus vocational workshop. 6. Observed active treatment, staff performance and environmental characteristics in the Childress, Cottages, Driscoll, and Fannin residences.

	Facility Self-Assessment: The Facility indicated that only Provision K2 of the SA, which relates to employing a qualified Chief Psychologist. was in substantial compliance. The Monitoring Team is in agreement with the Facility regarding the self-assessment. The Facility reported that the Fundamental Behavior Analysis Skills Evaluation (FBASE) was developed and implemented to assess Psychologists' knowledge and skills in basic Applied Behavior Analysis (ABA) principles and procedures. This is an outstanding example of how treatment integrity checks and mentoring can be combined to enhance staff skills. The FBASE should contribute to compliance with the SA in many areas. BSSLC reported that the revised Structural and Functional Assessment (SFA) was implemented in September 2010. The new format reflects a substantial improvement over previous functional assessment reports. Before the SFA can substantially comply with the SA, it will be necessary to address some of the weaknesses presented in Provision K5. Many of the changes reported by BSSLC in the Self-Assessment reflect improvement and progress toward substantial compliance with the SA. In addition to these improvements, however, BSSLC must clearly demonstrate awareness that the process of behavior change is more than a set of procedures. Efforts at behavior change must reflect a systematic implementation of an empirical, data-based approach to assessment and intervention.
	Summary of Monitor's Assessment: Based upon observation conducted during the site visit, as well as documents reviewed during and following that visit, it was apparent that substantial progress had been achieved within Behavior Services at BSSLC. The quality of functional assessment continued to improve, as the latest Structural and Functional Assessment (SFA) protocol revision reflected a coherent and logical approach to understanding behavior. Efforts to assess staff competence while providing support and mentoring was greatly enhanced by the development and implementation of the Fundamental Behavior Analysis Skills Evaluation (FBASE) process. Much of the progress achieved was due to the enthusiasm and diligence displayed by Dr. Terry Hancock, Shawn Cureton, Melissa Waters and Kathleen Williamson. In some areas, progress or the potential for progress was noted, but efforts had not sufficiently developed. Although the SFA had greatly improved, the protocol and process lacked attention to motivating operations (temporary environmental conditions that alter the power of a reinforcer or punisher) and setting events (environmental conditions that create a setting conducive to the display of the target behavior) in relation to both the assessment process and the recommended intervention strategies. A new data collection process had been initiated across the facility that addressed many of the limitations of the previous system. The new process, however, had the potential to underestimate high frequency behaviors and lacked the ability to measure other behavior topographies such as duration. A new data recording and presentation system had also been developed, but the system had not been fully implemented and was still being

	revised. The internal peer review process continued to evolve, although documentation revealed limitations in the review and recommendation process. It was evident that in some areas little progress had been achieved or considerable work remained to be completed. For example, the PBSPs continued to be refined but often lacked basic components necessary for behavior change such as specific strategies to address motivating operations and setting events. Furthermore, documentation often reflected little attention to the empirical foundation of behavior change whereby hypotheses and methods are rigorously tested rather than based upon intuition or reasoning. Considerable work also remained in the area of competency-based training, although it was indicated that a plan for addressing treatment integrity and reliability of data would be implemented in 2011. Despite the considerable amount of work that remained to be completed, BSSLC should not be discouraged. Considerable progress had been achieved within the first year of the monitoring process. **For Provision K.1:** The provision was determined not to be in compliance. The Facility had made substantial progress in providing training for Behavior Services staff, as well as developing a structured process for assessing the competence of staff in applied behavior analysis. At the time of the site visit, however, the staff training for BCBA certification was ongoing and the competency assessment process had only been partially implemented. More time will be needed before the effects of these efforts can be determined. **For Provision K.2:** This Provision was determined to be in compliance. The Director of Behavior Services possessed all required qualifications and was scheduled to sit for the board certification exam within a few weeks following the site visit. **For Provision K.3:** This Provision was determined not to be in compliance. The facility had implemented an internal peer review process, but problems were noted in the application of that process. In addition, external peer review had been temporarily halted due to the loss of the sole external reviewer. **For Provision K.4:** This Provision was determined not to be in compliance. New data collection procedures had been implemented, but the process continued to limit the types of data that could be collected. In addition, it was not evident that data collection and presentation possessed adequate specificity or that available data were being used effectively in the formulation of treatment decisions. **For Provision K.5:** This Provision was determined not to be in compliance. No changes had been implemented in psychological evaluation reports since the previous site visit. **For Provision K.6:**

	This Provision was determined not to be in compliance. Psychological assessments were not adequately current, accurate or complete. **For Provision K.7:** This Provision was determined not to be in compliance. The Facility did not have the means to ensure that, at the time of admission, the individual was provided with an intellectual assessment conducted no more than 5 years previously or an adaptive assessment within the previous 12 months. **For Provision K.8:** This Provision was determined not to be in compliance. Counseling/psychotherapy plans did not reflect the use of evidence-based practices. **For Provision K.9:** This Provision was determined not to be in compliance. Updated PBSPs continued to lack essential components. In addition, for an individual with a history of predatory sexual assault, neither the assessment nor intervention was sufficient to provide for a change in behavior or protection of the individual's peers. **For Provision K.10:** This Provision was determined not to be in compliance. Ongoing changes in various data systems prevented an assessment of current status. **For Provision K.11:** This Provision was determined not to be in compliance. A sample of the most recent PBSPs was indicated to possess adequate readability. Changes to the PBSPs were too recent, however, to expect that the sampled documents reflected the status of all active PBSPs. **For Provision K.12:** This Provision was determined not to be in compliance. Systems for ensuring treatment integrity and staff competence had not been fully implemented. **For Provision K.13:** This Provision was determined not to be in compliance. The facility continued to lack a sufficient number of BCBA credentialed staff.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide	During the previous site visit, the Facility had employed a single BCBA – Melissa Waters. Ms. Waters remained the sole BCBA at the Facility. Dr. Terry Hancock, the Director of Behavior Services, reported that recruitment of additional BCBAs had been aggressively pursued. This was supported by available documentation. It was anticipated at the time	Noncompliance

	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.	of the site visit that at least one BCBA would be hired in the near future although hiring had not been finalized. In addition to recruiting for new staff, BSSLC had taken steps to increase the level of competence in applied behavior analysis among the existing Behavior Services staff. These efforts were noted to include the following. • Eight Behavior Services staff psychologists and one Psychology Manager were enrolled in BCBA certification training. Four additional Behavior Services staff were participating in supervision required for BCBA certification. Kathleen Williamson and Dr. Hancock were scheduled to sit for the BCBA exam within a few weeks following the site visit. • All Behavior Services staff completed a six-month course in basic applied behavior analysis. The course was taught by Dr. Don Williams and was based upon the textbook Principles of Everyday Behavior Analysis. The fact that Dr. Williams is a BCBA and the text is used in BCBA training programs was positive. Some staff reported, however, that the training consisted primarily of readings and lecture, followed by a written test. Although staff reported that the training helped to familiarize them with the core concepts of applied behavior analysis, the training was not consistent with competency-based training. • A structured procedure for observing and assessing the competence of Behavior Services psychologists, called the Fundamental Behavior Analysis Skills Evaluation (FBASE), was developed by Melissa Waters. The FBASE included a process of documenting completion of essential tasks relating to behavior analysis, the development of behavior interventions and the monitoring of treatment response. In addition, the FBASE involved structured observations and the coaching of staff who conducted the behavior assessments and interventions. Based upon the documentation provided, the FBASE exceeded the elements of a more traditional integrity check or behavior drill. The efforts outlined above that were implemented by the Behavior Services department reflect a vigorous and innovative approach to developing competence in applied behavior analysis amongst the Behavior Services staff. At the time of the site visit, however, only the training by Dr. Williams had been completed, thereby limiting any determination of the effect achieved by the FBASE or BCBA certification training. Further assessment will be needed during additional site visits to determine the benefit, if any, from these efforts.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a	At the time of the site visit, BSSLC employed a full-time director of Behavioral Services--Terry Hancock, PhD. Dr. Hancock had extensive experience in the field of intellectual and developmental disabilities, was licensed as a Psychologist in Tennessee, and was scheduled to sit for the BCBA exam within a few weeks following the site visit. Based	Substantial Compliance

	qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	upon her credentials and demonstrated competence, the employment of Dr. Hancock by BSSLC satisfies this Provision of the Settlement Agreement.	
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	During the previous site visit, it was noted that progress had been made in developing and implementing a peer review process. Based upon observation and record review, the achievements noted previously were maintained in regard to internal peer review. • The internal Peer Review Committee met 22 times during the past 6 months. • 22 of 22 internal Peer Review Committee minutes documented discussion of and steps for revising PBSPs that specifically addressed behavioral issues. Despite the continuation of an internal peer review process, a review of Peer Review Committee minutes revealed problems in the decision-making process during the past 6 months. Specifically, the committee often failed to recognize the need for and require the application of a consistent and empirical model for behavior assessment and intervention. Examples of such circumstances are presented below. • A review conducted on 6/9/2010 regarding a PBSP for Individual #4 indicated inadequate severity ratings of behavior, a lack of both direct observation and indirect assessment in the behavior assessment, and the lack of a preference assessment. The decision of the committee was to have the assessment and plan revised and resubmitted. Under such circumstances, however, the PBSP lacked empirical support and a new, complete assessment was needed before a PBSP could be developed. Instead, the committee simply asked for revisions to the program without additional assessment. • A review conducted on 6/9/2010 regarding a PBSP for Individual #61 noted that "A preference assessment and structural and functional analysis should be done since they were not done on an earlier submission." The committee recommendation was to have the assessment and plan revised and resubmitted. Under such circumstances, however, the PBSP lacked empirical support and a new, complete assessment was needed before a PBSP could be developed. Instead, the committee simply asked for revisions to the program without additional assessment. • A review conducted on 8/16/2010 regarding a PBSP for Individual #547 noted that, "The SFA lists no physiological reasons for [the] behavior but in the PBSP p. 2 under Prevention or Antecedents, hyperthyroidism and medical problems are listed as triggers for [the] behaviors." The committee went on to recommend that the psychologist should, "make this information consistent between the two documents." Under such circumstances, however, it was not evident that the assessment process was valid. Revising the two documents to ensure consistency would not have addressed the apparent weakness of the initial assessment process. A thorough re-assessment that reviews all information, gathers additional information, and evaluates all information including health	Noncompliance

		and behavioral function was needed before a PBSP could be developed. Instead, the committee simply asked for revisions to the program without additional assessment. Failure to include an investigation of the health conditions very probably created an inaccurate set of assumptions upon which the remainder of the assessment was based. Going back and including a description of health conditions in the assessment report does not correct the erroneous assumptions. • A review conducted on 10/25/2010 regarding the PBSP for Individual#557 included the recommendation that the objectives should, "include information that when [the individual's] challenging behavior has decreased, the team will consider adding another replacement behavior that addresses appropriate requesting but it is more important currently to decrease challenging behavior before adding additional replacement behaviors." The statement reflected a lack of recognition regarding the role of replacement behaviors in reducing undesired behaviors. • A review conducted on 11/29/2010 regarding the PBSP for Individual #51 included the recommendation that the psychologist needed to, "add [inappropriate sexual behavior] to target behaviors and track masturbation as [the individual] has a roommate and this is inappropriate behavior." The development of a behavior intervention plan is an empirical process that requires careful analysis of undesired behavior, the context of that behavior, and the interventions necessary for change in the undesired behavior to be achieved. The recommendation by the committee reflected a failure to recognize that target behaviors cannot arbitrarily be added to the intervention plan. In order to add a target behavior, it would have been necessary to conduct an SFA to determine if inappropriate sexual behavior was functionally related to the other treatment targets. If so, then inappropriate sexual behavior could be integrated into the intervention methodology. If no functional relation was indicated by the SFA for inappropriate sexual behavior, then a new treatment methodology would need to be developed. The sample of problems listed above were of particular concern given that the Peer Review Committee is tasked with guiding the development of behavior intervention into compliance with practices accepted within applied behavior analysis. The failure of the committee to offer acceptable instructions and promote the use of behavior analytic practices was likely to undermine the intended goals of the peer review process. Another component of peer review is external peer review; the use of experts outside of the facility to review and critique the clinical aspects of behavior assessments and interventions. External peer review, although at times challenging to coordinate, brings a truly unique and powerful set of benefits to the peer review process. External peer review can provide additional objectivity and insight into especially challenging	

		behaviors. In addition, it provides an opportunity for facility staff to interact and exchange ideas with professionals and experts with whom they might not otherwise have contact. It is also important to note that efforts to change behavior and improve the lives of people living at the facility are always enhanced by increasing the pool of available resources. External peer review can substantially enhance the pool of available resources. It was noted that the external peer review process was put on hiatus following the departure of Dr. Don Williams in October 2010. Dr. Williams was the sole provider of external peer review for the Facility. At the time of the site visit, a contract had been approved for a new provider for the external peer review process. It was unclear what effect the change in providers would have upon external peer review. The circumstances with external peer review at BSSLC also illustrated the inherent limitations of reliance upon a single individual . Identifying an additional consultant would permit the Facility to continue rather than face a prolonged absence of any external peer review.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	During the baseline visit in 2010, as well as the first compliance visit, it was noted that data collection for PBSPs at BSSLC was inadequate to the task of measuring behavior and determining the need for or benefit from behavioral or psychopharmacological interventions. In 100% records reviewed during the previous site visit, data collection consisted primarily of narrative reporting initiated upon the display of an overt behavior. Since the previous site visit, BSSLC had implemented substantial changes to the data collection and monitoring process. A new data collection form and process had been implemented facility-wide in October 2010. The data collection form was redesigned. The new form used partial-interval data collection rather than narrative reporting, which presented the potential for increased data reliability. • 52 of 52 records reviewed (100%) included the revised data collection forms. While the move from narrative to interval data collection was a step in the desired direction, there are problems inherent to partial-interval data. Partial-interval data collection provides no information regarding the duration of behavior displays and, at best, only provides an estimate of the minimum rate of display for the behavior; the actual rate of higher frequency behavior is underestimated, often substantially. Based upon the information obtained regarding data collection, it was evident that BSSLC was making progress in this area. Partial-interval data collection can be an excellent method of data collection if the relevant aspects of the behavior fit the capabilities of the partial-interval procedure. It was highly unlikely, however, that the partial-interval	Noncompliance

		strategy provided valid measures for all targeted behaviors due to the wide variation in the characteristics of even the most common target behaviors. It will be essential that BSSLC continues to add to the available data collection tools and procedures so that a wide variety of target behaviors can be measured with accuracy and reliability. BSSLC was aware of the need for additional development in the area of data collection. During the 6 months prior to the most recent site visit, the Behavior Services department had also developed and piloted a new database system and process for tracking behavior data. The new database system required daily entry of behavior data, including behaviors targeted for reduction, replacement behaviors and other identified clinical markers. The database allowed for graphing of behavioral and pharmacological targets, as well as psychotropic drug dosages. The capability also existed to generate a presentation of the current and baseline data, progress or regression across months and baseline. It showed restraint information, sleep data, and injuries. The pilot of the database reflected progress toward meeting the requirements of the SA. At the time of the site visit, however, the database remained in the pilot phase. Full implementation of the database was planned, but included the challenge of providing the resources necessary for daily data entry across BSSLC. An additional limitation of the database system involved the differentiation between targets based upon intervention strategy or functional class. 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. During previous site visits, data and progress reports at BSSLC did not focus upon the specific behavior or functional class, but instead presented a variety of behaviors without indication of function or functional relationships. Because the same interventions might have varying effects on different behaviors that are in different functional classes, grouping the target behaviors into one aggregate data point may mask the effects of the intervention. The new database system did not reflect a process for focusing upon specific treatment targets or functional classes of behavior. • In 20 of 20 records reviewed (100%), intervention targets were presented and monitored congregately regardless of differing function, topography or other characteristics. • In 10 of 10 “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.	

		It was evident during the site visit that the Behavior Services department had made aggressive efforts toward improving data collection and providing the interdisciplinary teams with the information needed to make the appropriate treatment decisions. Progress thus far however, had not yet advanced to the point where data were of sufficient quality to support valid and meaningful treatment decisions. It also remained unclear, based upon provided information, that available data were used to identify the need for enhanced assessment or revised PBSPs. Records reflect that behavior data graphs were reviewed on a monthly basis in some context. It was not clear, however, that the interdisciplinary team was involved in this review process, or that the review produced meaningful changes in intervention strategies or behavior. This lack of a data-based process for treatment decisions is reflected in the examples below. • In two of 20 "best work" examples provided by the Behavior Services staff (10%), substantial increases in targeted behaviors did not result in revised behavioral intervention plans. When a program is ineffective, further evaluation should be done to determine what action to take. This could include observing to ensure the program is being implemented accurately, gathering interobserver agreement data to ensure the data taken continue to meet the definition in the PBSP, identifying changes in the environment that may serve as antecedents or changes in health status that might affect the behavior, or repeating the functional assessment to determine whether the hypothesis about function was or continues to be correct. The Facility must track the data regularly and not wait an extended time to conduct further assessment, consider actions such as revision of the program or retraining staff, and document rationale if no changes are made. • Individual #196 was diagnosed with autism and was prescribed Risperdal, Tenex and Ativan targeted at aggression and self-injury. Reports from the psychologist indicated that the majority of aggressive and self-injurious behaviors were associated with a lack of meaningful activities and other environmental factors. Due to elevated prolactin levels, an effort was made to supplant Risperdal with Seroquel. When withdrawal dyskinesia and aggression spiked after the discontinuation of the Risperdal, the decision was made to add a third antipsychotic medication without further exploration of environmental factors. Medication was used as a first line of treatment with no further attempt to assess function or develop non-medication treatment. • Individual #12 was diagnosed with Organic Mental Syndrome Secondary to Fetal Cocaine Exposure and was prescribed Pexeva, Benadryl, Seroquel, Risperdal and Tenex to address aggression, depression and hyperactivity. Narrative documentation provided by the psychologist described episodes of staff "confronting" and "yelling at" the Individual, followed by aggression and self-	

		injury by the Individual. The record reflected no effort to formally assess the role of staff actions in the displays of undesired behavior by the Individual.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	During the previous site visit, it was noted that intellectual assessments were not conducted at the Facility and adaptive assessments results included only the provision of scores without interpretation or identification of strengths and limitations. This was attributed to the fact that BSSLC did not employ a psychometrist or psychologist with the credentials necessary for intellectual or adaptive assessment. Specific findings from the last site visit included the following. • 20 of 20 records reviewed (100%) included no results from an intellectual assessment conducted within the previous five years. • 8 of 8 "best work" examples provided by the Behavior Services staff (100%) included no results from an intellectual assessment conducted within the previous five years. • 20 of 20 records reviewed (100%) included no interpretive findings from an adaptive behavior assessment conducted within the previous 12 months. • 8 of 8 "best work" examples provided by the Behavior Services staff (100%) included no interpretive findings from an adaptive behavior assessment conducted within the previous 12 months. Behavior Services staff reported during the current site visit that Facility records reflected no substantive improvements since the previous site visit in relation to psychological evaluation reports. It was also reported by the Behavior Services staff, however, that steps had been taken, some very preliminary, to address the shortcomings in the psychological assessment process. Specific steps taken at the time of the current site visit included the following. • A contract providing for the services of a Psychologist to conduct intellectual assessments and develop psychological evaluation reports had been submitted for final approval. • Manuals and protocols for the Vineland Adaptive Behavior Scales – Second Edition (VABS-2) had been ordered. It was planned that Behavior Services staff would complete VABS-2 assessments annually for all individuals at the facility. • Dr. Terry Hancock was scheduled to provide training to Behavior Services on the administration and scoring of the VABS-2. • The use of additional assessments had been explored, including the Adaptive Behavior Assessment System – II and the Assessment of Basic Language and Learning Skills. Previous site visits at BSSLC had documented that Behavior Services staff had not	Noncompliance

		routinely employed strategies of assessing behavior that comported with acceptable practices within applied behavior analysis. Since that previous site visit, Behavior Service staff reported, and documentation and observation reflected, a variety of initiatives to improve the quality of behavior assessment. • A revised Structural and Functional Assessment (SFA), integrating data from behavior logs, records, direct observations, QABF, and preference assessments, was developed and implemented. • Specific SFA protocols were developed to address sleep disturbances and covert inappropriate sexual behavior. • The FBASE (See K1) was developed and implemented. • The first analog functional analysis was completed. To assess the quality of the updated SFA, the 5 most recently completed SFAs were reviewed. These SFAs involved Individual #7, #51, #261, #337 and #399. The review revealed a variety of positive features of the SFA. • The latest SFA format was well organized and reflected a structure that guided the assessment process toward a conclusion of a behavior function. This was positive, as it was likely to make the SFA very intuitive and user friendly. • The SFA included the review of a set of health issues commonly associated with undesired behavior in people with intellectual disabilities. This again should make the format easy to use, especially for staff less familiar with health issues or applied behavior analysis. • The SFA format included the assessment of setting events, antecedents, functions and other environmental conditions. • Both indirect assessment and direct observation were required as a part of the SFA. • The SFA concluded with the identification of replacement behaviors and the method by which the replacement behaviors would be strengthened. Despite the strengths identified in the latest SFA protocols, there were noted limitations that were likely to weaken the findings of the assessment. • Although the SFA protocol included essential components such as direct and indirect assessment, the process lacked empirical rigor. Specifically, while the findings of the assessment process appeared rational and logical, little actual testing of any hypotheses was conducted. One of the goals of a functional assessment is to develop an hypothesis, a statement that proposes the reason for and the conditions under which a behavior is displayed. The following fictional examples may clarify what would be needed: "When Bill obtains less than four hours of sleep and is prompted repeatedly to finish his breakfast quickly, he will throw his spoon and curse, following which he will be sent to his room where he	

		goes to sleep." This hypothesis is what the intervention will be based upon. If less sleep and frequent prompts at breakfast motivate Bill to throw his spoon so he will be sent somewhere where he can sleep, then the intervention will need to address ways to increase sleep, change prompts and teach better ways to escape from irritating situations. With so much depending upon the hypothesis, it is important that the hypothesis have a high probability of being correct. Therefore, it is not sufficient to accept an hypothesis because it makes sense or appears reasonable. Observations must be conducted to "test" how accurate the hypothesis is. The Facility did not lay out hypotheses as in this example, nor was the Monitoring Team provided with any cases that included this type of case formulation or in a summary of an SFA. • The assessment process reflected an emphasis upon the three-term contingency (Antecedent, Behavior, Consequence) rather than the more sophisticated and useful four-term contingency (Motivating Operation/Setting Event, Antecedent, Behavior, Consequence). Although environmental conditions or setting events were at times discussed, the assessment process did not reflect a coherent investigation of the four terms of the contingency of the undesired behavior. A motivating operation is a condition that temporarily changes the power of a reinforcer. For example, someone who has not eaten in over 24 hours will experience food as a much more powerful reinforcer than someone who finished a large meal only 15 minutes ago. • Similarly, the SFA did not include a preliminary intervention plan addressing each of the four terms of the likely contingency. For example, the SFA concluded with a table outlining the target behavior, the function of that behavior, the replacement behavior and the consequence intended to strengthen the replacement behavior. The lack of identified intervention strategies for the motivating operation, antecedent, and behavior display and consequence points created a situation in which effective behavior change was far less likely. • The SFAs that were reviewed did not reflect the differentiation between functional classes of behavior. It was possible that in each of the 5 SFAs reviewed all the identified behaviors were of the same functional class. Given the diversity of behaviors, however, a statement or process that addressed functional classes would have eliminated ambiguity. However, information on all the behaviors for each SFA was aggregated with no differentiation by specific behavior; therefore, it was not possible to tell whether they had the same function or different functions. • The reviewed SFAs did not reflect the use of a formal preference assessment as part of the process used to identify potential reinforcing consequences. While a functional assessment may identify the reinforcers available in the environment, a preference assessment can identify reinforcers that are of even greater power, thereby making the behavior change process more efficient.	

		Despite the limitations noted immediately above, it was evident during the site visit that progress was being made in many areas.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Based upon the information presented in K5, documentation in the record continued to reflect that psychological assessments were not adequately current, accurate or complete.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Records reflected that individuals newly admitted to the Facility had a psychological assessment completed within 30 days of admission. Without employing a psychometrist or psychologist with the credentials necessary for intellectual or adaptive assessment, the Facility did not have the means to ensure that, at the time of admission, the individual was provided with an intellectual assessment conducted no more than 5 years previously or an adaptive assessment within the previous 12 months. See K5.	Noncompliance
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 12 individuals who were in need of counseling or psychotherapy. It was reported by Behavior Service staff, and reflected in a review of available counseling intervention plans, that counseling/psychotherapy plans did not reflect the use of evidence-based practices in relation to counseling/psychotherapy services. • 0 of 12 Counseling Treatment Plans reviewed (0%) included clearly defined and measurable goals. • 0 of 12 Counseling Treatment Plans reviewed (0%) included definitions for measuring goals • 0 of 12 Counseling Treatment Plans reviewed (0%) included specific and evidence-based counseling strategies and procedures to measure the acquisition of skills rather than reductions in undesired behavior.	Noncompliance
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	Informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information.	Noncompliance

	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.	• Implications of going without treatment and of treatment being postponed for different periods • The range of accessible diagnostic or treatment options • The benefits each option offers • The possibilities of diagnostic false results or treatment failures • The risks and discomforts of diagnostic or treatment options even when successful • Short-term injuries that diagnostic or treatment failures may cause • Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities It is the responsibility of the Facility to conduct the assessments essential for informed consent. Although improvement was noted in the behavioral assessment process, the evidence of continued weaknesses in the SFA process, as well as difficulties noted in the treatment monitoring process, indicated that BSSLC had not achieved success in meeting the obligation of providing sufficient information to the consenter. As a result, the Facility consistently failed to obtain valid and informed consent. To allow continuity in the assessment of the behavior assessment and intervention process, the PBSPs produced by the 5 most recent SFAs were reviewed. These PBSPs and SFAs involved Individual #7, #51, #261, #337 and #399. • Zero of five PBSPs (0%) included a rationale for selection of the proposed intervention. Several of the PBSPs included general statements of desired outcomes for the intervention, but none provided a clear statement of why the procedure in the PBSP was selected. • Zero of five PBSPs (0%) included a history of prior intervention strategies and outcomes. Several of the PBSPs listed a history of psychotropic drugs that had been prescribed, but none indicated what behavior interventions had been tried in the past or whether any behavior interventions had been successful. • Five of five PBSPs (100%) included consideration of medical, psychiatric and healthcare issues. • Five of five PBSPs (100%) included operational definitions of target behaviors. • Four of five PBSPs (80%) included operational definitions of replacement behaviors. • Four of five PBSPs (80%) included a description of potential function(s) of behavior. • Four of five PBSPs (80%) included the use of positive reinforcement determined to be sufficient for strengthening desired behavior. • Zero of five PBSPs (0%) included strategies addressing setting event and motivating operation issues. In several of the PBSPs, there were included general	

		guidelines for preventing or avoiding the undesired behavior. The difficulty here was that the SFAs did not involve specific procedures for identifying motivating operations, setting events or antecedents. Without the inclusion of these elements in the assessment, any prevention steps in the PBSP were based upon guesses and were unlikely to provide meaningful benefit. • Four of five PBSPs (80%) included strategies that involved the teaching of desired replacement behaviors. • Zero of five PBSPs (0%) included strategies to weaken undesired behavior. The strengthening of replacement behaviors can, if a true functional relation exists, weaken the undesired behavior. It most scenarios, however, it is essential to involve complementary procedures for strengthening desired behavior and weakening undesired behavior in the same intervention plan. This increases the probability of success and increases the efficiency of the behavior change process. None of the PBSPs reviewed at BSSLC included such procedures. • Zero of five PBSPs (0%) included a specific description of data collection procedures. • One of five PBSPs (20%) included baseline or comparison data. Although historical data were included in several PBSPs, it is important to recall that baseline data are data collected under specific conditions that provide for specific pre- and post-treatment comparisons. Too often data selected from an arbitrary point in time or that reflect an ideal treatment outcome are labeled as baseline data. Such practices obscure rather than reveal treatment effects. • Five of five PBSPs (100%) included treatment expectations and timeframes written in objective, observable, and measureable terms. It was not clear, however, upon what data such comparisons were to be based. • Five of five PBSPs (100%) included clear, simple, precise interventions for responding to the behavior when it occurs. • Four of five PBSPs (80%) included a plan, or considerations, to reduce intensity of intervention, if applicable. Of particular concern was the PBSP for Individual #337. The target behavior for this individual was inappropriate sexual touch. Throughout the SFA, the predatory and covert aspects of the Individual's behavior were used as a reason not to carry out an actual functional assessment. No effort to identify specific motivating operations, setting events or antecedents was described in the SFA, although the narrative described potential factors that were worthy of further investigation. Of special interest was the statement that, if data are correct, the behavior has occurred only twice in 7 years, but staff reported that this might be happening more often; the Facility did not attempt to develop observation protocols to identify whether there were additional instances. No functions for the behavior were identified, and it remained unclear whether the behavior was reinforced by sexual pleasure, aggression or a health condition. Due to the stated lack of	

		assessment information, the behavior intervention consisted of blocking and redirecting the behavior. Furthermore, no assessments specific to sexual offending and its treatment were carried out; there were no assessments of risk of re-offense or of factors that can direct treatment such as such as social skills, triggers for sexual excitement, and stimuli or conditions that can serve as establishing operations/motivating operations/setting events that increase likelihood of inappropriate sexual behavior and must be addressed in treatment. Forced sexual contact or predatory sexual contact can be particularly difficult to address under any circumstances. For this individual, based upon the content of the SFA and PBSP, the failure to utilize available information and devise an adequate behavior assessment eliminated the potential for an effective behavior intervention. As a result, the individual's peers were allowed to remain at risk of sexual assault.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	As described in K4, during the current site visit substantial changes were taking place in regard to data collection, recording and presentation. These circumstances rendered a review of previous practices meaningless while preventing an accurate assessment of practices under development. Further review will be conducted at the next scheduled site visit.	Noncompliance
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.	A Flesch-Kincaid Grade Level was obtained for the direct service staff instructions in the five most recently written PBSPs. Microsoft Word 2010 was used to obtain readability statistics. The measures revealed that direct service staff instruction consistently fell within the 7th to 8th grade reading level. Interviews with direct service staff, as well as residence administrators, indicated that staff infrequently experienced problems understanding PBSPs. It was unlikely that all active PBSP reflected the same level of readability as in the five most recent PBSPs. The five most recent PBSPs reflected the model for future intervention plans. Therefore, during future site visits a broader sample of PBSPs will be used to determine readability.	Noncompliance
K12	Commencing within six months of	At the time of the site visit, the facility did not have a competency-based approach to staff	Noncompliance

	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.	training. It was reported by the Behavior Service staff that a system of staff training that included treatment integrity checks and inter-observer reliability was under development. Implementation of this system was planned for early 2011. A review of this process will be conducted during the next site visit.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, BSSLC employed one staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every individual residing at the Facility and fell far short of the required ratio of one BCBA for every 30 individuals. If all staff positions eligible for BCBA credentialing were filled by a BCBA, the Facility would have one BCBA for every 21 individuals residing at the facility. BSSLC currently employs 11 Psychological Assistants. This would be sufficient to meet the ratio of one assistant for every two BCBAs even if all qualifying positions were staffed by a BCBA.	Noncompliance

Recommendations:

1. The internal and external peer review processes require careful review. The internal review process would benefit from a quality enhancement process that would assure the decisions and recommendations offered comport with the basic principles of applied behavior analysis. In regard to the external peer review process it is necessary to either expand the number of providers for peer review or establish specific policies to address the loss of a sole provider.
2. Data collection procedures require further expansion so that a wider variety of behaviors can be assessed. Specific strategies are required for measuring behaviors characterized by duration, high frequency or magnitude.
3. The ability to group data by intervention strategy and/or functional class in graphs and progress summaries is crucial. Without this ability, it is far too easy to misinterpret treatment effects.
4. The use of specific treatment expectations and additional clinical indicators must be integrated into the intervention review process. Current practices have resulted in decisions lacking a clinical basis or justification.
5. There is a need to ensure the integration of behavioral and pharmacological strategies in the treatment decision process. Documentation reflected that the first choice in response to a change in behavior is the addition of or change in a psychotropic medication.
6. The SFA process needs to be expanded to include the four-term contingency (Motivating Operation/Setting Event, Antecedent, Behavior, Consequence) rather than the three-term contingency (Antecedent, Behavior, Consequence). The four-term contingency should be integrated into both the assessment process and the recommended or preliminary intervention plan.
7. The SFA would benefit from an emphasis upon an empirical process including the development of formal hypotheses as a foundation for the behavior change plan. The latest SFA, despite many strengths, relies upon reasoning rather than empiricism.
8. The investigation of health conditions in the SFA would benefit from a more rigorous strategy. Many of the SFAs only indicated the date of the last

examination. Because of communication and cognitive limitations, as well as a predisposition toward some health conditions in certain individuals, a more in-depth investigation is often warranted and beneficial.

9. The PBSPs often fail to reflect or address the basic assumptions of applied behavior analysis, such as motivating operations, setting events, formal strategies to weaken undesired behavior and the use of replacement behaviors. A review of the existing format and required components would be helpful to identify and correct the weaknesses in the plans.
10. BSSLC needs to implement a comprehensive system of competency-based training in regard to applied behavior analysis and specific PBSPs. Plans to implement a treatment integrity process will be helpful, but staff also need to demonstrate competence in each PBSP before that plan is implemented.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. The clinical records of the following individuals were reviewed**:** #344, #229, #29, #23, #59, #33, #33, #505, #60, #42, #186, #417, #152, #379, #514, #86, #98, #375, #305, #65, #15, #61, #12, #420, #52, #294, #589, 2. Physician Procedure and Best Practice Guidelines, no date, no policy number. 3. Mortality review process and forms 4. BSSLC Plan of Improvement (POI), 12/29/10 5. BSSLC Cardiopulmonary Resuscitation Committee (CPR) Purpose, No Date 6. Texas Department of Aging and Disability Services, state supported Living Centers Policy: Medical Emergency Response, Policy Number: 044, Date: 7/21/10 7. BSSLC All Facility Safety Committee Meeting Minutes, July, 2010 through December, 2010 8. BSSLC Emergency Equipment Checklist for Driscoll, Health Center Building, Bowie, Childress, and Fannin, December, 2010 9. BSSLC New American Heart Association Healthcare Provider Renewal Training Manual for CPR, Revised: 1/6/11 10. BSSLC CPR Mock Medical Emergency Internal Operating Procedure, No Date 11. BSSLC Mock Medical Drill Schedules, July, 2010 through December, 2010 12. BSSLC Completed Mock Medical Emergency Drill Sheets, July, 2010 through November, 2010 13. BSSLC List of Staff Delinquent in First Aid, CPR or ACLS (if applicable) 14. BSSLC Oxygen Tank Guidelines – Training course provided to nursing staff. 15. Texas Administrative Code, Social Services And Assistance Department of Aging and Disability Services, Client Care – Mental Retardation Services, Deaths of person Served by TXMHME Facilities or Community Mental Health and Mental Retardation Centers, Title 40, Part 1, Subchapter K: 16. Rule § 8.70: Facility Campus-Based Programs and Facility Community-Based Services: Clinical Death Review 17. Rule § 8.271: Facility Campus-based Programs: Clinical Death Review Determination 18. Rule § 8.273: Facility Campus-Based Programs and Facility Community-Based Services: Clinical Death Review 19. Rule § 8.275: Facility Campus-Based Programs, Facility Community-Based Services, and Community Centers: Administrative Death Review 20. BSSLC Center Administration/Committees: Clinical Death Review Committee, Revised: 10/5/10 21. BSSLC Center Administration/Committees: Administrative Death Review Committee, Revised10/1/10 22. BSSLC Clinical and Administrative Death Review for Individuals #77, #344, #505, and #561 **People Interviewed:** 1. Brandy Todd, LVN III, Quality Assurance 2. Jill Quimby, RN Quality Assurance Nurse

	3. Bret Hood, MD, Medical Director 4. Kori Keim, PT, Habilitation Therapy Director **Meeting Attended/Observations:** 1. Observations were made of individuals at the following living areas: Childress, Driscoll, and Bowie Springs 2. PSP meeting for individual #294 on January, 11, 2010.
	Facility Self-Assessment: For provision L1 of the Settlement Agreement, the Facility reported that they remain out of compliance and had completed the following actions: 7/2010 - Emergency Kits are on all units; 7/1/2010 – MOSES is completed every 6 months and DISCUS is completed every 3 months. Side effects are assessed each month during PTRs and reviewed in the Quarterly Nursing Assessments or more frequently as warranted; and 9/20/2010 – In-service training on the DISCUS for Physicians and Pharmacists was provided through CTD. For provision L2 of the Settlement Agreement, the Facility reported that they remain out of compliance and provided the Monitor Team with the following progress report: This provision has not been established at this time. An internal review is completed. For provision L3 of the Settlement Agreement, the Facility reported that they remain out of compliance and stated that as of 12/20/10, there were weekly meeting with Dr. Moy, State Office, to discuss systems, medical issues, policy issues, results of department workgroup, and review of clinical pathway prepared by subgroup. For provision L4 of the Settlement Agreement, the Facility reported substantial compliance for the following reason: Policy was approved by the P&P Committee and physicians were trained. The Facility reported only a few actions taken to establish compliance. This rate of progression will not be adequate to bring the Facility into compliance with the provisions of this section within timelines established in the SA.
	Summary of Monitor's Assessment: The Monitoring Team recognizes some important improvements at the DADS State Office (SO) level. The SO conducts regularly scheduled meetings with medical leadership from all Facilities to address medical-administrative issues. This has led to a more unified structure of medical services. The SO, in collaboration with Facilities, is developing various clinical pathways, and their progress is commendable. The pathways that are developed through this enhancement activity will provide clinicians a better understanding of the most common and significant health care issues experienced by individuals with developmental disabilities. Review of Medical Services at the Facility led to the Monitoring Team having significant concern over the progress of providing basic health care services. There had been some improvement, on occasion, with

	follow-up to acute and chronic health care conditions and clinical documentation, and moderate improvement with the emergency response process. Under the leadership of pharmacy services, physicians (and nurses) at the Facility had also made impressive advances in the area of polypharmacy and reducing prescription errors. The Facility has developed a policy entitled "Physician Procedures and Best Practice Guidelines," which outlines quality standards for provision of care. Physicians at the Facility had all reviewed the policy but had not consistently adopted its standards into their clinical practice. As noted below under provisions L1, L2, L3 and L4, significant issues remain that must be promptly addressed by the Facility. Of particular concern is the lack of comprehensive understanding of the individual's health care needs, leading to appropriate follow-up and integration of health care issues by means of an interdisciplinary process. Many serious medical conditions go under-diagnosed and under-treated. The Facility utilized a mortality review process that included both a clinical review and an administrative review. This process had the potential to identify issues that could be addressed to improve medical care, but the Facility did not follow its own policies and procedures in conducting mortality reviews by not completing the reviews timely and as comprehensively as necessary to develop system improvements. The Facility's clinical review of deaths did not fully identify important clinical issues, and when issues were identified, there was no mechanism in place to provide on-going follow-up to ensure that when system enhancements are developed and implemented, that they are sustainable and efficacious. The Facility had not implemented or developed a medical review process that would involve a non-SSLC physician's review of clinical practice at the Facility. Of specific concern is the Facility's inability to readily retrieve, real-time, basic, clinical information. Without prompt attention in developing a strategic plan to address medical issues and related practice, the Facility will remain non-compliant with provision L of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance	During the on-site review, the Monitoring Team assessed compliance for Provision L1 by interviewing the Facility's Medical Director, Dr. Bret Hood, MD and reviewed the clinical records of 27 individuals (#344, #229, #29, #23, #59, #33, #33, #505, #60, #42, #186, #417, #152, #379, #514, #86, #98, #375, #305, #65, #15, #61, #12, #420, #52, #294, and #589). Issues, including standard of care practice, the Facility's adherence to its policies and procedures, documentation practices, record keeping and clinical outcomes were assessed. Case Reviews: Individual #294 The Monitoring Team attended an annual PSP meeting for individual #294 on January,	Noncompliance

	with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	11, 2010. Although a nurse was present, there was no physician participation at the time of the meeting. The annual medical assessment indicated an active problem list that included osteoporosis, benign prostate hyperplasia (BPH), post transurethral prostate resection (TURP), hypovitaminosis D, rectal digging, history of recurrent parasitosis and thoracolumbar scoliosis. The active problem list also included the diagnosis of stereotypic movements. The clinical record demonstrated that the individual underwent a colonoscopy on September 22, 2009 and noted parasites and colonic polyp. The team, including the nurse, was completely unaware of the individual undergoing a colonoscopy, history of intestinal parasites and BPH with TURP. Importantly, the nurse commented that although not diagnosed, the individual has constipation that recently required additional medical treatment. Also, psychology initiated a program for continued rectal digging. After review of the clinical record, it was noted that treatment for parasitosis was initiated in September, 2009; however, there was no information to document that treatment was effective by laboratory confirmation. A physician progress note indicated that the team should inform her if rectal digging remained problematic, which was not done by the PST. While observing the individual, the Monitoring Team observed the individual making numerous attempts to reach at his perianal area. Several important and potentially significant issues were raised subsequent to the team meeting: 1. The team was unaware that they were to closely monitor rectal digging and report to the physician 2. The team was unaware of the history of parasitosis and the potential impact on the individual and others at the center. Intestinal parasites can manifest in behavioral issues such as rectal digging, cause constipation, be very uncomfortable to the individual, and be highly contagious for others. This issue should have been closely monitored until documented resolution. 3. The team, including nursing services, was unaware of the recent history of the colonoscopy. Importantly, the results, and follow-up recommendations were not reported in the clinical record, nor known by the team. Given that a polyp was seen at the time of colonoscopy, it is important for the team to understand its histology and potential risk for colon cancer. Some polyps are benign, while others have a potential for developing into cancer. Constipation is a potential manifestation of colon cancer. 4. The team should be made aware of the importance to continue to monitor the individual secondary to his history of BPH.	

		The monitoring team reviewed the clinical record of Individual #294 to assess clinical care. On October 1, 2010 the individual was noted by nursing staff to have bilateral ankle edema. The physician evaluated the individual and prescribed Lasix for "dependent edema". Lasix is a potent diuretic medication usually used to treat hypertension and fluid retention secondary to heart failure or renal failure. Prudent clinical assessment and laboratory evaluation is critical during the first few weeks following initial administration of Lasix. Documentation of the initial physician examination, per the clinical record, was limited and did not include information such as review of system, physical examination or differential diagnosis. An order to obtain "electrolytes" in one month" was also written by the physician on the day prescribing the medication. No further review by the physician was noted in the clinical record until the laboratory result were returned on November 4, 2010, which demonstrated critical and potentially life threatening results that included a sodium level of 168, a BUN of 83 and creatinine of 2.97. These results demonstrate severe dehydration, most likely secondary to treatment with Lasix. Importantly, the individual's amylase and lipase were noted to be 312 and 157 respectively, suggesting possible pancreatitis, which is a common medication side effect from Lasix. The documented initial assessment for edema, and treatment without careful monitoring for side effects during the initial few weeks of prescribing Lasix, clearly falls outside of standard of care practice and placed the individual at risk for adverse outcome. Review of the individual's health rating tool demonstrated that the individual had a low risk for seizures and constipation; however, upon review of the clinical record it was noted that the individual actually had a diagnosis of seizure disorder and constipation. These findings support critical failures in the health tool assessment process. Clearly, if an individual has an actual diagnosis of a condition, the assessment tool should list a high risk for that condition. The individual was noted to have two of three positive stools for occult blood on August 9th and September 21st of 2010. The only documented response to this potentially serious finding, in a person with known anemia, was the explanation that the person received suppositories. Importantly, at the time of the individual's most recent hospitalization in November, 2010, the hospital noted both positive hemoccults and gastrocults and suspected gastrointestinal bleeding and immediately transfused the individual with blood products. All positive hemoccults must be further evaluated to exclude potentially life threatening gastrointestinal bleeding. Hypothesizing that positive results are secondary to the administration of suppositories is not adequate. The most current active problem list, dated November 10, 2010, and last annual health care review did not comment on the diagnosis of hypothermia; however, upon further review of the clinical record, there were documentation and physician orders warning staff of the condition and to ensure that the person is kept warm during episodes of	

		hypothermia. Hypothermia may indicate a serious medical condition and the etiology should be explored by a comprehensive medical evaluation that may include special imaging studies and consultations. No such evaluation was noted in the clinical record, nor was a diagnosis of the condition noted in current records. Per review of his PSPs, none of the issues outlined for this individual were well known by the PST, demonstrating complete failure to integrate important health issues into the person's total care and support by the Facility. Following review of the annual and addendum PSP reports for individuals #294, the monitoring team concludes that the facility did not adequately incorporating health care issues in an integrated manor. Following review of annual PSPs for 26 additional individuals (#344, #229, #29, #23, #59, #33, #33, #505, #60, #42, #186, #417, #152, #379, #514, #86, #98, #375, #305, #65, #15, #61, #12, #420, #52, #589) the Monitoring Team determined that in no cases were health care issues adequately integrated within the PSP. Individual #60 The clinical record of individual #60 was conducted by the monitoring team to assess clinical care related to the individual's chronic constipation and worsening ability to ambulate. The individual is known to have a significant history of chronic constipation. The individual was hospitalized on two occasions in November of 2010 for constipation and one occasion for possible PICA. The individual received multiple bowel stimulants, stool softeners and bulk forming agents, as well as prn enemas. Bulk forming agents are generally determined to be helpful in cases of constipation; however, the individual must be very well hydrated, otherwise these supplements can actually cause constipation and possibly obstruction and perforation of the bowel. Although the physician ordered extra fluids to be given between meals, laboratory date at the time of hospitalization demonstrated that the individual was dehydrated. Also, laboratory data found within the clinical record on 11/3/10 demonstrated a BUN/Creatinine ratio of 43 and on January 17, 2010, 29, suggesting the possibility of subclinical dehydration. More careful monitoring of fluid intake is warranted for all persons that receive bulk forming agents. The individual's progressive loss of ability to ambulate has been attributed to Parkinson Disease. Its important to note, however, that although not listed on the problem list or annual medical review, an X-ray completed in 2008 of the thoracic spine demonstrated degenerative disease of the thoracic spine and "old deformity of the clavicle." It was also noted that the individual has marked kyphoscoliosis and leans to the left and has clonus of the left lower extremity (as noted by physical therapy). The issue of degenerative spine disease should have been more assertively explored. Issues such as compression fractures, prolapsed disc disease and arthritis of the spine are conditions that should be included in a differential diagnosis for the individual.	

		Individual #59 A clinical record review and interview with the director of habilitation therapy services were completed to assess the functional decline of individual #59. This individual has had a long-standing issue with mild to moderate ataxia. During the past 12 months, the individual was noted to have experienced significant deterioration with his ability to ambulate and worsening ataxia. He also developed severe oropharyngeal dysphagia, which necessitated the placement of a PEG tube. He was hospitalized for Lithium toxicity on August 23, 2010. A CT of the abdomen and pelvis done August 28, 2010, demonstrated an old (and unknown to the Facility) fracture of his a portion of his spine (transverse process of L3), as well as fluid accumulation measuring 4.2 cm by 2.0 cm in the subcutaneous space of the right hip region, which was suggestive of a hematoma, abscess or tumor. The Facility physician ordered an orthopedic consultation on June 5, 2010. The individual was reported not to be cooperative during the orthopedic consultation and the physician was unable to perform an examination and ordered a Spica wrap, which the individual did not comply with. A neurologic consult was ordered for September 29, 2010 for progressive decline in function, worsening gait disturbance and a negative MRI of the brain. The consulting neurologist suspected that the individual had a neurodegenerative disorder and that no treatment was available and no follow-up was required. The Facility's Physical Therapist reported that she evaluated the person in March 25, 2010, for unsteady gait following a course of injuries. The individual experienced severe aggression, which limited the ability of the Physical Therapist to fully examine the person, but the individual demonstrated significantly worsening ataxic gait and a more dyskinetic gait and clonus when compared to the examination completed in September of 2010. Given that this person most likely sustained a significant trauma to the spine, which resulted in a fracture of the transverse process of L3, and taking into context the individual's inability to ambulate, worsening ataxia and clonus, the physical therapist concurs with the Monitoring Team that musculoskeletal issues, including the possibility of spinal cord injury, should be included in a comprehensive differential diagnosis of the individual. Importantly, the PST was not well informed of his medical issues and important clinical information, such as recurrent injuries, a history of a fractured spine (which was not documented anywhere in the clinical record), clonus suggesting an upper motor neuron disorder, worsening weakness of his lower extremities, suggestion of a lower motor neuron disorder, worsening dyskinesia, worsening aggression and agitation and now his confinement to a wheel chair. Following review of the clinical record, the Monitoring Team also determined that the orthopedic and neurology consultants were not provided adequate information to fully understand the clinical issues of the individual. At a minimum, a comprehensive plan to determine the root cause of this condition must be entertained by the clinical team and the PST, including the LAR. The etiology of his condition may never be fully known; however, the Facility has an obligation to understand and develop rational possibility based on known facts in the clinical record, longitudinal observations, and physical assessments.	

		Individual #33 The clinical record of individual #33 was reviewed by the Monitoring Team to assess clinical competency. The individual is known to have CHARGE syndrome, history of cryptorchidism (undescended testicles), which were surgically repaired, severe gastritis and oropharyngial dysphagia with aspiration. The individual also had a series of chest x-rays that demonstrated a persistent infiltrate in the medial base of the lung behind the heart that required close follow-up, and a follow-up chest x-ray was ordered on August 6, 2010 but was never completed by the Facility. On November 16, 2010, the individual was sent to the hospital for possible aspiration and the hospital radiologist, again, requested follow-up x-ray for the suspicious infiltrate. Nowhere in the clinical record or the PSPs had CHARGE syndrome been delineated as an important medical condition that requires life-long monitoring and treatments for co-morbid medical and psychiatric conditions. CHARGE syndrome is complicated by many serious medical and behavioral issues that require close monitoring throughout the individual's life, including urogenital problems, gastritis, GERD, and cardiac conditions, among others. The individual was surgically treated for cryptorchidism (undescended testicles); however, this condition was not closely monitored, nor were its implications clearly known by the PST. Cryptorchidism is one of the leading causes of testicular cancer, and despite surgical correction, the individual must be monitored closely for signs and symptoms of testicular cancer. A specific health care plan should be delineated for this condition. Individual #24 Individual #24 has a significant medical history consisting of many serious conditions, including Marfan syndrome, congestive heart failure, atrial fibrillation, hypothyroidism, chondromalasia of the knee, history of lithium toxicity, mitral valve prolapse, thrombocytosis (potential bleeding risk factor) and history of deep venous thrombosis and pulmonary emboli, requiring chronic anticoagulation therapy, among other conditions. Because of challenges with anticoagulation therapy, the individual underwent a procedure to have a mechanic filter placed into the inferior vena cava to prevent thrombosis from traveling to the lung. Despite the significant medical diagnosis, known heart failure, osteoporosis, and a serious connective tissue disorder, the individual remains a full code, and there was no discussion with the PST and LAR about the possibility of altering the code status. More important, the PST was not made aware of the significant health issues and how physical and mechanical restraint would be very	

		high risk in this individual. The Monitoring Team raised serious concerns with the Facility's Medical Director when it learned that the individual was cleared medically for unrestricted use of mechanical and physical restraint, in the event of a behavior issues. In this case, the PST should be well aware of the many clinical concerns, especially the diagnosis of Marfans, atrial fibrillation, risk for deep venous thrombosis and pulmonary emboli (despite the placement of a filter), and special precautions, monitoring, and awareness by staff of these conditions in the event restraint would be required. Documentation Issues: On Monday, January 10, 2011, at approximately 15:00, the Monitoring Team requested a list of names of individuals who had various medical diagnoses, such as diabetes, hepatitis, degenerative spine disease, arthritis, among others. The Facility was not able to provide the Monitoring Team with any information regarding this most basic request until Thursday, January 14th. When the requested information was provided, it was provided in a way that was not useful for clinical applications, When the Monitoring Team discussed the issue with the Medical Director, Dr. Bret Hood, the Monitoring Team was informed that the Facility has no mechanism to quickly retrieve accurate clinical information and must rely on nurses and other staff to actually review all of the clinical records at the Facility. The information requested by the Monitoring team was basic information that all Facilities must have access to on a regular, real-time basis. It is essential that the Medical Director and other clinical leadership have immediate access to vital clinical information necessary to make clinical decisions and to monitor health related outcomes at the Facility. For example, a medical director must be able to access a real-time list of all persons with diabetes or aspiration pneumonia, so he can assess and ensure that these conditions are managed appropriately at the Facility. Not having ready access to basic health care information is unacceptable for a Facility that provides the level of health care demanded of a developmental center. Emergency Procedure and Drills: Review of the Facility's completed Mock Medical Drills indicated that required drills were completed July 2010 through December 2010. However, not all required Mock Medical Drills were completed according to schedule for August, September, October, November, and December, 2010. Incomplete drills were carried over to the following month. Incomplete drills for December 2010 were carried over until January 2011, but were not complete at the time of the tour. The monitoring team interviewed Brandy Todd, LVN, who assists the Risk Manager in coordinating the Mock Medical Drills and asked what the barriers were to timely completion of the drills. Ms. Todd stated, *"There is not enough emphasis and/or support on the importance of these drills from supervisors or upper administration. It was not really the importance that the drill gets completed but the importance of the drill's purpose itself. The only time they stress the drills need to be done is in the last week of the month. Ninety percent of the scheduled employees wait until the last*	

		few days to complete their drills despite the schedule being sent out at the beginning of the month and reminders throughout the month of drills still needing to be completed. Supervisors receive these e-mails as well. If a drill fails twice or a staff member refuses to participate in the drill, there is no follow up or PPM (Personnel Performance Management) *action done by the managers/supervisors."* Recognizing these problems Ms. Todd stated, *"I am going to start getting copies of the drills when they are turned into* the Risk Manager *and reviewing each one and recording the date done and compiling the data. The new form* (Mock Medical Emergency Drill form) *came out in July 2010 and six months later we are still getting incorrect forms; there needs to be more accountability held by the CPR Instructors/RNs scheduled to completed the drills so if a drill is turned in on the wrong form it will have to be redone on the correct form."* The monitoring team reviewed all of the various Facility Safety Committee Meeting Minutes, July 2010 through December 2010, in order to determine if the Committee reviewed and critiqued the Mock Medical Drills. It was rare to find any discussion regarding Mock Medical Emergency Drills. There were a few mentions in some of the Committee minutes regarding CPR drills. The comments were limited to the need for personnel responsible for conducting the drills not to wait until the end of month to conduct the drills or the fact that drills were completed a month late. Several times the Risk Manager stated in the Facility Safety Committee Meeting Minutes that he, "w*ould appreciate that all CPR Mock Drills are done in a timely manner, rather than waiting until the end of the month to complete."* For the Risk Manager to simply encourage the staff responsible for conducting Mock Medical Emergency Drills was not effective means of corrective action, since as of December 2010, numerous drills were not conducted. Waiting until the end of the month or completing drills a month late is not acceptable practice as it violates the State's Emergency Response Policy and does not maintain the readiness of the staff to respond to an actual code requiring CPR. The Facility should take aggressive corrective action with staff responsible for conducting Mock Medical Emergency Drills to ensure that they are completed in a timely manner and in accordance with drill schedules. The document request included a request for the Facility's Medical Emergency Response Trend Analyses, but this was not received. The Facility failed to meet the State Medical Emergency Response Policy's Quality Assurance requirement that included: A. The State Center must have a system in place to: 3. Ensure a trend analysis is completed. B. Data must be reviewed at least monthly and trends must be analyzed quarterly. C. Documentation of trends and follow-up on systemic corrections of identified issues must be maintained. D. The facility's quarterly trend analysis report and corrective actions will be shared with the State Office Quality Enhancement Coordinator.	

		The Facility should evaluate compliance with the State Medical Emergency Response. The Facility's Quality Assurance Department should include audits of the Emergency Response System. Review of the recently established (December, 2010) CPR Committee's purpose stated the following: • This Committee was created to meet and review any CPR occurrence at BSSLC. • The Committee will meet within three business days of the occurrence on campus. • The Committee consists of: o Physician o QA Nurse o Risk Manager o Nurse Manager o Chief Nurse Executive o Other staff as needed based on incident Ms. Todd reported there had been no CPR occurrence since the Committee was created. The Committee will be implemented with next CPR occurrence. This was a positive finding since the last tour; however, the Committee's purpose implies that the Committee was designed for an actual code when CPR was applied. This does not negate the need for this Committee to periodically critique the effectiveness and correctness of the Mock Medical Emergency Drills. Any problems with staffs' readiness and competency should be identified and corrected before an actual code requiring CPR occurs. The Facility should strengthen the Emergency Response System by including the involvement of the Medical Director and Chief Nurse Executive in periodically critiquing the Mock Medical Emergency Drills. Review of 125 completed Mock Medical Emergency Drills sheets indicated that one (0.8%) of 125 completed drills was marked as failed. The one failed drill conducted on Bowie B on 9/25/10 at 2:05 p.m., documented in the Comment/Concerns section, *"Staff was walking around the home with the TV remote, another one said that she was too old. CPR did not get started until … LVN came in".* There was no plan of corrective action documented. While there was only one failed drill identified, it was questionable that out of 125 drills only one drill failed. It is important that the staff conducting the drills accurately assess the competency of the staff performing the drill. The Facility, according to the State's Emergency Response Policy and the Facility's CPR Mock Drills internal operating procedures, should take the following corrective action: State's Emergency Response Policy, IV. Immediate Plan of Action states: A. Immediate concerns and recommendations will be noted by the person responsible for conducting the drill on the checklist following each drill. A	

written plan of action will be developed to address the concerns and recommendations for each drill with follow-up documentation noted on the outcome of actions taken.

B. A file for completed drill checklists will be maintained at each State Center. (Hence, the purpose of the filed drill checklists was for the Facility's personnel responsible for reviewing completed drills to review and ensure that drills were completed according to Policy.)
C. When an error is committed during a drill, the drill monitor will document an action plan on the drill checklist addressing what action will be taken to correct the error. The action plan will be developed by the person responsible for conducting the drill.
D. Any direct service staff member who fails a drill and also fails the retry will not be allowed to work unsupervised with individuals until this staff member completes and passes the drill. The person responsible for the drill will ensure follow-up until each staff member completes and passes the drill satisfactory.

BSSLC CPR Mock Drill internal operating procedures:

- If a scheduled drill fails:
  - Retraining is to be completed immediately and documented on the mock drill sheet.
  - The drill is performed again immediately following retraining.
  - If the drill is failed the second time, the immediate supervisor is notified and the employee must attend a CPR refresher as soon as possible. This is to be determined by the supervisor.

Review of the 125 completed Mock Medical Emergency Drills found numerous outdated drill forms, as was identified in the last tour, e.g., forms dated 10/27/08 and 2/2/10. According to the Facility's POI and interview with Ms. Todd, a system was put in place in August, 2010 whereby a copy of the current drill form, dated 7/21/10, was e-mailed to the drill coordinators along with the drill schedule to use when completing drills. Since the outdated drill forms were found on review, this method of eliminating the use of outdated forms was not effective. The Facility should develop an effective method of eliminating the use of outdated Mock Medical Emergency Drill forms. The current Mock Medical Emergency Drill form failed to contain a space at the top of the form to check whether the drill was passed or failed. The Facility should modify the current Mock Medical Emergency Drill form to include a space at the top of form to check where the drill was passed or failed.

Copies of the last six month's completed Emergency Equipment Checklists were requested in the document request but were not made available. Monitoring team requested onsite copies of at least December, 2010's checklist for review. Copies of the December, 2010 checklist were received for all areas except for the Cottages. The Nurse

		Manager for the Cottages apologized for not having the Cottage checklist available and explained he knew they would be needed but was unable to locate them for review. Review of the available Emergency Equipment Checklist for Bowie, Driscoll, Childress Fannin, and Health Center Building revealed that two (40%) of the five areas, Driscoll and the Health Center Building, were completed daily with all equipment checked. Bowie, Childress, and Fannin failed to consistently check equipment daily. Bowie and Fannin consistently failed to indicate the daily psi of the oxygen tanks. Fannin staff initialed this item and the Bowie staff stated that the "bag was sealed" as opposed to documenting the psi of the oxygen tank. There was documented evidence that the five (100%) areas' Emergency Equipment Checklists were audited monthly by the Nurse Managers or designees. However, the Nurse Managers or designees auditing Emergency Equipment Checklists in Bowie and Fannin failed to recognize and correct the lack of daily recording of the psi of the oxygen tanks. It is important to daily assess the psi of the oxygen tank to ensure there is always an adequate supply of oxygen available to use in an emergency and to know when to reorder oxygen. The Nurse Managers or designees auditing Bowie, Childress, and Fannin also failed to take corrective action for items not checked daily on the Emergency Equipment Checklist. The Nursing Department should ensure when Emergency Equipment Checklists are not checked correctly or completely that the Nurse Managers or designees take immediate corrective action and document such action on the checklist. Review of the list of staff delinquent in First Aid, CPR, or Advanced Cardiac Life Support (ACLS) certifications (if applicable), indicated that across all disciplines there were 36 staff delinquent in such certifications. The Facility's managers and supervisors should ensure that all staff remains current in First Aid, CPR or Advance Cardiac Life Support (ACLS), if applicable for ACLS, certifications.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	With regard to provision L2 and the Facility's progress in developing, and implementing a meaningful process to conduct medical reviews, that includes non-Facility physicians to enhance quality of medical care and performance, the Facility's Medical Director, Dr. Bret Hood, reported to the Monitoring Team that the Facility had not implemented or developed a medical review process that would involve a non-SSLC physician's review of clinical practice at the Facility. There were no data or other information provided by medical services that could support any progress for this provision of the SA. For this reason, the Monitoring Team had determined the Facility is not in compliance with provision L. 2 of the Settlement Agreement. Compliance will require a process that provides regular and on-going assessment of clinician practice, and ensure their performance meets or exceeds standard of care practice, and that they adhere to all of the Facility's policies and practice guidelines, with regards to clinical practice. The Monitoring Team spent considerable time reviewing the Facility's approach to	Noncompliance

		reviews of death at the Facility by reviewing policies, interviewing personnel, assessing forms, and conducting reviews of clinical records of persons who recently expired. Following the review, the monitoring team noted that the Facility did not follow its own policies and procedures in conducting mortality reviews by not completing the reviews timely and as comprehensively as necessary to develop system improvements. The Facility's clinical review of deaths did not fully identify important clinical issues, and when issues were identified, there was no mechanism in place to provide on-going follow-up to ensure that when system enhancements are developed and implemented, that they are sustainable and efficacious. The purpose of a mortality review process is to ensure that individual and system issues are promptly addressed, and that lasting remedies are implemented. The following outlines issues related to the Facility's progress in developing a quality of care process and specific issues related to mortality review and clinical findings through a review of clinical records of persons who recently expired at the Facility. Four deaths occurring during the past six months were reviewed for compliance with the Facility's Clinical Death Review Committee and Administrative Death Review Committee Policies and Procedures. The death review system required the following action steps: <u>Clinical Death Review Committee</u> 1. Within five working days of notification of death, the physician completes a death/discharge summary for the record. 2. Within 14 working days of notification of death (45 calendar days in cases in which an autopsy is performed) the Clinical Death Review Committee meets. 3. Within 21 calendar days of completion of review by the Clinical Death Committee (52 calendar day in cases in which an autopsy is performed) the Clinical Death Review Committee will forward a report to the Administrative Death Review Committee 4. Copies of all Clinical Death Review information will be sent to DADS Medical Coordinator at State Office. 5. Timeline Exceptions: The Facility Director is authorized to grant variances from the timelines described above on a case-by-case basis. <u>Administrative Death Review Committee</u> 1. Within 14 days of receipt of the information from the Clinical Death Review the Administrative Death Review Committee will conduct a review. 2. Within 14 calendar days of the receipt of the information from the Clinical Death Review Committee, the Administrative Death Review Committee will submit copies of the following information to the Department of Aging and Disability Services (DADS) Medical Services Coordinator: a. Death/Discharge Summary b. Preliminary investigation c. Death certificate	

		d. Preliminary or full autopsy report, if available e. Probable final diagnosis, including contributory causes, and reasons for variance from the death certificate, if any f. Recommendations that are systemic in nature from the Clinical Death Review Committee and Administrative Death Review Committee g. Documentation of the effort to obtain external membership for the Clinical Death Review Committee and/or Administrative Death Review Committee, if no such medical professional and/or representative of the public was available 3. Within 28 calendar days following the submission of the above stated elements, the Director or designee will submit a summary of the resulting actions taken in response to the recommendations of the Administrative and Clinical Death Review Committees to the DADS Medical Services Coordinator. Four deaths occurred from July, 2010 through November, 2010. The Clinical Death Reviews and Administrative Death Reviews were made available for review during the onsite visit. Three of the deaths reviewed had the Death Certificates listing final first and second causes of death. The Death Certificate for the fourth death was not available for review. <u>Clinical Death Review Committee reviews</u> • There were no autopsies performed on the four deaths. • Four of four Clinical Death Review Committees had the required membership present, including an external physician, except State Office Medical Coordinator or designee. • Four of four Death/Discharge Summaries were not completed within the required five working days. • Four of four Clinical Death Review Committees were not convened within the required 14 working days. • Four of four of the Clinical Review Committees' reports were not forwarded to the Administrative Death Review Committee within the required 21 calendar days of the completion of the Clinical Death Review Committee. • According to the Quality Assurance Nurse's discussion with the Facility Director, permission was not granted for variances from the established timelines for the various components of the four Clinical Death Reviews. <u>Administrative Death Review Committee review</u> • Four of four Administrative Death Review Committees were not convened within the required 14 calendar days from receipt of the information from the Clinical Death Review Committee. • Documentation was not available for review verifying that the Administrative Death	

		Review Committee sent the required Clinical Death Review Committees' information from the four deaths to DADS Medical Coordinator. An interview with the Quality Assurance Nurse explained the procedure for follow-up to Nurse Death Review Summary findings and recommendations. During and/or upon completion of the Nurse Death Review Summary, usually completed within one to two working days, the Quality Assurance Nurse verbally reports and sends copies of the Nursing Death Review findings and recommendations to the Chief Nurse Executive and Nursing Operations Officer. The Nursing Department performs a plan of correction when indicated. The Quality Assurance Nurse follows up to see that the corrective action plan, if any, was satisfactorily implemented and carried out. If not, the Quality Assurance Nurse makes suggestions and/or requests for improvement. An example given by the Quality Assurance Nurse was for a recommendation for the Nurse Educator to in-service nursing staff on Nursing Considerations when Administering Lasix. Upon follow up the Quality Assurance Nurse found that an information sheet for the administration of Lasix had been developed and posted in all medication rooms on 12/22/10. The Quality Assurance Nurse sent the Nurse Educator an e-mail explaining that an information sheet on the administration of Lasix was not sufficient and requested a more active approach to training. At the time of the tour the there was no documentation that the Nurse Educator had followed up on the Quality Assurance Nurses recommendation. This issue will be followed up on the next tour. After review of medical records for the four individuals, there were concerns identified regarding early identification and treatment of acute respiratory illnesses for individuals #344 and #505, as described below. For both these cases, further detail may be found in Provision M1. • The monitoring team reviewed clinical records for individual #344, 7/12/10 through 8/19/10. Individual #344 had a diagnosis of asthma and allergic rhinitis with a history of pneumonia and bronchitis. The Integrated Progress Notes on 8/10/10 at 5:30 p.m. documentation indicated an acute change in individual #344's respiratory status. The direct care professionals reported to the nurse that individual #344 was coughing and gagging. The nursing assessment documented audible coughing and wheezing with oxygen saturations (O_2Sats) were 89 to 91%. Levalbuterol nebulizer treatment was administered. Vital signs were Temperature 99.0°, Blood pressure 116/75, and respirations 18. Pulse was not documented. After the nebulizer treatment O_2Sats increased to 91 to 96% on room air. No further coughing or wheezing was heard. Although the acute respiratory symptoms subsided there was no documentation that the nurse either notified the physician of individual #344's acute change in respiratory status or the Nurse Case Manager. The nurse's note stated "Will continue to monitor." Individual #344's respiratory status	

		continued to be monitored every four hours twice then each shift through to 8/14/10 at 4:27 a.m. without further respiratory symptoms. A note stated monitoring was no longer needed. Although, the per necessary (PRN) nebulizer treatment of Levalbuterol was carried out as ordered with symptomatic relief the nurse should have notified the physician of the acute change in respiratory status in order to keep the physician informed and to determine if individual #344 needed to be seen. The Nurse Case Manager should have also been notified for follow-up. The Nursing Department needs to ensure that when individuals experience acute change in health status that the physician and Nurse Case Managers are notified of such changes. After review of the clinical records for individual #344 numerous issues of grave concern were identified: The nursing staff and physician failed to recognize and appreciate individual #344's deteriorating respiratory status at the onset at least 24 hours preceding hospitalization and provide or seek aggressive medical intervention, rather individual #344 was treated symptomatically until reaching the crisis point. The Facility needed to, but did not, question whether individual #344 might have survived if the individual had received timely and aggressive medical intervention at the onset of acute changes in respiratory status. • The monitoring team reviewed clinical records for individual #505, 7/10/10 through 9/14/10. Individual #505's current active medical diagnoses included: Profound mental retardation, spastic quadriplegia, constipation, and fibrocystic breast disease. The Integrated Progress Notes on 8/22/10 at 5:10 a.m. documentation indicated an acute change in individual #505's respiratory status. The direct care professional informed the nurse that individual #505 "felt warm". Vital signs were recorded as temperature 99.5 ° , pulse 120 (baseline pulse reported at 82 in 8/12/10 Annual Nursing Assessment), respirations 30 unlabored, blood pressure 109/52, and O_2Sats 92%. Lungs were assessed and documented as breath sounds present in all four quadrants with lungs CTA. At 2:45 a.m. the temperature increased to 100.6° . Other vital signs were not documented. A Tylenol 650 milligram was administered for the elevated temperature. At 3:40 a.m. and 5:00 a.m. individual #505s' temperature was documented at 99° and individual #505 was sleeping. No other vital signs were documented. The nurse documented "will continue to monitor and inform nurses during shift report." There was no documentation that the physician or Nurse Case Manager was notified of individual #505's acute change in respiratory status. Monitoring continued. Through out the review of Individual #505's clinical record only the temperature was recorded without the other vital signs. Because individual #505 frequently had elevated pulse and respiration rates, and low O_2Sats these measurement were important to accurately monitor health status. The Nursing Department needs to ensure that when temperatures	

		are taken that a completed set of vital signs are also taken. On 9/710 at 8:00 a.m. the nurse documented that individual #505 was lying in bed with eyes closed and had not opened them this morning. Vital signs were documented as temperature 97.8° (T), pulse 92, respirations 32, blood pressure 118/77, and O_2Sats 85% with oxygen as 3 liters per minute. Oxygen was increased to 4 liters per minute and O_2Sats increased to 94% with 4 liter per minutes. The nurse documented that congestion was found but no respiratory assessments were documented. There was no documentation that the physician was notified of the decreased in O_2Sats. On 9/7/10 at 9:30 a.m. the physician examined individual #505. The physician assessed individual #505 as hypoxia, decreased level of consciousness, and tachypnea. The physician ordered individual sent to the emergency room via Emergency Medical Services. On 9/7/10 at 9:45 a.m. individual #505 was transported to the emergency room via Emergency Medical Services. Individual #505 was admitted to the hospital with a diagnosis of respiratory failure. Individual #505 remained in the hospital until the time of death on 9/15/10 at 6:10 a.m. Review of the clinical records for individual #505 numerous issues of grave concern were identified in this record, as was identified in review of individual #344: The nursing staff and physician failed to recognize and appreciate individual #505's acute change in the respiratory status and provide or seek aggressive medical intervention, rather individual #505 was treated symptomatically and empirically until reaching the crisis point. It was not clear that medical review identified these issues for these individuals or medical care provided generally by the Facility, or that recommendations for system change to resolve these kinds of issues had ever been made. For the above reasons, the Monitor Team had determined the Facility is not in compliance with provision L. 2 of the Settlement Agreement. Compliance will require a process that provides regular and, on-going assessment of clinician practice, and ensure their performance meets or exceeds standard of care practice, and that they adhere to all of the Facility's policies and practice guidelines, with regards to clinical practice. Mortality reviews must be conducted in a more comprehensive manor, with the development and implementation of remediation actions that are sustainable and efficacious, based on post-implementation assessments.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a	During the Monitor Team's interview with the Facility's Medical Director, the Monitoring Team inquired about progress in developing a quality improvement process for medical services at the Facility, such as developing policies and procedures for a quality improvement process, data collection for trends analysis and outcome studies and	Noncompliance

	medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	mechanisms to develop and initiate quality enhancement programs and assessing their effectiveness. The Monitoring Team was informed By Dr. Bret Hood that the Facility had made no progress in this area and no information was provided that would support compliance or progress towards compliance for provision L. 3 of the Settlement Agreement. Of specific concern is the Facility's inability to readily retrieve, real-time, basic, clinical information. As stated under provision L1, above, when information such as lists of people with common medical conditions were requested, it required days of significant manual labor to produce just a list of names for each condition. This is a very serious issue for the Facility.	
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.	The Monitoring Team conducted an interview with the current Medical Director and reviewed the newly developed policy on providing medical care, entitled "Physician Procedures and Best Practice Guidelines" (no policy number or date). The procedure is appropriate, and detailed, and if well implemented would enable enhanced clinical practice at the Facility. Physician staff were provided copies of the procedure and signed training documentation indicating that they were familiar with the procedure. Following review of clinical practice at the Facility, the Monitoring Team determined that physicians were not adhering to the procedure; hence, the procedure had not been fully implemented. During an interview with the Facility's Medical Director, Dr. Hood corroborated the observation that physicians were not adhering to the procedure. For this reason the Monitor team cannot concur with the Facility's self-assessment of being in compliance with L.4. Policies and Procedures must be fully implemented and functional before they can be considered in compliance.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility must immediately ensure that the Facility's newly developed Physician Procedures and Best Practice Guidelines is implemented accurately by clinician staff and is functional.
2. Clinicians must immediately ensure that all clinical issues are addressed timely and provide appropriate follow-up to care through resolution of an acute problem, and in accordance with best practices for chronic conditions. In doing so, Clinicians must also ensure that their practice and documentation for all clinical issues is in accordance with the Facility's Physician Procedures and Best Practice Guidelines.
3. The Facility must immediately enhance its ability to provide health care services in an integrated team process. The team must be made much more aware of clinical issues, treatments, risks and benefits, outcomes of treatment, alternate treatments, prognosis and also have the ability to share relevant information with clinicians at the Facility.
4. The Facility must develop and implement a mechanism to provide clinical staff and leadership with real-time data that at a minimum includes diagnosis, treatment planes, and other relevant information necessary to enable that will enable leadership the ability to provide on-going assessment of clinical practice at the Facility, enable clinicians the ability to provide standard of care practice, and allows for the communication of

relevant health care information to appropriate members of the PST.

5. The Facility must immediately develop and implement a quality assurance process, that utilizes real-time clinical data, enables longitudinal data analysis, provide individual and system improvements that enhance clinical services for individuals served at the Facility.
6. The Facility must immediately develop and implement a process that enables on-going, and comprehensive review of medical services at the Facility that ensure standard of care practice is provided by physicians at the Facility. The system must include case review by a non-Facility physician.
7. Nurses must notify physicians when they identify clinical indicators indicating changes from individuals' baseline health status that suggest further assessments be completed to identify the underlying cause and/or changes in treatment.
8. Nurses must notify the physician and Nurse Case Managers when individuals experience acute change in health status..
9. All clinicians at the Facility must immediately conduct a comprehensive review of all individuals at the facility and begin a process to clearly and concisely outlines clinical issues, diagnosis with differential diagnosis when necessary, and treatment plan, by an interdisciplinary, integrated process.
10. The Facility should take aggressive corrective action with staff responsible for conducting Mock Medical Emergency Drills to ensure that they are completed timely and in accordance with drill schedules.

The following are offered as additional suggestions to the facility:

1. The Facility should evaluate compliance with the State Medical Emergency Response and their internal operating procedures for CPR Mock Drills.
2. The Facility's Quality Assurance Department should include audits of the Emergency Response System.
3. The Facility should strengthen the Emergency Response System by including the Medical Director and Chief Nurse Executive in periodically critiquing the Mock Medical Emergency Drills.
4. The Facility should develop an effective method of eliminating the use of outdated Mock Medical Emergency Drill forms. The current Mock Medical Emergency Drill form failed to contain a space at the top of the form to check whether the drill was passed or failed. The Facility should modify the current Mock Medical Emergency Drill form to include a space at the top of form to check where the drill was passed or failed.
5. The Nursing Department should ensure when Emergency Equipment Checklists are not checked correctly or completely that the Nurse Managers or designees take immediate corrective action and document such action on the checklist.
6. The Facility's managers and supervisors should ensure that all staff remains current in First Aid, CPR or Advance Cardiac Life Support (ACLS), if applicable for ACLS, certifications.

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: #513, #342, #318, #305, #52, #282, #163, #434, #281, #189, #361, #187, #255, #19, #181, #417, #392, #9, #523, #165, #425, #316, #543, #403, #397, #399, #293, #138, #33, #60, #173, #90, #92, #94, #440, #494, #53, #97, #377, #23, #229, #78, #595, #102, 497, #59, #185, #184, #557, #87, #492, #15, #24, #79, #196, #170, #37, #118, #34, #269, #420, #398, #38, #1, #112, #50, #344, #505, and #244 2. BSSLC Sutures List since 12/21/09 3. BSSLC Fracture List since 12/21/09 4. BSSLC Health Status List, printed 12/22/10 5. BSSLC Injury Details, printed 12/6/10 6. BSSLC Hospital and Emergency Room Visit List January through December, 2010 7. BSSLC Facility Meeting Schedule 8. BSSLC Plan of Improvement, 12/29/10 9. Texas Department of Aging and Disability Services: BSSLC Nursing Guidelines: a. Assessment of Individuals i. Charting Guidelines b. Bowel Management c. DNR Status d. Emergency Equipment e. Staff Present During Exams f. Staffing g. Flow-Sheets h. Needlestick i. Abuse and Neglect j. Sexual Incidents k. PICA l. Bites m. Program Service Guidelines n. Medication Administration Guidelines o. Oxygen Tank Guidelines 10. Texas Department of Aging and Disability Services Procedure: Nurse Competency Based Training Curriculum, Date: August 2010 11. BSSLC Nursing: Observing Health Status Training Curriculum 12. BSSLC Nursing: Minimum Staffing Requirements – Preferred Staffing requirements 13. BSSLC Nursing Ratios – Case Managers 14. BSSLC Nursing – Direct Care nursing – Day and Evening Shifts 15. Texas Department of Aging and Disability Services, BSSLC Agency Nurses Competency Agreement 16. BSSLC Job Specific Description for Agency Nurses

	17. BSSLC Shift Manager Staffing Reports, July 1, 2010 through December 6,2010 18. BSSLC Nursing Call-in for June , 2010 through November, 2010 19. BSSLC Environmental Checklist (blank), revised August 6, 2010 20. BSSLC Facility Safety Committee Meeting Minutes for all Facility areas for past six months 21. BSSCL Nursing Meeting Minutes, all levels of nursing meetings for the past six months 22. BSSLC Pharmacy and Therapeutic Committee Meeting Minutes, July 29, 2010 and October 28, 2010 23. BSSLC Medication Error Committee Meeting Minutes, including monthly Medication Error Reports for June 29, 2010, July 27, 2010, August 31, 2010, September 28, 2010, October 29, 2010, November 30, 2010 24. BSSLC Infection Control Lesson Plan 25. BSSLC Infection Control Spreadsheet, January, 2010 through December, 2010 26. BSSLC Infection Control Report for Employees, November, 2010 through December, 2010 27. BSSLC Antibiogram January, 2010 through October, 2010 28. BSSLC Infection Control Committee Minutes, June 30, 2010, September 30, 2010I 29. BSSLC Immunization Spreadsheet 30. Center for Disease Control And Prevention (CDC), Questions and Answers: a. What's new about the flu vaccine for the 2010 – 11 flu season? b. Fluzone High – Dose Seasonal Influenza Vaccine c. Seasonal Influenza Vaccine Safety: A summary for Clinicians 31. BSSLC List of Individuals with Active Infections, to date 32. BSSLC List of Pressure Ulcers Currently Open 33. BSSLC Lists of Infection Reports by Type: Soft Tissue, Urinary Tract, Upper Respiratory, Ophthalmic and Otic, and Pneumonia, Range 9/1/10 through 1/10/11 34. Infection Control Report Form, Revised: 12/10/10 35. BSSLC List of Individuals receiving Enteral Nourishment 36. BSSLC Infection Control Policy 37. BSSLC Completed Infection Control Monitoring Tools – Environmental Monitoring, October through November, 2010 38. BSSLC Employee Infection Control Policy 39. BSSLC Completed Medication Observation Sheet November, 2010 40. BSSLC Quarterly Medication Observation Schedule 41. BSSLC Personal Support Plan Notification Calendar – July 2010 **People Interviewed:** 1. Debra Williams, RN, Chief Nurse Executive 2. Sara Colvin, RN, Nursing Operations Officer 3. Jill Quimby, RN, Quality Assurance Nurse 4. Jim Cloud, RN, Nurse Manager, Cottages 5. Joanne Guard, RN, Infection Control Nurse 6. Mary Wheeler, RN Nurse Case Manager, Bowie 7. Brenda Calvin, RN, Nurse Case Manager, Bowie 8. Nancy Witt, RN, Nurse Case Manager, Bowie 9. Joy Sorenson, RN, Nurse Case Manager, Bowie

	10. Johanna Montgomery, RN, Nurse Case Manager, Cottages 11. Brandy Todd, LVN III, Quality Assurance **Meeting Attended/Observations:** 5. Meeting with the Chief Nurse Executive, Nursing Operations Officer, and Quality Assurance Nurse. 1/10/11 6. Meetings with Quality Assurance Nurse to review Clinical and Administrative Death Review and Restraint Checklists, 1/11/11 7. Nursing Administrative and Management Meeting at 2:00 p.m., 1/11/11 8. PSP Meeting for individual #440 at10:00 a.m., 1/12/11 9. Prescribed Medical Oversight Committee, at 2:p.m., 1/12/11 10. Meeting with Infection Control Nurse at 3:30 p.m., 1/12/11 11. Tour of Homes and Medication Pass Observations in Driscoll D and Fannin Villa 504, 1/13/11 12. Pharmacy and Therapeutic Committee Meeting, at 3:00 p.m., 1/13/11
	Facility Self-Assessment: The POI reported compliance with Provisions M.1, M.2., M.4., and M.5. Most of the items listed as in compliance primarily related to recommendations made during the last tour and listed for compliance a sequence of actions taken since the last tour. Because the items focused on actions taken, the self-assessment for most provision did not actually check for compliance with the requirements of the provisions. For example, there were several items that stated that auditing (for example, auditing of nursing assessments) had been implemented but no statements reporting that the auditing had found the requirements to be met (for example, that nursing assessments now were updated as indicated by the individuals health status as required in Provision M2). Although many of the actions reported were verified by the monitoring team, they were not yet adequate or were implemented too recently to establish compliant practices on a routine or widespread basis. The Nursing Department reported the following information for each of the provisions they determined to meet compliance. Provision M.1: • Nurse Managers, Shift Managers, Nurse Case Managers, or designee reviews individual records on a monthly basis to assure compliance with professional standards. The Quality Assurance Nurse randomly selects records for review. The Quality Assurance Nurse had developed and revised a data collection tool and information is shared with Nursing Management for follow-up/training as needed. • In December 2010, hired two RNs for the 10/6 shift in Cottages and had coverage on all units on the 6/10 shift. Agency usage continues to decrease with additional hires. At the current time only four positions were open. Staffing rations had improved. • Health Care Protocols: Handbook for Developmental Disability Nurses was being used. • Nurse Case Managers' caseloads were being reviewed and changing. • Nursing students from area schools were doing nursing clinical [rotations] on campus. • Received additional B/P monitors and new feeding pumps. • Continuous Medical Record (Kardex) and Physical and Nutritional Management Plans (PNMPs) were located in the Medication Administration Record (MAR). Provision M.2: • Quality Assurance Nurse or designee reviews individual records on a monthly basis to assure

	compliance with professional standards. Audits completed on assigned individuals, selected through the Quality Assurance process. • Assessments updated, audit process continues, data collection and analysis continues. • Signature date line added to quarterly and annual assessments. Provision M.4: • Education was presented to Home Leader's group. • Daily audit of RN log, Shift to Shift Log, and Sick Call Log. • Self Administration of Medication program was in place. • Case Manager, Nurse Manager or designee continued to utilize the Pain Management Monitoring Tool monthly and reviewed report results with appropriate staff. • Shift Manager or designee continued to utilize the Urgent/Emergency Room Visits and Hospitalizations, Transfers and Readmissions Monitoring Tool monthly and review/report result to appropriate staff. • Developed Continuous Medical Record (Kardex), which was used on hospital transfers to assure that pertinent information [was] sent to the hospital. • Training was completed for all nursing staff on Heath Care Guidelines, Care plan Development for individuals with DD and Nutritional Management. New nursing staff receives this training in New Employee Orientation. • Auditing was done on a monthly basis. Audits were done by Nurse Managers, Case Managers or Shift Managers. Audits were submitted to Quality Assurance, who collected and compiled results. The information was then returned to Nurse Managers for follow-up and retraining as needed. • Appropriate Pharmacy and Therapeutic information was shared at the Medication Error Committees. • Nursing Protocols were developed and in place. Provision M.6: • Nurse Manager or Designee continued to utilize Medication Administration and Documentation Monitoring Tool monthly and review report results to appropriate staff. • Nurse Manager or Designee continued to utilize the Medication Administration Observation Monitoring Tool quarterly and review report result to appropriate staff. • Nurse Manager or Designee continued to utilize the Medication Administration Observation for Enteral Administration through G-tube Monitoring Tool quarterly and review report result to appropriate staff. • Lippincott Manual of Nursing Practice was used as guidelines for Medication Administration. • Each nurse receives a quarterly medication observation to assure medication standards were met. • Nursing Operations Officer reviewed data from all disciplines and monitored nursing deficiencies and educated as needed. • Medication observation tool was revised and implemented. • PNMPs were located in the MARs. • The Nursing Department was providing privacy during medication administration passes by removing individuals from group setting during med passes, utilizing direct care professions to assist in maintaining privacy, and by designating areas for med passes. • Medication Administration Observation Audit included PNMP and enteral feedings. • Medication Error Committee was tracking medication errors.

	• The change had been made [in calculating medication error from percentages to ratios. • Auditing was being done on a monthly basis. Audits were done by Nurse Managers, Nurse Case Manager or Shift Supervisors. Audits were submitted to Quality Assurance, who collected and compiled results. The information was returned to Nurse Managers for follow-up and retraining as needed. • Corrective action was developed in the Medication Error Committee. Provisions identified as not in compliance included some activities performed toward compliance: Provision M.3: • Validation lines were added to Quarterly and Annual [Nursing] Assessment [form] and Nursing Care Plans. • Training was done on Developmental Disabilities Care Plans. • Hospital Liaison [Nurse] continues to track all hospital admissions and emergency room (ER) visits. • Auditing was being done on a monthly basis. Audits were done by Nurse Managers, Nurse Case Managers or Shift Managers. Audits were submitted to Quality Assurance, who collected and compiled results. The information was returned to Nurse Managers for follow-up and training as needed. Provision M.5: • Infection Control Nurse or Designee continued to utilize the Infection Control Monitoring Tool monthly and report results to appropriate staff and provide training as needed. • Good hand washing techniques were taught in all new employee orientation [training]. • All new admissions were evaluated and chest x-rays were done as appropriate (tuberculosis infection or disease). All individuals were tested on a yearly basis. Testing was repeated on all individual and staff after a suspected exposure. • Nursing Department continued to utilize Section M monitoring Tool monthly and report results to appropriate staff and provide training as needed. • Weight database was developed and was in the process of being implemented. • Antibiogram [usage] had been developed. • Infection Control Nurses received reports in a timely manner. • Braden Scale was utilized. • Auditing was being done on a monthly basis. Nurse Managers, Nurse Case Managers or Shift Managers did audits. Audits were submitted to Quality Assurance, who collected and compiled results. The information was returned to Nurse Managers for follow-up and training as needed.
	Summary of Monitor's Assessment: **Provision M.1:** The Facility was not in compliance with this provision. The Nursing Department had recently modified the Nursing Monitoring Tools from 21 tools to 12 tools. Consequently, the Quality Assurance database was also revised. At the time of the tour Nursing Peer Review data were not analyzed and trended to be able to develop plans of corrective action. The Nursing Department had added numerous other monitoring tools related to nursing practices, but there was not a formalized database developed to analyze and trend the additional monitoring activities. The Nursing Department had made improvements in nursing staffing and coverage since the last tour,

	particularly with regard to the hiring of two additional Registered Nurses for the 10 to 6 shift in the Cottages. The minimum staffing requirements were consistently met. The Nursing Department had added a Staffing Coordinator to ensure that staffing ratios were consistently maintained. The Nursing Department had made progress in documentation and was consistently using the Date, Action, and Response method of charting; therefore, the quality of the documentation had improved. The Nursing Department and the Quality Assurance Nurses were auditing individuals' records with acute illnesses and injuries, and those who were hospitalized. There was improvement in the early recognition of signs and symptoms of acute illnesses and injuries with prompt notification to physicians. However, there were instances where this did not occur, resulting in negative outcomes. Refer to Section L.2 for reports on these instances. The Hospital Liaison Nurse consistently followed up on individuals who were hospitalized and documented findings in the Integrated Progress Notes as well as placing the information on the S drive for the Qualified Mental Retardation Professionals and other Personal Support Team Members to review. The Nursing Department needs to continue to aggressively monitor nursing practices regarding nurses' ability to recognized and respond promptly to individuals showing signs and symptoms of change in their health status. **Provision M.2:** The Facility was not in compliance with this provision. The Nursing Department was using the Comprehensive Nursing Assessment form. The nursing assessments were beginning to show improvement in the content and quality, but they need to improve on how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing quality nursing assessments. Section XI (Nursing Summary) primarily consisted of raw clinical data, statements to continue Health Maintenance Plans, and lists of recommendations and goals as opposed to stating whether individuals' health status were progressing, maintaining, or regressing in relation to their established goals. The summary section of the nursing assessment should provide a clinical analysis of the raw data from the previous sections. To determine individual's health status, data should be compared to the previous quarter's assessment regarding the individual's progress related to their health and behavioral goals. State Facility Chief Nurse Executives had finalized the draft for Nursing Physical Assessment Training and were waiting final approval from the State Office. Nursing Physical Assessment Training must be competency-based to build solid foundational skills. The training should also include how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing quality nursing assessments. When the Nursing Physical Assessment Training is finalized and implemented the Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive competency-based training. **Provision M.3:** The Facility was not in compliance with this provision. The Health Care Protocols: Handbook for Developmental Disability Nurses was used to assist with developing nursing care plans. Nursing Care Plans were beginning to be more individualized, but most contained information copied directly from the Health Care Protocols: Handbook for Developmental Disability Nurses and contained information that was not necessarily applicable to the individuals. The Nursing Department needs to continue to strengthen and refine their ability to individualize care plans to meet the special needs of the

	individuals and ensure that goals are realistic, achievable, and measurable as well as are preventative and proactive in nature. **Provision M.4:** The Facility was not in compliance with this provision. Many of the nursing policies, procedures, and protocols were still in draft waiting for final approval from the State Office. Numerous other policies, procedures, protocols and training curricula were in the development phase. There was evidence that the Nursing Department had provided increased training to the nursing staff since the last tour, as listed below in this section. The Nursing Department needs to ensure that all training is competency-based. **Provision M.5:** The Facility was not in compliance with this Provision. The Infection Control Program had made progress toward this provision with the development and implementation of a new Infection Control Data base system. This database demonstrated a significant improvement over the previous Infection Control database. Since it was recently implemented the Infection Control Program staff were in the process of populating the database.. At the time of the tour not enough data had been entered to complete a trend analysis. However, with the information available in the database Infection Reports by Type were beginning to be generated. A part time Infection Control Nurse had been added since the last tour. Antibiograms had been developed and implemented. Infection Control Nurses received reports in a timely manner. Braden Scale Assessments were completed on all individual at the time of their Annual and Quarterly Nursing Assessments. The Infection Control Program needs to begin tracking, analyzing, and trending data information related to all infection control issues to identify trends that are individual specific as well as systemic and take corrective action, as indicated. There needs to be closer collaboration between the Infection Control Committee and Safety Committee to address environment issues that affect the health and safety of individuals. Antibiograms were put into use since the last tour and were used by the physicians to make clinical decisions regarding the selection of antibiotics in treating infections. Since the last tour the Infection Control Program had developed and implemented an Immunization database to track immunizations as well as tuberculosis testing status. **Provision M.6:** The Facility was not in compliance with the provision. It was apparent since the last tour that the Nursing Department had made significant improvements in their medication administration practices, monitoring, and reporting, tracking, analyzing, and trending medication errors. It was positive to find that two additional audits for medication administration practices were initiated since the last tour. The new audit tools were for Medication Administration Records and Medication Room Checklist. Although numerous improvements were made in the Facility's medication administration practices, the monitoring team did not find this provision in compliance for the following reasons: • Since the last tour the Medication Administration Observation Form was revised in December, 2010 to include monitoring for following the individual's PNMP during medication administration. This was a positive finding. • The Nursing Department continued to complete Medication Observations for oral and enteral

	medication administration. • Monitoring data relating to medication administration practices were not fully analyzed and trended to yield enough data to adequately develop comprehensive plans of corrective action. • The Medication Error database system, developed and implemented in August, 2010, while it represented improvement from the previous database, was continuing to undergo refinement and modifications. The data points collected were changing from month to month as refinements were made. By the time of the next tour the database system for tracking, analyzing, and trending data should be solidly in place producing consistent and reliable data. • The Medication Error Reports needed continuous improvement to ensure that reports are complete, accurate, timely, and demonstrate that corrective actions were taken in response to medication errors. • The drafted Medication Administration Guidelines and Medication Variance Procedures had not been finalized and implemented.

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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.	Staffing During the past six months from July, 2010 to December, 2010, the Nursing Department had not fallen below the established minimum staffing requirements. According to the Nurse Operations Officer, this was accomplished by having a dedicated Staffing Coordinator who reviewed the nursing staffing schedule several times during the day, filling shifts as call-ins occurred to ensure minimum staffing requirement were met, and keeping Nursing Management informed of staffing status. Experienced agency nurses, familiar with Facility residents, were used at a minimum to fill-in for any staffing shortage. Nurse Managers were involved in scheduling, assisting with requests for time off by assessing coverage prior to submitting requests to the nursing staff coordinator, and working with their staff to increase teamwork and coverage within the Unit when able. After hours, the Shift Manager maintained weekends and holiday shifts by reviewing the schedule and filling open shifts as they occurred. The Nursing Department had filled several vacant positions on all shifts during the past six months. In December, 2010, two additional Registered Nursing (RN) II positions were added to the 10-6 shift for the Cottages. There was some realignment of nursing staff for improved coverage. This represented a significant improvement from the previous tour. At the time of the tour all Licensed Vocational Nursing Positions were filled. There were four unfilled RN II positions, two for the 6-2 shift in Childress and two for the 2-10 shift in the Cottages. The Nursing Department continued to serve as a preceptor for three nursing schools. While not a requirement for the Settlement Agreement, serving as a preceptor for the nursing schools demonstrated a good recruitment resource. The Facility was able to recruit and employ several of their graduates, plus it provided student nurses with clinical experience in developmental disability nursing of which few schools of nursing provide such experience.	Noncompliance

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		The Chief Nurse Executive and Nursing Operation Officer continued to demonstrate excellent leadership abilities and maintained a stable administrative and management staff as well as a stable direct care nursing staff with minimal staffing turnover. In meetings attended and through personal interviews conducted with nursing administrative, management and direct care nursing staff, all demonstrated a high degree of motivation, enthusiasm, and great effort toward achieving compliance with the Settlement Agreement and Health Care Guidelines. However, to achieve full compliance with all of Section M Provisions and their respective components requires a high degree of expertise and due diligence. The State Office should consider contracting with a nursing expert to provide State Supportive Living Center nursing staff with onsite technical assistance and mentoring. The monitoring team reviewed all levels of Nursing's Meeting Minutes for the last six months for the various levels of nursing, e.g., Nurse Managers/Nurse Shift Supervisors, Nurse Case Managers/RN IIs, and LVNs. Meetings were conducted at least monthly; minutes were comprehensive, and well written. The Minutes served to keep the nursing staff apprised of changes, identified issues that required attention and/or correction, and provided clear guidance and direction. <u>Quality Assurance – Peer Review Efforts</u> Since the last tour the Nursing Peer Review Policy and Procedures were developed and implemented. In December, 2010, the statewide nursing workgroup reduced the 21 Nursing Monitoring Tools down to 12 tools. Interpretive guidelines were developed for each tool to ensure continuity among auditors, both within the Facility as well as across all State Supported Living Centers. The interpretive guidelines also addressed quality of care for the items monitored. The 12 revised tools contained the same content as was contained in the original monitoring tools develop by the monitoring team. The tools were streamlined to make them more functional in their use, e.g., the Annual and Quarterly Nursing Assessment tools were combined into one tool. The tools continued to cite the Settlement Agreement references. ICF/MR tag references were added to the tools, which should further serve to strength the audit process, prevent duplicate audit tools, and save time for the auditors. Because of the change in format of the tools, the database for collecting data was revised to accommodate the revisions. Since the revised tools were implemented in late December, 2010, coupled with the necessity for revisions to database, it was too soon for enough data to be entered to make clinical judgments regarding the audits completed at the time of the tour. This will be followed-up on the next tour. As the data are compiled, extrapolated, and analyzed, the results will be provided to Nursing Management for follow-up/corrective action, and training as results indicate. Through interviews with the Chief Executive Nurse and Quality Assurance Nurses, it was	

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		apparent that a cohesive and collaborative relationship existed between the Nursing Department and the Quality Assurance Nurses. The processes and procedures for conducting audits and compiling data were in place. The Quality Assurance Nurse selected the records for audits using a random method of selection by selecting every tenth record and further refining the selection by sorting by homes. Presently, two records from each unit were audited monthly, with the exception of the Cottages where three charts were audited. One Infection Control chart per month was audited. The plan was to incrementally increase the percentage of charts audited until they reached a goal of auditing 20% of the charts. The goal of the audit outcomes was to achieve 90% compliance with the audit tools. Specific assignments were made for conducting audits and included: • Medication Administration audits - completed by the Nurse Managers. • Acute Illness/Injury audit - completed by specifically assigned Shift Managers • Skin Integrity/Infection Control – completed Infection Control Nurse • Documentation – completed by specifically assigned Shift Managers • Prevention – completed by Quality Assurance Nurse • Quarterly/Annual Nursing Assessments – completed by Quality Assurance Nurse • Hospitalization – completed by all auditors along with other types of audits, when identified in the selected charts for review The monitoring team requested onsite and received copies of other nursing audits completed in addition to the 12 Monitoring Tools used for Quality Assurance and Peer Review Audits. The Nursing Department had completed monthly numerous additional audits; each of the audit tools reviewed contained a front sheet of instructions for conducting the audits and corrective actions. Additional audit tools included: • Post Sedation Chart Review. This audit began in November, 2010 and was completed by the Quality Assurance LVN III. • Care Plan Audits • Enteral Medication Administration Observation • Medication Administration Observation (oral intake) • Medication Room Checklist • Injury Report Follow Up • Medication Administration Record • Medical Chart Audit for Weight Management. The monitoring team reviewed copies of the above-completed audits for November and December, 2010. When deficiencies were identified by Nurse Managers, Nurse Shift Managers, and/or Nurse Case Managers on the individual audit tools there was documentation that "on the spot" corrections were made. The completed audit tools were submitted to the Nursing Operation Officer and Chief Nurse Executive for review.	

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		Copies of all monitoring tools and analyses for the past six months were requested as part of the document request for onsite review but were not received. The Nursing Department needs to develop and implement a database to capture data to analyze and trend for each of the following audits: • Post Sedation Chart Review. This audit began in November, 2010 and was completed by the Quality Assurance LVN III. • Care Plan Audits • Enteral Medication Administration Observation • Medication Administration Observation (oral intake) • Medication Room Checklist • Injury Report Follow Up • Medication Administration Record • Medical Chart Audit for Weight Management The additional audit tools listed above, with the exception of the Enteral Medical Observation and Medication Room Checklist, contained similar, if not the same, items as the 12 monitoring tools. If there are additional items on these tools that are not on the 12 monitoring tools, it would be more efficient and effective to add those items to the 12 monitoring tools to avoid duplication of effort and to provide more comprehensive data with continuity to the data audited and analyzed by the Quality Assurance Department. The Nursing Department should consider evaluating all audit tools used in addition to the 12 revised monitoring tools and incorporate those audit tools into the 12 monitoring tools to improve the efficiency and effectiveness of the monitoring process. Since the last tour the Nursing Department had begun to participate with other disciplines and directors in conducting monitoring of meals and snacks. Nurse Case Managers were monitoring mealtime and snacks. Their monitoring reports were turned in and included in the overall monitoring reports for the Physical and Nutritional Management Team. Copies of their monitoring results were requested but not received. This will be followed up on during the next tour. <u>Accessibility of Medical Records and Quality of Documentation</u> Since the last tour the Facility's record keeping practices improved significantly. Documents were organized, accessible, and it was easy to locate relevant information. The hand writing legibility improved considerably, but some signatures and titles remained difficult to read. The nursing staff fairly consistently documented using the Data, Action, Response (DAR) method of charting. However, the "R" documentation usually stated, "continue to monitor." The "R" should document the reactions of the individual in response to treatments or interventions performed by the nurse, not what the nurse will do. The method temperatures were taken was seldom documented. A	

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		complete set of vital signs, including oxygen saturation, was not always taken when temperatures were taken. It is important to document the method because of the variance in the degree of temperature measured. All vital signs, including oxygen saturation, need to be taken along with temperature to provide a comprehensive assessment of the systems related to temperature, e.g., cardiac and respiratory systems. There were some abbreviations used in the documents that were not in the Facility's standardized abbreviation list. The use of abbreviations not included on the Facility's standard abbreviation list limits the interpretation of the clinical data for disciplines not familiar with the abbreviations used. There was evidence of additional more fully developed integrated progress notes written by disciplines, e.g., physicians, nurses, occupational and physical therapist, and dentist. The Nursing Department needs to ensure that nurses document the methods that temperatures are taken. The Facility needs to ensure that standardized abbreviations are used. If additional abbreviations need to be added, they need to be reviewed and approved. <u>Assessment and Documentation of Individuals with Acute Changes in Health Status</u> The monitoring team reviewed documentation for 25 individuals: #513, #255, #196, #107, #37, #60, #318, #305, #61, #181, #392, #33, #90, #19, #97, #59, #24, #79, #37, #229, #420, #118, #102, #344, #505, and #79. Since the last tour, the records demonstrated progressive improvement in managing acute illnesses and injuries by promptly completing assessments and carrying out interventions of individuals experiencing signs and symptoms of acute illnesses and injuries, promptly notifying the physicians, and timely developing and implementing Acute Care Plans and follow-up assessments until the acute illnesses or injuries were resolved. Improvements were evidenced by the development and use of a new Hospital Transfer form that included information to send with individuals to the hospital. The Hospital Liaison Nurse continued to visit individuals in the hospital and/or maintained regular contact with hospital personnel, and kept the other integrated team members informed of hospitalized individuals' health status. The Hospital Liaison Nurse continued to document in the Integrated Progress Notes. Below are examples of records reviewed relating to acute illnesses or injuries: • Review of clinical records for individual #344, 7/12/10 through 8/19/10. Individual #344 had a diagnosis of asthma and allergic rhinitis with a history of pneumonia and bronchitis. The Integrated Progress Notes on 8/10/10 at 5:30 p.m. documentation indicated an acute change in individual #344's respiratory status. The direct care professionals reported to the nurse that individual #344 was coughing and gagging. The nursing assessment documented audible coughing and wheezing with oxygen saturations (O_2Sats) were 89 to 91%. Levalbuterol nebulizer treatment was administered. Vital signs were	

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		Temperature 99.0°, Blood pressure 116/75, and respirations 18. Pulse was not documented. After the nebulizer treatment O_2Sats increased to 91 to 96% on room air. No further coughing or wheezing was heard. Although the acute respiratory symptoms subsided there was no documentation that the nurse either notified the physician of individual #344's acute change in respiratory status or the Nurse Case Manager. The nurse's note stated "Will continue to monitor." Individual #344's respiratory status continued to be monitored every four hours twice then each shift through to 8/14/10 at 4:27 a.m. without further respiratory symptoms. A note stated monitoring was no longer needed. Although, the per necessary (PRN) nebulizer treatment of Levalbuterol was carried out as ordered with symptomatic relief the nurse should have notified the physician of the acute change in respiratory status in order to keep the physician informed and to determine if individual #344 needed to be seen. The Nurse Case Manager should have also been notified for follow-up. The Nursing Department needs to ensure that when individuals experience acute change in health status that the physician and Nurse Case Managers are notified of such changes. There were no Integrated Progress Notes documented for individual #344 on 8/15/10. On 8/16/10 at 1:15 p.m. the nurse documented in individual #344's the Integrated Progress Notes that individual #344 was crying out. The nurse documented that the crying was off and on and was apparently due to discomfort. Comfort measures were provided to reposition and for toileting to no avail. The abdomen was assessed and found to be soft with bowel sounds present in all four quadrants. No coughing or wheezing was noted. Lungs were assessed and CTA. Vital signs were documented as 98°, pulse 88, respirations 18, blood pressure 100/60, and O_2Sats 96% on room air. There was no documentation that the physician was notified and informed of the assessment findings, however, an order was written on the Physician's Order form at 2:30 p.m. to give Tylenol 650 milligrams twice a day for seven days and send to sick call. The physician's diagnosis was: possible pain. Individual #344 was administered Tylenol 650 milligrams at 1:15 p.m. for "apparent discomfort". At 2:15 p.m. it was noted that there was less crying. At the request of the direct care professional and occupational and physical therapy staffs, individual #344 was assessed by the nurse at 3:15 p.m. The nurse documented that individual #344 had a non-productive cough and wheezing otherwise the lungs were CTA. Individual #344's position was transferred from custom positioning into the wheelchair. Individual #344 was uncooperative and the nurse was unable to check blood pressure. Other vital signs were recorded as temperature 99°,	

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		pulse 111, and respirations 20, and O_2 Sats 93%. There was no documentation that the PRN Levalbuterol nebulizer treatment or oxygen were administered to improve O_2 Sats nor was the physician notified of the low O_2 Sats and elevated pulse. Later in the note when the nurse reported off to another nurse it was noted that individual #344 was not crying out, coughing, or wheezing. At 5:00 p.m. the nurse documented vital signs as temperature 97.8°, pulse 86, respirations 20, blood pressure 104/58, and O_2Sats 96%. At 6:00 p.m. the nurse documented that individual #344 continued to "holler" at intervals. At 8:00 p.m. the nurse documented that individual #344 would sleep a little, wake up "hollering" and then go back to sleep. The nurse failed to notify the physician and nursing supervisor of individual #344's continuing distress. There was no further nursing documentation until 8/17/10 at 8:10 a.m. when the home leader reported individual #344 was coughing and had an excessive amount of mucous. Vital signs were recorded as temperature 98°, pulse 128, respirations 28, blood pressure 105/72, and O_2Sats 94% with a moist cough and bilateral breath sounds noted with wheezing. A Levalbuterol nebulizer treatment was administered with interval suctioning. The physician was notified at 8:30 a.m. and informed of individual #344's coughing and condition. Guaituss DM 10 cc per tube was ordered and given. At 9:35 a.m. Individual #344 was seen in sick call and ordered transferred to the emergency room for evaluation of cough, temperature, and left lower lobe rales. The nurse's transfer notes stated that individual #344 was transferred via state van accompanied by staff. Individual #344 was admitted to the hospital's Intensive Care Unit and expired there on 8/19/10 at 4:00 p.m. According to the Death Certificate individual #344's first cause of death was respiratory failure with second cause listed as viral pneumonia. After review of the clinical records for individual #344 numerous issues of grave concern were identified: The nursing staff and physician failed to recognize and appreciate individual #344's deteriorating respiratory status at the onset at least 24 hours preceding hospitalization and provide or seek aggressive medical intervention, rather individual #344 was treated symptomatically until reaching the crisis point. The method/route that temperatures were taken were seldom documented. The methods/route in which temperatures are taken varies and is important to know in order to accurately assess the individual's true temperature. Individual #344's clinical indicators of past respiratory history, persistent cough, chest congestion, low grade temperature, increased pulse rate, low O_2Sats, blood pressure lower than baseline of 112/78, and physical distress should have	

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		alerted the nursing staff and physician that individual #344's respiratory status was deteriorating. Nursing documentation consistently stated "will continue to monitor" even when clinical indicators indicated variances from individual #344's baseline health status. When clinical indicators varies from the baseline this should alert the nurse of changes in the health status that requires further evaluation to determine the underlying cause and/or alerts the nurse to notify the physician. Simply continuing to monitor abnormal findings without further investigation or intervention is not adequate nursing practice. It was of further concern, considering individual #344's deteriorating and unstable respiratory status, that individual #344 was transferred to the emergency room via state van accompanied by staff because had individual #344 experienced respiratory arrest or other complications during transport there were no means to provide and support resuscitation efforts or manage complications. The medical and nursing staff needs to critically evaluate the risks and benefits of transporting medically unstable individuals to the emergency room via state van accompanied by direct care professionals. Another concern was the apparent lack of the nursing staffs' understanding regarding the ramifications of the clinical indicators regarding O_2Sats falling below 95%. The Nursing Department needs to provide nurses with in-service training regarding assessment of oxygen saturation parameters and ramification of levels falling below 95% as well for low grade temperature elevations in medically fragile individuals. The Nursing Department needs to ensure that nurses also include the method and route temperatures are taken. The Nursing Department needs to ensure that when nurses identify clinical indicators indicating changes from individuals' baseline health status that further assessments are completed to identify the underlying cause and/or notify the physicians of the changes. • The monitoring team reviewed clinical records for individual #505, 7/10/10 through 9/14/10. Individual #505's current active medical diagnoses included: Profound mental retardation, spastic quadriplegia, constipation, and fibrocystic breast disease. The Integrated Progress Notes on 8/22/10 at 5:10 a.m. documentation indicated an acute change in individual #505's respiratory status. The direct care professional informed the nurse that individual #505 "felt warm". Vital signs were recorded as temperature 99.5 ° , pulse 120 (baseline pulse reported at 82 in 8/12/10 Annual Nursing Assessment), respirations 30 unlabored, blood pressure 109/52, and O_2Sats 92%. Lungs were assessed and documented as breath sounds present in all four quadrants with lungs CTA. At 2:45 a.m. the temperature increased to 100.6° . Other vital signs were not documented. A Tylenol 650 milligram was administered for the elevated temperature. At 3:40 a.m. and 5:00 a.m. individual #505s' temperature	

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		was documented at 99° and individual #505 was sleeping. No other vital signs were documented. The nurse documented "will continue to monitor and inform nurses during shift report." There was no documentation that the physician or Nurse Case Manager was notified of individual #505's acute change in respiratory status. There was no concern expressed regarding the low O_2Sats 92%. The next entry into the Integrated Progress Notes was on 8/22/10 at 5:00 p.m. The nurse documented that this was a follow-up (10 hours later) to the morning temperature of 99° . At that time individual #505's temperature was documented as 100.8° and was administered Tylenol 650 milligrams. At 6:30 p.m. individual #505's temperature was documented as 99.2° with respirations of 20 and in no distress. No other vital signs were documented. There was no documentation that the physician or nursing supervisor was notified of individual #505's health status. On 8/23/10 at 1:10 a.m. individual #505's temperature was documented as 100.8° , pulse 107, respirations 24 even and unlabored, and O_2Sats 91%. The note documented that nasal congestion was present making lung sounds difficult to assess, there was no coughing, and individual #505 was in no distress. Individual #505 was administered Tylenol 650 milligrams for fever. At 2:30 a.m. temperature was documented as 100.1° (TA), with O_2Sats 90 to 92% with auditable nasal congestion but individual #505 was reported in no distress. Again there was no concern documented regarding the low O_2Sats. At 5:40 a.m. a temperature of 98.9° was documented. No other vital signs were documented. At 8:00 a.m. vital signs were documented at 98.8° (TA), pulse 113, respirations 20, blood pressure 99/54 and O_2Sats 93%. There was no documentation in the notes indicating that the physician or Nurse Manager was notified on individual #505's health status. However, on 8/23/10 at 9:30 a.m. there was a note written by the physician in the Integrated Progress Notes. The physician documented that individual #505, "*had a temp 100.9° this weekend – Had Tylenol X* one – *No temp since – No observed cough. DX (?) rales LLL. RX Neb with Albuterol and get chest x-ray."* The physician's note was of significant concern because it was obvious that he did not review individual #505's Integrated Progress Notes for the weekend and/or the nursing staff failed to adequately inform the physician of individual #505 health status over the weekend. The physician's entry was written on a separate Integrated Progress Note and was not contained chronologically within the other notes for that day, as was an entry by the Nurse Manager. On 8/23/10 at 12:00 noon the Nurse Manager documented that an Acute Care Plan (ACP) was established for an upper respiratory infection (URI) and the direct care professionals were	

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		trained on the ACP. At 1:30 p.m. the Nurse Manager completed an assessment as a follow-up to the URI and stated, "*skin W/D to touch. No cough or nasal drainage noted – Neb.2x 6/2 done earlier per nursing staff - V/S WNL. T – 98.2 (T). Tol feedings. No crying out. No S/O pain/discomfort – Will cry out when something is wrong. Will monitor PRN.*" On 8/23/10 at 10:10 a.m. the Physician's Order form contained orders for chest x-ray but did not specify when it was to be done, and an order for Albuterol Nebulizer 0.083%, three times a day for two days. On 8/23/10 at 12:30 p.m. the initial treatment of Albuterol was administered and tolerated. After the treatment O_2Sats were documented as 91% with a pulse of 118. On 8/23/10 at 11:45 p.m. individual #505's temperature was documented at 98.3° with even and unlabored respirations. On 8/24/10 at 3:50 a.m. Vital signs were documented as 98.7° , pulse 96, Respirations 20, blood pressure 99/73, and O_2Sats 92% with unlabored respiration, no cough, or signs and symptoms of pain/discomfort. On 8/24/10 at 12:00 noon vital signs were documented as temperature 98.9° , pulse 107, respirations 20, and O_2Sats 90%. A nebulizer treatment was administered and tolerated. After the treatment O_2Sats were 91% with a pulse of 104. On 8/24/10 at 6:30 p.m. the nurse documented that individual #344 had no coughing, wheezing or nasal drainage. The abdomen was soft with bowel sounds present in four quadrants. Vital signs were documented as temperature 98.8° (TA), pulse 96, respirations 22 and unlabored, blood pressure 85/52, and O_2Sats 93%. On 8/25/10 at 4:30 a.m. the nurse documented a temperature of 98.8° but no other vital signs were documented. No coughing or signs of pain or distress were documented. On 8/26/10 at 8:00 am the nurse documented a temperature of 98.7° but no other vital signs were documented. No coughing or signs of pain or distress were documented. On 8/26/10 (time not documented) the nurse documented a temperature of 98.7° but no other vital signs were documented. No coughing or signs of pain or distress were documented. There was no further documentation until 8/31/10 regarding individual #505's respiratory status or that the ACP for URI was discontinued with a resolution note. At this time individual #505 had been reported afebrile since 8/23/10 at 5:40 a.m., consequently, the nursing staff must have seen no reason to continue monitoring individual #505's health status. However, individual #505's continued to have an elevated pulse rate, ranging 90 to 118 with low O_2Sats ranging from 90% to 93%. These clinical indicators should have alerted the nursing staff and physician of a potential underlying medical problem that needed further evaluation. A complete set of vital signs were not always completed when temperatures were taken. On 8/31/10 (time not documented) the nurse documented brief coughing. No vital	

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		signs or other respiratory assessments were documented. An initial dose of Robitussin DM was administered per tube. There was no documentation that the physician was notified of individual #505 coughing. However, on 8/31/10 at 9:00 a.m. the Physician's Order form contained a verbal order for Robitussin DM 10 ccs, per tube, four times a day for five day with a diagnosis of cough. On 9/1/10 the nurse documented vital signs as temperature 98.3°, pulse 93, respirations 22 even/unlabored, blood pressure 107/73, and O_2Sats 94%. The notes stated individual #505 had an intermittent non-productive cough with lung sounds and upper airway congestion heard but there were no wheezes or crackles. There were no signs or symptoms of a pain or discomfort and Individual #505 was reported to be resting. On 9/1/10 the physician documented in the Integrated Progress Notes that individual #505 had a persistent non-productive cough and was afebrile. The physician stated that the chest x-ray of 8/23/01 was not reported. The chest x-ray had been ordered seven days ago and should have been followed upon. The decision was to treat empirically with Amoxil and Robitussin pending the chest x-ray report. Subsequently, the physician wrote an order on 9/1/10 at 8:45 a.m. for a chest x-ray to be completed that day and order Amoxil 500 milligrams per tube three times a day for seven days. On 9/1/10 at 12:30 p.m. the nurse documented that individual had a chest x-ray at the hospital. Amoxil 10 cc was given per tube. The nurse reported that individual #505 sounded congested but lung assessments were not completed. Vital signs were reported as temperature 98°, pulse 106, respirations 20, and O_2Sats 90%. The blood pressure was not documented. On 9/1/10 at 2:00 p.m. the nursed documented that bilateral breath sounds were present and that individual #505 continued to have a non-productive cough. Vital signs were reported as temperature 98.2° (T), respiration 18 regular and unlabored, and O_2Sats 94%. The pulse and blood pressure were not documented. The nurse noted individual #505 was in no distress. An ACP for URI was established and the direct care professional instructed in the ACP. On 9/1/10 (no time documented) the nursed documented that individual #505 continued to have a non-productive cough. Vital signs were documented as temperature 98°, pulse 90, respiration 20, blood pressure 110/70, and O_2Sats 93%. On 9/2/10 the nurse documented vital signs as temperature 98.3° (TA), pulse 100, respiration 22 even/unlabored, blood pressure 123/58, and O_2Sats 93%. Lungs were CTA with audible nasal congestion, and a non-productive cough. Individual #505 was reported not to have signs and symptoms of pain/discomfort. On 9/2/10 at 4:00 p.m. the nurse documented that individual #505 was coughing at intervals with audible nasal congestion. No nasal drainage or wheezing was observed. Vital signs were	

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		documented as temperature 98.6°, pulse 105, respirations 22, blood pressure 129/86, and O_2Sats 95%. No pain or discomfort was noted. On 9/2/10 at 7:30 p.m. the nurse documented that individual #505 had facial grimacing, possibly due to discomfort. Tylenol 650 milligrams was administered per tube. Vital signs were documented as temperature 98.4°, pulse 107, respirations 20, blood pressure 122/86, and O_2Sats 95%. At 9:50 p.m. the nurse noted that the Tylenol was effective. On 9/3/10 at 3:00 a.m. the nursed documented vital signs as temperature 98.4°, pulse 115, respirations 22, blood pressure 129/86, and O_2Sats 93 to 96%. Lungs sounds were noted as CTA with audible nasal congestion. No coughing was heard and there was no nasal drainage observed. There were no signs and symptoms of pain or distress noted. On 9/3/10 at 8:00 a.m. vital signs were documented as temperature 98.4°, pulse 120, respirations 22, blood pressure 124/84, and O_2Sats 84 to 88% on room air. The physician was notified and orders were received to start oxygen at three liters per minute. On 9/3/10 at 8:20 a.m. the physician order individual #505 sent to the emergency room for evaluation due to low O_2Sats with moist breath sounds and questionable rales in the right low lobe of the lung. On 9/3/10 at 9:20 a.m. the nurse documented that individual #505 left for the emergency room. The method of transportation and whether staff accompanied individual #505 to the emergency room was not documented. On 9/5/10 at 3:45 p.m. the nurse documented a comprehensive nursing assessment when individual #505 returned home from the hospital. The nursing assessment revealed a continuing problem with low O_2Sats ranging from 84% to 88%. Oxygen was applied at 8 liters per minutes but the O_2Sats continued low, readings varied from 67% to 94%. Emergency Medical Services was called and individual #505 was sent back to the hospital. On 9/5/10 at 8:00 p.m. the nurse document that individual #505 had returned home after being seen again at the hospital for respiratory distress and low O_2Sats. The admission nurse completed and documented a comprehensive nursing assessment upon return from the hospital. Vital signs were documented as temperature 99.2°, pulse 114, respirations 24, blood pressure 124/84, and O_2Sats 90% with 4.5 liters per minute. Other than the continued the elevated temperature and pulse, and low O_2Sats, even with oxygen, there were no other remarkable physical findings documented. Upon receipt of new physician's orders individual #505 was returned home. On 9/5/10 at 10:00 p.m. the nurse documented that individual #505 was resting in bed, in no distress, and was receiving 4.5 liter per minutes of oxygen. Vital signs were not documented. On 9/6/10 at 2:00 a.m. the nurse documented vital signs as temperature 98.6°, pulse 89, respirations 24 even/unlabored, blood	

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		pressure 125/85, and O_2Sats 98% with 4.5 liter per minute. The nurse documented that she was unable to assess lung sounds due to snoring. There was no audible wheezing noted and individual #505 was resting. On 9/6/10 at 4:46 a.m. vital signs were documented as temperature 98.6°, pulse 99, respirations 27 even/unlabored, blood pressure 119/86, and O_2Sats 99% with 4.5 liter per minute. It was noted that lung sounds were unable to be assessed due to snoring but no adventitious sounds were heard. Individual #505 had minimal amount of non-productive coughing at intervals. There was no pain/discomfort or distress documented. On 9/6/10 at 9:00 a.m. nurse documented vital signs as temperature 98°, pulse 90, respirations 28, blood pressure 139/91, and O_2Sats 95 to 99 % with 4.5 liters per minute. Oxygen was decreased to 3 liter per minutes. No other respiratory assessments were documented. On 9/6/10 at 6:00 p.m. nurse documented vital signs as temperature 100.4° both axillary and temporal, pulse 111, respirations 20 eve/unlabored, blood pressure 142/88, and O_2Sats 93% with 3 liters per minute. Tylenol 650 milligrams was administered per tube. The nurse noted that individual #505 was diaphoretic and had a decrease in "normal pigmentation", and snoring. No other respiratory assessments were documented. There was no documentation that the nurse notified the physician or supervising nurse of the elevated temperature and elevation in blood pressure and of the diaphoresis and change in color. 9/6/10 at 7:25 p.m. nurse documented the axillary temperature as 100.0° and temporally was 99.1°. On 9/6/10 at 8:30 p.m. the nurse documented a temperature of 98.2°, method temperature was taken was not documented. The O_2Sats were documented as 94%. On 9/7/10 at 4:10 a.m. nurse documented vital signs as Temperature 98.6° (TA), pulse 84, pulse 84, respirations 24 even/unlabored, blood pressure 139/84, and O_2Sats 95% with oxygen at 3 liters per minute. The nurse was unable to assess lung sounds due to snoring. Individual #505 has an intermittent non-productive cough. At the nursed documented the temperature as 99.5° (TA) with O_2Sats 94% with oxygen at 3 liters per minute. Skin was warm and dry to touch with normal coloring. Individual #505 was noted to be resting quietly. Through out the review of individual #505's clinical record only the temperature was recorded without the other vital signs. Because individual #505 frequently had elevated pulse and respiration rates, and low O_2Sats these measurement were important to accurately monitor health status. The Nursing Department needs to ensure that when temperatures are taken that a completed set of vital signs are also taken.	

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		On 9/710 at 8:00 a.m. the nurse documented that individual #505 was lying in bed with eyes closed and had not opened them this morning. Vital signs were documented as temperature 97.8° (T), pulse 92, respirations 32, blood pressure 118/77, and O_2Sats 85% with oxygen as 3 liters per minute. Oxygen was increased to 4 liters per minute and O_2Sats increased to 94% with 4 liter per minutes. The nurse documented that congestion was found but no respiratory assessments were documented. There was no documentation that the physician was notified of the decreased in O_2Sats. On 9/7/10 at 9:30 a.m. the physician examined individual #505. The physician assessed individual #505 as hypoxia, decreased level of consciousness, and tachypnea. The physician ordered individual sent to the emergency room via Emergency Medical Services. On 9/7/10 at 9:45 a.m. individual #505 was transported to the emergency room via Emergency Medical Services. Individual #505 was admitted to the hospital with a diagnosis of respiratory failure. Individual #505 remained in the hospital until the time of death on 9/15/10 at 6:10 a.m. Review of the clinical records for individual #505 numerous issues of grave concern were identified in this record, as was identified in review of individual #344: The nursing staff and physician failed to recognize and appreciate individual #505's acute change in the respiratory status and provide or seek aggressive medical intervention, rather individual #505 was treated symptomatically and empirically until reaching the crisis point. • Individual #342 had Health Risk Screening Scores of medium risk for: Aspiration, Choking, Respiratory, and Challenging Behaviors. Individual #342 had active medical problems of Asthma and Chronic Obstructive Pulmonary Disease with a history of frequent hospitalizations for respiratory problems. On 11/10/10 at 5:50 a.m., the direct care professional reported to the nurse that individual #342 was having difficulty breathing and had regurgitated with pale yellow emesis coming from the nose. The nursing assessment revealed coarse rhonchi in all lung fields; individual #342's nose was blue in color. Xopenex nebulizer treatment was started. Temperature was 96.3, pulse 120, and O_2Sats were 71%. At 6:00 a.m. O_2Sats were 89% on oxygen at 4 liters per minute with a pulse of 112. Individual #342's color improved. The physician was notified and ordered individual #342 sent to the emergency room. At 6:15 a.m., the individual was transported by Emergency Medical services to the emergency room. Individual #342 was admitted to the hospital 11/10/10 diagnosed with Aspiration Pneumonia. The Hospital Transfer information was sent to the hospital. The Nurse Case Manager informed individual #342's mother of the hospitalization on 11/10/10 at 8:30 a.m. At 11:45 a.m. the Nurse Case Manager	

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		contacted the hospital and received an update from the Intensive Care Unit nurse on individual #342's status. The Hospital Liaison Nurse's documentation revealed that visits were made almost daily throughout individual #342's hospital stay. The Hospital Liaison Nurse's notes regarding individual #342's health status were thorough and well documented. Individual #342 was discharged on 11/24/10. Individual #342 returned home at 12:00 noon and received a head to toe nursing assessment upon return to home. On 11/24/10 at 2:30 p.m., the Nurse Case Manager developed and implemented ACPs for Ineffective Airway Clearance and Impaired Skin Integrity and documented that the Home Leader and direct care professionals were trained on the plans. This was a good example of nursing management of an acute illness. • Individual #305 had Health Risk Screening Scores of medium risk for: Aspiration, Choking, and Medical Concerns. On 12/27/10 at 11:30 p.m. individual #305 was assessed with a red face, cough, and rapid respirations. Vital Signs included temperature 104 axillary, pulse 96, respirations 24, and O_2Sats 98%. Individual #305 was wheezing in both lungs. The nurse notified the physician who ordered individual #305 transferred to the emergency room. Individual #305 was transferred to the emergency room at 8:00 a.m. and was admitted for Pneumonia. There was documentation in the Integrated Progress Notes of Hospital Liaison Nurse's follow-up on individual #305's hospitalization from 12/28/10 and 12/29/10. Individual #305 was discharged home on 12/30/10. At 12:35 p.m. a head to toe nursing assessment was completed. On 12/30/10 the Nurse Case Manager developed and implemented an ACP for Pneumonia. The training on the ACP Pneumonia was provided to the Home Leader. Individual was monitored every shift for 72 hours then daily. The ACP for Pneumonia had not been discontinued at the time of the review. The review of individuals #342 and #303 for nursing care were in sharp contrast to the reviews for individuals #344 and #505. The two more recent cases indicated improvement in nursing assessment and recognition of acute changes in health status with timely notification of and follow up by physicians. The individuals were sent timely for hospitalization and, upon return, nurses provided complete physical assessment and, on day of return, established acute health care plans. There was evidence direct care staff were trained on the plans. Monitoring through to resolution was done according to health care plan.	
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	Since the last tour the Nursing Department had trained all Nurse Managers and Nurse Case Managers on the revised Comprehensive Nursing Assessment Guidelines and form. However, there was no evidence that formalized competency-based training was provided for completing the Comprehensive Nursing Assessment. The Chief Nurse Executive stated that the State Chief Nurse Executives had finalized the draft for Nursing	Noncompliance

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	care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Physical Assessment Training and were waiting final approval from the State Office. Nursing Physical Assessment Training should be competency-based to build solid foundational skills. The training should include how to clinically analyze data, write the findings of that analysis, and adequately measure the nurses' competency in producing quality nursing assessments. The Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive competency-based training on Nursing Physical Assessment Training. Annual and Quarterly Comprehensive Nursing Assessment were reviewed for 24 individuals: #513, #255, #196, #107, #37, #60, #318, #305, #61, #181, #392, #33, #90, #19, #97, #59, #24, #79, #37, #229, #420, #118, #102, and #79. All of the 24 Annual and Quarterly Nursing Assessment were completed according to their Personal Support Plan calendar. The 24 individuals' Annual and Quarterly Nursing Assessments reviewed included assessments completed on the revised Comprehensive Nursing Assessment form and the previously used Mental Retardation Nursing Assessment form. Nursing assessments completed on the Comprehensive Nursing Assessment form contained more complete assessment information. The Comprehensive Nursing Assessment Sections I through IX showed more improvement than Sections X and XI. The summaries in Sections I through IX contained more substantive information than was observed at the last tour. However, issues identified in summary sections were not consistently included in Section X Nursing Summary. The Nurse Case Managers' completed assessments were consistently signed and dated, and placed in the S drive for Qualified Mental Retardation Professionals (QMRPs) and for other Personal Support Team Members to review. Sections X (Nursing Problems and Diagnoses) did not contain nursing problems written in the North America Nursing Diagnosis Association (NANDA) format. They did not consistently contain nursing diagnoses for Health Risk Scores greater that one, or include nursing diagnoses for stable but chronic conditions listed on the Medical Active Problem List for which they were receiving medical interventions that required nursing assessments/monitoring and interventions to ensure that individuals remained stable or for the ability to identify regression in health status. Section XI (Nursing Summary) primarily consisted of raw clinical data, statements to continue Health Maintenance Plans, and lists of recommendations and goals as opposed to stating whether individuals' health status were progressing, maintaining, or regressing in relation to their established goals. The summary section of the nursing assessment should provide a clinical analysis of the raw data from the previous sections. To determine individual's health status, data should be compared to the previous quarter's assessment regarding the individual's progress related to their health and behavioral goals. Examples of problematic findings are listed below:	

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		• The monitoring team reviewed individual #492's Annual Comprehensive Nursing Assessment, dated 11/3/11. The assessment listed the following Nursing Problems: Organic Encephalopathy, Vitamin D Deficiency, Right Extropia, and PICA. Review of the Section VIII Physical did not contain baseline vital signs, however; Hypertension and Hypercholesterolemia were added to the Nursing Problem list after having been diagnosed 11/30/10, and after the Annual Comprehensive Nursing Assessment was completed on 11/3/10. The Nurse Manager indicated that that a HMP for Hypertension would be started with the "Annual." Section XI Nursing Summary was not updated to describe the circumstances leading up to the development of Hypertension or the status on individual #492's blood pressure or whether a HMP for Hypertension had been developed and implemented. The assessment should have been revised with the change in health status. The Nursing Summary contained the follow information: o *[Individual # 492] is a … year … that was admitted to BSSLC in 1979, and [individual #492] currently resides on [Individual #492] functions in the profound range of MR. [Individual #492] ambulates, and feeds self independently, and … does require some assistance with ADL's. [Individual #492] has functional vision and hearing. [Individual #492] is either seen or reviewed monthly in PTR's with the Psychiatrist. [Individual #492] has had an uneventful year without any illnesses and one minor injury that resulted in a cut to the R eyebrow that … he got from jumping in to the shelf by the radio. [Individual #492's] SAMS program is for him to wash hand over wrist [with] assistance.* o *Audiology: Due 10/10* o *Ophthalmology: Noted not to have any issues with … vision, will get a baseline exam around the age of 40.* o *SAMS: 11/2/10* o *Immunizations up to date* o *Health Risk assessment tool: Overall* o *Nursing Recommendations:* ▪ *Continue to monitor monthly and as needed by the Psychiatrist.* ▪ *Continue to monitor weight monthly, and implement needed intervention for weight loss/gain.* ▪ *Continue to administer flu vaccine and PPD test for preventative care.* ▪ *Follow the nursing protocol for PICA* ▪ *Continue lab levels to monitor Tegretol level, and vitamin D level.* ▪ *Continue to be seen for preventative health care appointments on and off campus as needed.* o *Goals:* ▪ *[Individual #492] will maintain good health, and have no injuries over the*	

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		next year that requires an acute NCP. ▪ *[Individual] will continue to maintain within … ideal weight range.* ▪ *[Individual #493] will not have any PICA behaviors that require nursing interventions.* ▪ *[Individual #492's] Tegretol level and vitamin D will remain in the therapeutic range over the next quarter.* Many of the recommendations and goals listed above should be included in a HMP. Simply to list recommendations and goals does not describe the individual's current health status, compare progress or lack there of from quarter to quarter. It was of concern that several of the assessments were not completed in Sections I through IX; they included: Vital Signs, EENT/Head and Neck, Cardiac, Respiratory, Gastrointestinal, Musculoskeletal, and Neurological.. The fact that baseline vital signs and cardiac assessments were not completed was particularly concerning due to individual #492's diagnosis of Hypertension on 11/30/10. Nor were vital signs and cardiac assessments summarized in Section XI Nursing Summary. The Comprehensive Nursing Assessment should have been revised on 11/30/10 based on the change in health status related to Hypertension as well as describing the circumstances leading up to the development of Hypertension, the status of individual #492's blood pressure, or whether a HMP for Hypertension had actually been developed and implemented. Individual #492 should also have had a HMP for Hypercholesterolemia. The lack of a comprehensive assessment of all systems limited the Nurse Case Manager's ability to adequately evaluate individual #492's comprehensive health status. The Nursing Summary should be derived from data identified in each of the Sections I through IX. Just because an individual does not have active problems or may have a low Health Risk Screening Score in some of the systems does not negate the need for assessments. Individual #492 was due to have an Audiology examination 10/10. The assessment was completed 11/3/10. There should have been a note of explanation as to the reason the examination was not completed timely and plans for rescheduling. The monitoring team reviewed the Admission/Initial Comprehensive Nursing Assessment for four of the six individuals admitted to the Facility within the last six months. Review of assessments upon admission is relevant to this Provision because it establishes a baseline from which changes in health status may be identified (in addition to identifying nursing interventions needed to comply with Provision M3). Of the four individuals reviewed, three of the four had an Admission/Initial Comprehensive Nursing Assessments completed within 30 days of admission. The one Admission/Initial Comprehensive Nursing Assessment not completed within 30 days of admission was	

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		only overdue by two days. • Individual #170 was admitted to the Facility on 12/9/10. The Admission/Initial Annual Comprehensive Nursing Assessment was completed on 12/16/10, within 30 days of admission. Individual #170's Active Medical Problem List included: Profound Mental Retardation, Aggression secondary to Intermittent Explosive Disorder, Down Syndrome, Seizure Disorder, Hypothyroidism, Allergic Rhinitis, Vitamin D Deficiency, Constipation, Acne, and Dermatitis. The Admission/Initial Comprehensive Nursing Assessment was adequately completed for the assessment Sections I through IX with appropriate summary statements for each section. Section X Nursing Problems/Diagnosis only listed Seizures and stated since admission individual #170 had not experienced seizure or side effects to the anticonvulsant medication. The Nurse Case manager failed to use the North American Nursing Diagnosis Association (NANDA) nursing diagnosis for seizures. Other active medical problems that were not listed which should have a nursing diagnosis included: constipation, downs syndrome, aggression, hypothyroidism, allergic rhinitis, dermatitis, and acne. Section XI, Nursing Summary contained the following information: o *Recommendations:* ▪ *To be seen by the Psychiatrist.* ▪ *To go to consults as ordered (Neurology, Podiatry).* ▪ *To maintain a healthy life style of living and will be referred to our MD as or if needed.* ▪ *To start a Health Maintenance Plan for seizures.* o *Goals: [Individual #170] will have a decrease in seizure activity, and no injuries D/T to seizure activity over the next year, and will have no adverse effects of Lamictal.* o *[Individual #170] was admitted to BSSLC 12-9-10. [Individual #170] has had no major or minor illnesses since admission. Labs were ordered and completed and were unremarkable. [Individual #170] needs much encouragement to go to medical appts. or for any medical procedure. [Individual #170] remains on 1:1 supervision at this time. [Individual #170] did receive a flu shot and a TB test was done on 12-14-10, it was negative.* Because individual #170 was recently admitted, it would not be expected for the Nursing Summary to make comparisons with previous health status. However, until adequate baseline data can be established and a Health Risk Screening conducted, individual #170 should have had nursing diagnoses for the active medical problems listed, e.g., constipation, downs syndrome, aggression, hypothyroidism, allergic rhinitis, dermatitis, and acne. A Health Maintenance Plan (HMP) was developed and implemented on 12/9/10 and there was evidence documented on the HMP and in the Integrated Progress Notes that the	

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		home leader and direct care professionals were trained on the HMP and verbalized understanding. Individual #170 should also have had HMPs developed and implemented for Constipation, Downs Syndrome, Aggression, Hypothyroidism, and Allergic Rhinitis. Although at the present time these conditions may have been stable, individual #170 was receiving medications for these chronic conditions all of which need monitoring for treatment effectiveness and side effects and/or adverse reactions. Several of the medications require routine monitoring of lab work. The medications included: Lamictal for Seizures, Seroquel for aggression, Levothyroxine for Hypothyroidism and Docusate Sodium for Constipation, and Singular. HMPs serve as a blue print for nursing assessments, interventions, and provide training for individual #170 and direct care professionals. It is imperative that the direct care professionals are trained to recognize and report signs and symptoms of changes in health status for individual #170's chronic conditions as well as to recognize potential side effects and/or adverse drug reactions to the prescribed medications. The failure to have HMPs to address individual #170's chronic conditions, at least until baseline data are established, has the potential to put individual #170 at risk of harm if there were changes in the status of the chronic conditions or if individual #170 experienced side effects and/or adverse drug reactions to medications that were not quickly identified and treated. Individual #170 was diagnosed on 12/10/10 with Dermatitis on the chest, abdomen, and back and was prescribed Triamcinolone cream; and Acne on the face and back of upper legs. Individual #170 should also have had ACPs for Dermatitis, Acne, and the Psychotropic Medication, e.g., Seroquel, until stabilized on the medication, and then it should be incorporated in HMP for aggression. The HMP for Aggression should be developed collaboratively with the Positive Behavior Support Team. • Individual #255 was admitted to the Facility on 10/21/10. The Admission/Initial Annual Comprehensive Nursing Assessment was completed on 11/22/10, which was 32 days after admission. Individual #255's Active Medical Problem List included: Profound Mental Retardation, Impulse Control Disorder, history of Attention-deficit/Hyperactive Disorder, history of Autism, Developmental Receptive and Expressive Disorder, history of Asthma, Anemia-mild normocytic- normochromic, history of Extrapyramidal Symptoms-opisthotonus, Seizure Disorder, and Overweight. The Admission/Initial Comprehensive Nursing Assessment was adequately completed for the assessment Sections I through IX with appropriate summary statements for each section. Section X Nursing Problems/Diagnosis: The Nurse Case Manager failed to use the North American Nursing Diagnosis Association (NANDA) nursing diagnosis for listing current nursing problems. Nursing Problems were listed as: Seizure, Asthma, Anemia, and Overweight. Nurse Case manager failed to use the	

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		North American Nursing Diagnosis Association (NANDA) nursing diagnosis for seizures. Section XI Nursing Summary provided a brief summary that stated individual #255 had been very quiet since admission with no documented injuries or illnesses, and appeared to have adjusted to BSSCL. The Nursing Summary listed the following information: *Recommendations:* ▪ *Continue HMP for seizures.* ▪ *Continue monthly visits with Psychiatrist.* ▪ *Continue to monitor for side effects of medications with MOSES every 6 months & DISCUS every 3 months.* ▪ *Continue nursing assessments quarterly, and all preventative health care appointments on and off campus as needed.* ▪ *Continue monthly weights. Since [individual #255] is a new admit, Dr. Lochiel recommends to monitor weight trend over the next few months before addressing weight.* ▪ *Continue with quarterly finger sticks for high risk medications.* ▪ *Continue with ordered labs to monitor status.* *Goals:* ▪ *[Individual #255] will be free from illness and injury during the next year.* ▪ *[Individual #255] will be within normal range and therapeutic.* ▪ *[Individual #255] will be free of side effects from medications.* ▪ *[Individual #255] will be able to have baseline ophthalmology exam after desensitization.* The information above should have been included in HMPs. The only HMP developed and implemented was for Seizures. Due to the numerous psychoactive medications individual #255 was receiving, e.g., Cogentin and Zyprexa, individual #255 needs a HMP for Psychoactive Medication developed in collaboration with the Positive Behavior Support Team. • Individual #196 was admitted to the Facility on 8/23/10. The Admission/Initial Annual Comprehensive Nursing Assessment was completed on 8/26/10, within 30 days of admission. Individual #196's Active Medical Problem List included: Severe Mental Retardation, Disruptive Behavior Disorder NOS, Autistic Disorder, Cerebral Palsy, Seizure Disorder, Enuresis, and Microcephaly. The Admission/Initial Comprehensive Nursing Assessment was adequately completed for the assessment Sections I through IX with appropriate summary statements for each section. Section X Nursing Problems/Diagnosis: The Nurse Case Manager failed to use NANDA nursing diagnoses for listing current nursing problems. Nursing Problems were listed as: Seizure/Anticonvulsant and Head Trauma/Minor. Section XI Nursing Summary provided a summary of	

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		individual#196's difficult adjustment since admission by dropping to the floor, head banging, biting self and the staff. Ativan was ordered to help with adjusting to the new environment in relation to having anxiety. At the time of the summary it was noted that individual #196 was becoming better adjusted. HMPs were developed and implemented for Seizure Disorder and Head Trauma. These HMPs were established 9/20/10, over three weeks after admission. Due to the numerous psychoactive medications individual #196 was receiving, e.g., Benztropine, Guanfacine, Lorazepam, and risperidone, individual #196 should have a HMP for Psychoactive Medication developed in collaboration with the Positive Behavior Support Team. • Individual #513 was admitted to the Facility on 10/4/10. The Admission/Initial Annual Comprehensive Nursing Assessment was completed on 10/15/10, within 30 days of admission. Individual #513's Active Medical Problem List included: Mild Mental Retardation, Bipolar Disorder, Autistic Behavior, Attention-deficit/Hyperactive Disorder, Sleep Disorder, secondary to Bipolar Disorder, Turner's Syndrome, and Enuresis. The Admission/Initial Comprehensive Nursing Assessment was adequately completed for the assessment Sections I through IX with appropriate summary statements for each section. Section X Nursing Problems/Diagnosis: None were listed although there were multiple psychiatric diagnoses listed in the Active Medical Problem list. Consequently there were no HMPs. Due to the numerous psychoactive medications individual #513 was receiving, e.g., Thorazine, Trileptal, Trazadone, Clonidine, and Ritalin individual #513 needs a HMP for Psychoactive Medication developed in collaboration with the Positive Behavior Support Team. Section XI Nursing Summary consisted of a summary of individual #513's adjustment since admission. Individual #513 had a few challenging behaviors since admission--not wanting to take medication, and complaining of chest pain when medications were taken. It was determined that individual #513 was not drinking enough liquids with medications and was encouraged to drink more. The nurse did not indicate in the summary if individual #513 increased fluid intake with medication or whether the complaints of chest hurting was resolved. Recommendations in the summary included: • *Continue to be seen in the PTR's by Psychiatrist monthly and prn.* • *Continue follow ups with doctor prn.* • *No NCP or HMP needed at this time.* Review of individual #513 Quarterly Comprehensive Nursing Assessment, 1/5/11 found it was virtually a repeat of the Admission/Initial Comprehensive Nursing Assessment. There were no Nursing Problems listed or need of HMPs.	

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		The Nursing Summary included raw data regarding the past quarter's health care. The only exception was that adjustments had been made to decrease some medication (which medication decreased were not listed) and the Trazadone was discontinued. Individual #513 continued to need a HMP or Psychoactive Medications.	
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.	Since the first compliance review the Nursing Department had provided training to the nursing staff on the Health Care Protocol for Developmental Nursing to assist with care planning. A signature and date line had been added to the Heath Maintenance Plans (HMP) and Acute Care Plan (ACP) for the Home Leader to sign and date to verify that direct care professionals had been trained in the plan. Copies of care plans were kept in a Care Plan Notebook in each home for easy access for the nursing and direct care professional to use. Care Plans Review of a sample of care plans, July through December, 2010 for individuals #24, #33, #19, #392, #181, #61 revealed the following findings and trends: • Most of the care plans reviewed were developed using the Health Care Protocols: Handbook for Developmental Disability Nurses. The care plans showed improvement over the older generic plan previously used. The nursing staff were beginning to individualize the care plans but on some only the individual's name, baseline data, and goal was changed while others were individualized. Of the 10 care plans sampled, 6 or 60% had some degree of individualization and four or 40% did not. This was a positive finding since the last tour where almost none were individualized. The individualized care plans contained pertinent information for the individuals' health problem. The sample included: o Care Plans not individualized: • Individual #61 - Sprain - Acute Care Plans, dated 11/10/10. Care plan failed to contain the signature of the Home Leader validating that direct care professional were trained on the plan. Resolved 12/28/10. • Individual #61 - Wound/Suture Removal, dated 8/30/10. Care plan failed to contain the signature of the Home Leader validating that direct care professionals were trained on the plan, 9/8/10. • Individual #392 – Urinary Tract Infection, dated 11/25/10. Contained training records validating direct care professionals had been trained. Resolved 12/2/10. • Individual #33 – Gastro-Esophageal Reflux Disease HMP, dated 11/3/11. The care plan contained the signature of the Home	Noncompliance

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		Leader validating that direct care professionals were trained on the plan, 11/4/11. o Care Plans individualized: • Individual #181 - Alteration in Skin Integrity R/T Surgery/Skin Friability/Allergy HMP, date 12/2/10. Contained Training Roster validating training of direct care professionals. • Individual #392 – Ineffective Airway Clearance and Skin Integrity, Impaired ACP, 11/24/10. The plans did not contain the signatures of the Home Leader validating direct care professionals had been trained. Resolved 11/22/10. • Individual #392 – Seizures, Prolonged, date 12/1/10. Contained Training Roster validating training of direct care professionals. Resolved 12/21. • Individual #19 – Acute Skeletal Fracture – ACP, dated 12/1/10. There was validation through Training Roster that only the 10-6 direct care staff had been trained. • Individual #24 – Skeletal Fracture-ORIF Right Hip, date revised 11/8/10 from acute to post hospital care 11/8/10. There was no validation by the Home Leader or Training Roster that direct care staff were trained on the plan. • Individual #24 – Wound from I & D, Post Pneumonia, Anemia, Post Vena Cava Filter Placement- Post Hospitalization - ACP, 11/8/11. Resolved 12/9/10. There was no validation by the Home Leader or Training Roster that direct care staff were trained on the plan. • The monitoring team reviewed HMPs for four recently admitted individuals. The quality of these care plans were of concern. Findings included the following: o Reviewed Individual #170's HMP for Seizures Prolonged, established 12/19/10. The only part of the plan that was individualized was individual #170's name on the baseline data and goal. The remainder of the Seizure HMP was directly copied from the Health Care Protocols: Handbook for Developmental Disability Nurses. The section for direct care professional training failed to include instructions for seizure medication. The section for direct care professional training failed to include instruction for seizure medication. There was evidence that the home leader had signed the HMP verifying staff training. o Reviewed Individual #255's HMP for Seizures Prolonged, established 10/21/10 and revised 12/26/10 after a low Dilantin blood level. The only part of the plan that was individualized was individual #255's name on the baseline data and goal. The remainder of the Seizure HMP was directly	

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		copied from the Health Care Protocols: Handbook for Developmental Disability Nurses. The section for direct care professional training failed to include instruction for seizure medication. The section for training direct care professionals was modified to include: items to protect individual #255 from injury during seizure, care after the seizure, pertinent facts about seizures, and to notify nursing personnel. Training was not included on seizure medication, including side effects and/or adverse drug reactions. There was evidence that the Home Leader had signed the HMP verifying staff training. o Reviewed Individual #196's HMP for Seizures, Chronic HMP was established 9/20/10. The only part of the plan that was individualized was individual #196's name on the baseline data and goal. The remainder of the Seizure HMP was directly copied from the Health Care Protocols: Handbook for Developmental Disability Nurses. The section for direct care professional training failed to include instruction for seizure medication. There was evidence that the home leader had signed the HMP verifying staff training. o Reviewed Individual #196's HMP for Head Trauma, Minor was established 9/20/10. The only part of the plan that was individualized was individual #196's name on the baseline data and goal. The remainder of the Head Trauma, Minor HMP was directly copied from the Health Care Protocols: Handbook for Developmental Disability Nurses. There was no home leader signature on the HMP validating that the direct care professionals were trained on the HMP. <u>HMPs for Psychotropic Medications</u> The monitoring team requested onsite copies of Psychotropic Medication HMP and/or ACPs of the10 most recently prescribed psychotropic medications for individuals: #538, #1, #112, #425, # 397, #173, #50, #184 and #196, who had two new prescriptions for psychotropic medications. Copies of these HMP and/or ACPs were not received. The monitoring team reviewed copies completed by the Quality Assurance Nurse, November and December, 2010 using the Psychotropic Medications-Nursing Responsibilities Monitoring Tools for individuals # 538, #425, #196, and #397. None of the four were found in 100% compliance with the tool. Example of the Quality Assurance Nurses' finding for items listed on the Psychotropic Medications-Nursing Responsibilities Monitoring Tool included: Of the 12 items listed on the Psychotropic Medications-Nursing Responsibilities Monitoring Tool, none (100%) of the four records contained the items listed below: • There is documentation that medical, behavioral services, nursing, therapy, and direct care staff participated in the positive behavior support planning process. • There is evidence that the nurse assisted other PST members in data collection	

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		and review to ensure medications are prescribed at the lowest effective dosage level. • A nursing care plan (HMP) was developed with individualized goals and interventions to meet the individual's needs. The HMP included interventions for specific side effect monitoring by the staff and referenced behavioral interventions outlined in the Behavior Plan. • There is evidence that the nurse and the PCP educated the individual, family/guardian and PST regarding PTMs and included information regarding the signs, symptoms, causes and associated health problems (e.g. swallowing problems, risk of falls etc.) for the following as needed: ▪ Tardive Dyskinesia (TD) ▪ Neuroleptic Malignant Syndrome (NMS) ▪ Drug toxicity ▪ Extra Pyramidal Symptoms (EPS) Of the 12 items listed on the Psychotropic Medications-Nursing Responsibilities Monitoring Tool, two of the four records (50%) contained the items listed below: • Informed consent was obtained from the legally authorized representative (LAR) prior to initiating a psychotropic medication (PTM) or other restrictive procedures, except in emergency situations. The terms of the consent included any limitation on the use of the medication or restrictive procedures and identified associated risks. • There is evidence of ample documentation by the PCP/Nurse and Psychologist/Psychiatrist indicating ongoing review of the effectiveness and potential side effects of the PTM will be evident in the records. Of the 12 items listed on the Psychotropic Medications-Nursing Responsibilities Monitoring Tool, two of the four records (25%) contained the items listed below: • There is a system using standard assessment tools such as MOSES or 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. • There is evidence that the nurse and the PCP educated the individual, family/guardian and PST regarding PTMs and included information regarding the signs, symptoms, causes and associated health problems (e.g. swallowing problems, risk of falls etc.) for the following as needed: ▪ Tardive Dyskinesia (TD) ▪ Neuroleptic Malignant Syndrome (NMS) ▪ Drug toxicity ▪ Extra Pyramidal Symptoms (EPS)	

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		Of the 12 items listed on the Psychotropic Medications-Nursing Responsibilities Monitoring Tool, two of the four records (50%) contained the items listed below: • The nurse will collaborate with other PST members in assessing, planning, implementing and evaluating programs and other activities that impact upon the individual's behavior. • There is evidence that the nurse participated in the quarterly review to assess the individual's response to medications. Of the 12 items listed on the Psychotropic Medications-Nursing Responsibilities Monitoring Tool the two items below were marked not applicable. • The use of chemical restraints was: o In accordance with State Mental Retardation Facility policy. o PTMs have not been ordered on a PRN basis except at end of life situations. o Use of chemical restraint for an individual more than three times in a rolling 30-day period resulted in review by the individual's PST. • There is evidence that the nurse promptly reported any possible medication side effects or changes in the individual's behavior to the PCP and included this information in the nursing continuity of care reports. The monitoring team's review of the Psychotropic Medications-Nursing Responsibilities Monitoring Tools completed by the Quality Assurance Nurse identified significant deficiencies in meeting the requirement set forth the Settlement Agreement and Health Care Guidelines. The Facility needs to ensure their processes and practices for management of psychotropic medications are strengthened to meet compliance with the Settlement Agreement and Health Care Guidelines. <u>Knowledge of Direct Care Professionals about HMPs</u> During the tour three direct care professionals, responsible for providing care to individuals #79, #102, and #37 were interviewed regarding care related to individuals' HMP and ACP. The direct care professionals were able to explain their responsibilities for care of the individuals, knew where the Care Plan Book and Me Books were located and showed the book to monitoring team. It was of concern, while functionally useful, to have copies of the care plans in a Care Plan Book. There is the possibility that the original care plans will not be placed in individuals' primary records or that revisions made to the care plans will be made on the copies and not the original care plans or when the care plans are resolved it will not be documented on the original care plans. Although there was documented evidence that the Home Leader had signed many of the	

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		care plans validating that direct care staff were trained, it is important that the nursing staff provide the training on all shifts to the direct care professionals. The Home Leaders are not nurses and should not be responsible for training their staff, only for ensuring that the staff are trained. This is solely a nursing responsibility that should not be taken lightly. The Nursing Department needs to ensure that the nursing staff train the direct care professionals on care plans. While there was much improvement in individualizing care plans to meet the individuals' special needs either for HMPs or ACPs it is important to only use the Health Care Protocol as resource guide in the development of care plan. Extraneous information that is not applicable to the individuals' care should be deleted from the stock care plan template when writing the care plans. For the care plans to be meaningful they must meet the specific needs of the individuals for whom they are written. The care plan should accurately reflect what the nurse is doing for prevention, health maintenance, and health promotion for the individuals. The care plans should contain goals and objectives that are realistic, measureable, and specific to the individual. The care plans should include specific interventions with measurable outcomes that are proactive in nature. The Facility's POI indicated they were not in compliance with this provision and the monitoring team concurs. While there had been progressive improvement in this provision, the Nursing Department needs to continue to make improvement in ensuring that all nursing care plans are individualized to meet the individuals' special health needs; address preventative and/or proactive interventions, and interventions that would minimized health risks.	
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.	According to the Chief Nurse Executive, specific nursing areas identified statewide were in need of standardized processes to ensure best nursing practice and the highest quality of care in the State Supported Living Centers (SSLCs). Workgroups were currently working on development of standardized processes and procedures. These workgroups include nursing participation from all SSLCs and have given many nurses the opportunity to contribute to the projects based on their area of expertise. Such activities are represented below. Workgroups presented draft processes and procedures at the statewide Chief Nurse Executive Meeting in November, 2010 and were finalized in December, 2010. These processes and procedures were awaiting final approval by the State Office. They included: • Acute Illness and Injury • Agency Nurse Orientation • Medical Restraint Nursing Protocol	Noncompliance

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		• Medication Administration Guidelines • Seizure Management • Nursing Physical Assessment Training • Skin Management and Wound Prevention • Medication Variance Procedure The SSLC Infection Control Nurses met in November, 2010, to review and finalize the following activities: • Infection Control – Education and Monitoring/Auditing • Infection Control – Policy and Procedure Manual • Infection Control – Data Collection/Trend analysis/Infection Control Meetings The SSLC Nurse Educator Nurses workgroup met in October, 2010 to develop and standardized training for nurses: • Nursing Orientation, Education and Training – workgroup will reconvene in January, 2011 to continue to develop these items • Other future topics identified for development and improvement are planned as soon as the other processes and procedures listed above are finalized: o Skin Integrity Committees – standardization o Bowel Management Program o Pain Management o Nurse Case Manager Training Since the last tour the nursing staff had received training on the following items: • Texas Department of Aging and Disability, State Supported Living Centers Policy: At Risk Individuals, Policy Number: 006.1, Date Approved: 12/29/10, Implementation: 1/1/11. The percentages of nurses trained were requested but not received. • BSSLC Aspiration Pneumonia/Enteral Nutrition Evaluation Procedures, No Date. The percentages of nurses trained were requested but not received. • Texas Department of Aging and Disability, State Supported Living Centers, Nursing Protocol: Post Anesthesia Care, Date: June 2010 and Medical/Dental Restraint Policy, Date: 10/28/10. Review of the BSSLC Nurses' Training Database validated that 100% of the nursing staff had been trained on these policies and procedures. New nurses will be trained on this procedure during New Employee Orientation. • Review of BSSLC Nurses' Training Database validated that 21 (81%) of 26 Nurse Managers, Nurse Case Managers, and Administrative completed refresher training (10/5/10) on MOSES and DISCUS assessments. Plans were projected for 100% completion by 1/31/11. • Review of the BSSLC Nurses' Training Database validated that 100% of the required nursing staff had been trained on the Health Care Guidelines' specific policies and	

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		BSSLC Nursing Guidelines as well on Care Plan Development. • All (100%) of the current nursing staff received Physical Management training according to signed Training Rosters. New employees receive Physical Management training in New Employee Orientation. • All current RNs (100%) received training on the Health Care Protocols: Handbook for Developmental Disability Nurses according to signed Training Rosters. New employees receive this training in New Employee Orientation. • All (100%) nursing staff were trained on Nutritional Management as verified on BSSLC Active Employee Course Participation Report.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	Since the last tour the Health Risk Screening Policy and Procedures were revised to the Texas Department of Aging and Disability, State Supported Living Centers Policy: At Risk Individuals, Policy Number: 006.1, Date Approved: 12/29/10, Implementation: 1/1/11. At the time of the tour, the Facility had recently implemented the revised policy. According to the Nurse Educator the required nursing staff were trained. The percentages of nurses trained were requested but not received. The Health Screening Policy had been recently revised. At the time of the tour only two individuals had been screened using the revised Health Screening Procedure. Since the last tour the Infection Control Program had added another part-time (50%) Infection Control Nurse. This was a positive finding due of the complex and multifaceted responsibilities of the Infection Control Program. The primary Infection Control Nurse showed the monitoring team that she had independently taken continuing education courses to enhance her knowledge and skills, e.g., Department of State Health Services, Communicable Disease Provider Reporting Training, 9/30/10, Interactive Core Curriculum on Tuberculosis (Web-based), WB3071, for 6.1 contact hours, 10/19/10, and Oral Care, 10/25/10. The State should consider enhancing opportunities for the Infection Control Nurses to gain further knowledge and skills. One way to do this would be by supporting membership to the local Texas Association for Professionals in Infection Control and Epidemiology (APIC. As the infection Control Nurses work to revise the Infection Control Procedures and training, it would also be beneficial for the State to contract with an expert Infection Control Nurse to provide onsite technical assistance and mentoring. In December, 2010, the Infection Control Department worked collaboratively with the Data Analyst and had adopted and implemented the Infection Control Access Database developed by the Richmond State Supportive Living Center. The database was more comprehensive than the previous database that was in an Excel program which was limited in its capability to link clinical data. The purpose of this improved database system was to collect meaningful and valid data that can be utilized to trend over a	Noncompliance

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		designated date range as well as to quickly assist clinical staff in identifying emerging infectious issues so that the Facility staff can address them expeditiously. The data elements are collected and tracked from three sources: Individual Infection Control Forms, Pharmacy notifications, and State Lab Reports. These three data sources were used to validate the integrity of the Infection Control data. The database was based on infection type episodes (onset and resolved dates) for an individual. An individual can have multiple episodes with corresponding infection types, e.g., upper respiratory infections, soft tissue boils/abscesses. Within any given episode, multiple medications can be captured as well as x-rays, cultures, and other diagnostics. Having the ability to link clinical data will be useful in making clinical decisions for the individual as well as identifying systemic trends. Information from the Infection Control database can be used by clinical disciplines as well as other disciplines in making clinical decisions, for example: • Infection Control Nurses can utilize the reports to determine if any infectious issues were emerging as well as to assist with individual care planning, and nursing assessments. • Medical staff can also use the application for individuals/homes/units trends and infection histories as well as accessing antibiogram data. • Habilitation clinical staff, Physical therapist, Occupational Therapist, and Speech Language Pathologist, can utilize the database, primarily regarding pneumonia information to identify high risk individuals to be closely monitored by the Nutritional Management Team with proactive PNMPs. • Unit Director and Upper Administrative staff can utilize the database to identify general campus-wide trends that may require corrective action. The adoption and implementation of this database demonstrated a significant improvement over the previous Infection Control database. Since it was recently implemented the Infection Control Program staff were in the process of populating the database. At the time of the tour not enough data had been entered to complete a trend analysis. However, with the information available in the database Infection Reports by Type were generated for the following examples, for the period 9/1/10 through 1/10/11: • Soft Tissue o Bowie – 1 o Childress – 1 o Driscoll – 3 o Cottages – 3 For a total of - 8	

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		• Urinary Tract Infections o Bowie – 1 For a total of - 1 • Upper Respiratory Tract Infections o Bowie – 3 o Childress -1 o Cottages – 3 For a total of - 7 • Pneumonia o Bowie – 1 For a total of - 1 • Ophthalmic and Otic o Childress – 1 o Cottages – 1 o Driscoll – 2 For a total of – 4 The ability for clinical disciplines and other disciplines to quickly access the Infection Control Database will assist in identifying emerging infection trends by unit, home or facility so that swift intervention can be initiated when trends are identified. According to an interview with the Infection Control Nurse, infection control information was submitted more timely and consistently since the last tour. This was in part due to the development and implementation of a new Infection Report form and retraining of the nurses to ensure that all reportable infections were reported timely. The Infection Control Program continued to report infectious and communicable disease for: Methicillin-resistant Staphylococcus aureus; Hepatitis, A, B, and C; Positive Tuberculin Skin Test; Human Immunodeficiency Virus; urinary tract infections; and antibiotic use. The data were reported on Individual Infection Control Forms, Pharmacy Notifications, and State Lab Reports. These three data sources were used to validate the integrity of the Infection Control data. When the monitoring team requested a report of all active infections for the past month, the Infection Control Nurse was able to printout from the database a list of all active infections by unit, home, and individual. The list included the type of infection, date it was diagnosed, treatment received, and if resolved that date. Antibiograms were put into use since the last tour and were used by the physicians to make clinical decisions regarding the selection of antibiotics in treating infections. Since the last tour the Infection Control Program had developed and implemented an Immunization database to track immunizations as well as tuberculosis testing status.	

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		This should provide physicians and Nurse Case Managers with immediate access through the S drive to review individuals' immunization status and identify when immunizations were due. An example for tetanus toxoid was provided demonstrating how immunizations that were due could be identified through requesting a list for a particular immunization. The database printed out the names of individuals who needed their booster up-dated and when they were last received. It was positive to find the Infection Control Nurse was beginning to use the Infection Control Monitoring Tools. This monitoring had recently started and at the time of the review there were no analysis and trend data available to review. The monitoring team requested an onsite report regarding the status of flu vaccinations and tuberculosis screenings for residents and employees. The report indicated the following information: • Flu vaccine: Three hundred and twenty-two (98%) of 330 individuals residing on campus had received the flu vaccine this fall. The remaining eight (2%) of 330 individuals not immunized all had justifiable reasons for not being immunized with the flu vaccine. Three hundred and eighty-seven or 30% of the employees were immunized with the flu vaccine. • Tuberculosis screening: Three hundred and twenty-six (99%) of 330 the individuals residing on campus had received annual tuberculosis screenings. Three (1%) of 330 individuals had not received annual tuberculosis screening. The Infection Control Nurse stated those three individuals not screened would be screened the next "round" of tuberculosis testing on campus. The date of the next "round" was not specified. The monitoring team reviewed the Quarterly Infection Control Committee Minutes for 6/30/10 and 9/30/10. The December, 2010 minutes were not available for review onsite as requested in the document request. In the 6/30/10 minutes it was documented that 125 employees still needed tuberculosis skin testing. It was further reported that a few of the 125 had received the tuberculosis skin testing but had not returned to have the testing read and retested. It was also reported that it was difficult to track chest-rays on employees who had new positive tuberculosis skin tests. Concern was expressed for the risk of tuberculosis exposure to individuals by these staff until chest x-rays were completed. According to the minutes the infection Control Committee recommended that staff be given 48 hours to have the chest x-ray; if not completed, the employee was not to return to work until the chest x-ray was	

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		completed and read. An e-mail was sent to the employees' Residential Director/Assistant Director informing them of the need for their employees to have chest x-rays completed. In the 9/30/10 Infection control Minutes there was only a brief mention of the problem of employees receiving tuberculosis skin testing and chest x-ray, except to state, *"Completed, staff on ESL will receive the testing/screening when they return".* In a separate report provided onsite, the Infection Control Nurse reported there were 204 or 16% employees with a history of past positive tuberculosis skin test, only 87% of these employees had received annual tuberculosis skin testing. Follow-up by the Facility to ensure employees to receive annual tuberculosis screening is critically important. According to the CDC, Morbidity and Mortality Weekly Report, March, 20, 2009, provincial data for 2008 ranked Texas as one of four states with the highest incidents of tuberculosis. The Infection Control Committee Minutes included the summarized reportable Quarterly Infection Reports that calculates the rate of infection by units and facility. Neither set of minutes discussed whether or not trends were identified in review of the Quarterly Infectious Disease Reports. This information was requested in the document request for onsite review but not received. Because of the high incidents of tuberculosis in Texas the facility working with the Infection Control Program needs to ensure that all employees are current with tuberculosis testing/screening. The Infection Control Nurse needs to prepare a quarterly summary of reportable infection by type and rate per unit as well as facility-wide to use in tracking and trending infections. During the Nurse Managers meeting on 9/15/10, it was noted that due to confusion with the need for consents, no consent needed to be obtained for individuals to receive the flu vaccine. However, the list that the monitoring team was given by the Infection Control Nurse gave the reason that of some of the individuals who did not receive the flu vaccine was due to refusal of the individuals' legal guardian. Consent is no longer required by law for the influenza vaccine; however, providing the Vaccine Information Statement to the individual and legal guardian explaining the purpose of the vaccine as well as risks and benefits is required. Since there was refusal for some of the individuals to receive the flu vaccine it would seem that they were told about the vaccine and chose not to receive it. Documentation was not available to confirm that individuals and LARs received the VIS. The Facility needs to clarify the policy regarding consents for immunizations. The 6/30/10 Infection Control Minutes reported there were two cases of Methicillin-resistant Staphylococcus aureus (MRSA) and one individual residing in Childress had pinworms three times. It was of concern why the same individual contracted pinworms three times. There was no discussion regarding probable causes for the re-infestation or	

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		what management and/or treatment had been provided to other residents or staff residing and working in that home. Pinworms are highly contagious and can easily spread throughout an individual's living environment. It could not be discerned from the minutes if the physician treated the other individuals and staff in the home or what environmental precautions were put in place to prevent the spread of pinworms. Review of the Infection Control Training Curriculum did not include training on intestinal parasites. The Infection Control Nurse needs to ensure that the Facility follows CDC guidelines for treating intestinal parasites as well as including such training in the Infection Control Training Curriculum. There were two reported incidents for contagious infectious disease reported involving employees. • One employee had contracted scabies on 12/3/10. This employee was seen in the emergency room and was treated and placed off duty until 12/8/10. There were no reported cases of scabies within the resident population. There was no documentation available for review to determine what action was taken to assess individuals the employee might have come in contact with or education provided to staff regarding scabies. • One employee had a confirmed diagnosis for Pertussis on 11/30/10. The Infection Control Nurse contacted the local Health Department for advice on how to manage the individuals and staff with whom the employee might have had contact. The Health Department advised that all should be treated for Pertussis before they developed symptoms and spread the infection. The Medical Director explained the situation and treatment alternatives. The Medical Director recommended Z-pac as treatment and for the staff to request the Diphtheria, Tetanus, and acellular Pertussis vaccine at their next annual medical exam. A list of individuals who came in contact with the employee in the clinic was generated. Individuals who were in contact with the employee were treated preventively with Z-pac and observed for symptoms. Exposed employees were provided with Z-pac medication through the Pharmacy if they choose to take advantage of the medication. There were no cases of Pertussis reported in the resident population 21 days after exposure. The infected employee was placed on leave until cleared by a physician to return to work. The follow up steps taken in the management of this case of Pertussis were appropriate and effective. The Infection Control Report indicated that 21 days after the incubation period had passed none of the individuals were reported to have contracted Pertussis. In the 9/30/10 Infection Control Minutes it was reported that the Health Center was having problems with improper disposal of biohazard waste. There was documented evidence that staff responsible for disposing biohazard waste had received in-service on	

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		proper disposal of biohazard waste. There was documentation on 10/13/10 that the Infection Control Nurse had checked the Biohazard Room and found it cleaned up and met inspection. This was a positive finding that the issue of improper disposal of biohazard waste was identified, addressed, and followed up through to resolution. The monitoring team reviewed completed Infection Control Monitoring Tools, October through November, 2010, for Main Kitchen and Health Center Building. Two completed monitoring tools from each area were available for review through document request. There was evidence when environmental problems were identified in the Health Center Main Kitchen that corrective was taken and followed through to resolution. This sample was too limited to determine compliance with completing environmental surveillance. The document request for onsite review included a request for copies of the past six months' environmental surveillance monitoring. There was documented evidence that Monitoring for handwashing on campus was being completed, however, there was no documentation describing to what degree it was being completed. Therefore, it was not possible to discern if the monitoring was adequate. The Infection Control Nurse needs to establish procedures, criteria, sample size, and frequency for monitoring environmental issues and handwashing across campus. The Infection Control Program needs to develop and implement a database for collecting, analyzing and trending environment surveillance and handwashing data to identify areas that may need plans of corrective action for environmental health and safety issues and handwashing. After this information is analyzed it needs to be incorporated into other Infection Control data to identify if there were correlations with transmission and/or cross contamination with incidents of infectious diseases. Review of the Safety Committee Minutes for the past six months identified numerous environmental and health issues as well as other infection control issues such as health and hygiene checks for individuals who wear protective briefs because of the risk for urinary tract infections and skin breakdown, and black mold growing on the ceiling tiles in the Recreational Building. The release of mold spores into the environment has the potential to cause increase risks for respiratory illnesses as well as other health problems, such as skin allergies/rashes and other health conditions. This is an issue that the Infection Control Nurse needs to pay attention to due to the high incidence of respiratory illnesses, as demonstrated by review of hospital and emergency admissions. Review of the various Safety Committee Meeting attendance lists failed to include the attendance of the Infection Control Nurse, particularly at the Facility Safety Committee Meetings. Since safety, environmental, and health issues are inter-related, it is important that the Infection Control Nurses participate in this committee. The list of employees delinquent in Infection Control training was requested for onsite review but was not available.	

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		Review of the list of active pressure ulcers at the time of the review indicated that four individuals had pressure ulcers, e.g., individuals #60, #79, #38, and #269. One individual's pressure ulcer was hospital acquired; the other individuals' were Facility acquired. Individual #79 had a stage II pressure ulcer of the left greater trochanter and a stage III pressure ulcer of the right iliac crest. Individual #38 had a stage II pressure ulcer of the left buttock. Individual # 60 had a stage II pressure ulcer of the right buttock. Individual #60 was in the hospital at the time of the review. Individual # 269 had stage III pressure ulcer of the left buttock and coccyx. Individual #269 was in a long term acute care facility at the time of the review. Review of individuals' #79, #69, # 38, and #269 records, July2, 2010 through January 13, 2011, indicated that these individuals had chronic problems with skin breakdown/pressure ulcers. The review of the Integrated Progress Notes, Physician's Orders, E-Z Graph Wound Assessment System Tools, Pressure Ulcer Healing Charts, and Acute Care Plans and Health Maintenance Plans for Skin Integrity, validated that the nursing staff consistently assessed the status of the skin breakdown daily and/or every shift when indicated, from the onset until the wounds were resolved, and again when prior healed wounds broke down. Physicians were notified, prescribed treatments, nursing staff carried out the treatment, and Acute Care Plans were established and followed to resolution. It was positive to find that there was evidence that the Acute Care Plans and Health Maintenance Plans were individualized with realistic goals and appropriate interventions. There was evidence that the direct care staff were trained on the Acute Care Plans and the Health Maintenance Plan. The nursing assessments were well documented in the Integrated Progress Notes and on other relevant other skin assessment documents. There was evidence in the documentation that individuals received nursing services that were integrated across clinical disciplines, e.g., physicians, occupational and physical therapists, and dietitian. The nursing care rendered by this Nurse Case Manager, and nursing staff was exemplary. The Skin Integrity Committee Minutes were requested in the document request for onsite review but were not available. The SSLC Infection Control Nurses met in November, 2010, to review and finalize the following activities: • Infection Control – Education and Monitoring/Auditing • Infection Control – Policy and Procedure Manual • Infection Control – Data Collection/Trend analysis/Infection Control Meetings This was a positive finding since BSSLC's Infection Control Policy and Training	

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		Curriculum had not been up dated since 2003.	
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.	Since the last tour the Medication Administration Observation Form was revised in December, 2010 to include monitoring for following the individual's PNMP during medication administration. This was a positive finding. The Nursing Department continued to complete Medication Observations for oral and enteral medication administration. This was evidenced through review of the quarterly schedule indicating that all medication nurses were observed for the first quarter (September through November). The Nurse Managers completed the observation on the 2-6 and 6-10 nursing staff and the Nurse Shift Manager completed observation on the 2-6 nursing staff. The Nurse Managers and Nurse Shift Managers, when indicated, provided on the spot retraining, which was documented on the observation form. The completed observation forms were submitted to the Nursing Operations Officer and Chief Nurse Executive. Audits were to be reviewed by the Nursing Operations Officer and Nurse Managers. There were no formalized analysis, trend, or corrective action reports available to review for Medication Administration Observation data. The Nursing Operation Officer needs to develop and implement a database to capture the Medication Administration Observation data, analyze, trend, and develop plans of corrective action. This data needs to be incorporated into the Facility's Quality Assurance database. Reviewed 71 completed first quarter Medication Administrative Observation forms, for both oral and enteral administration. It was amazing to find that none (100%) of 71 completed Medication Observation forms required retraining. The monitoring team reviewed completed Enteral Medication Administration Observations, October through November, 2010. The Quality Assurance Nurses completed random monthly Enteral Medication Administration Observations on three homes with enteral feeding tubes, e.g., Driscoll, Bowie, and Childress. The Quality Assurance Nurses, when indicated, provided on the spot retraining and documented it on the observation form. The completed observation forms were submitted to the Nursing Operations Officer, and Chief Nurse Executive. Audits were to be reviewed by the Nursing Operations Officer and Nurse Managers. There were no analysis, trend, or corrective action reports available to review for Medication Administration Observation data. The monitoring team reviewed 49 completed Medication Administrative Observation forms, October though December, 2010. Of the 49 observations reviewed, 14 or 29% required on the spot retraining. Of the 14 observations that required retraining, eight or 57% were for failure to assess bowel sounds and abdominal distention, 4 or 29% were for failure to implement individuals' Self-Administration of Medication (SAM) programs, one or (7%) was for failure to check for tube placement, and one or (7%) was for failure to wear gloves while handling tubing. When comparing the Medication Administration Observations completed by the Nurse	Noncompliance

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		Managers and Nurse Shift Managers with observations completed by the Quality Assurance Nurses; the Quality Assurance Nurses identified 29% more issues requiring retraining than did the Nurse Manager and Nurse Shift Manager who identified none. The Nursing Operations Officer or designee needs to conduct periodic observations of the Nurse Manager and Nurse Shift Managers to evaluate competency of the nurses performing the observation and ensure inter-rater reliability of the Medication Observation performed. Medication Administration Observation forms completed by both the Nurse Managers, Nurse Shift Nurse Managers, and the Quality Assurance Nurses indicated that the nurses were observed only administering medication to one individual, and not observing the entire medication administration pass. Conducting observations for one or a few individuals is appropriate for random spot checks but not for the quarterly medication observations that are conducted to ensure that nurses are following correct procedures for safe medication administration practices. The Nursing Department and Quality Assurance Department need to ensure that the nurses conducting Medication Administration Observations observe entire medication administration passes during the quarterly Medication Administration Observations. The monitoring team observed medication administration observations, onsite, for individuals living in Driscoll D and Fannin 504. It was positive to find since the last tour that individuals were provided privacy during medication administration and that the direct care professionals were assisting the nursing staff by bring individuals to the nurses for medication administration. During the medication administration, correct and safe medication practices were followed except for the few items listed below. • Medication administration in Driscoll D for individual #303, observed individual #303 sitting in a recliner in his room without his roommate during medication administration. The nurse took the medicine cart into the room with the Medication Administration Record. The nurse informed individual #303 what medications were being administered and explained their purpose. The nurse stated that individual #303 was not on a SAM program. Individual #303 received medication enterally. When the nurse exposed the abdomen to inspect the stoma site, the nurse realized immediately that he had not donned gloves. Gloves were put on and worn throughout the administration of medication. After the nurse checked the stomach contents for residual, the plunger was separated from the syringe and laid on top of the plastic bag used to hold the syringe, contaminating the outer surface of the bag. The nurse explained that in order to administer individual #303's medication, gentle pressure with the plunger was required to push the medications through the tube. There was no special instruction on the Medication Administration Record to use gentle pressure when administering medication through the tube. Individual #303	

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		was sitting upright in a recliner during medication administration, however; individual was leaning forward slightly. The monitoring team discussed the potential for the forward leaning position to increase intra-abdominal pressure, which might contribute to the difficulty with the medication flowing into the tube by gravity flow. The monitoring team recommended that this issue should be evaluated. If the use of gentle pressure is necessary to deliver the medication, special instructions should be ordered. The PNMP was not reviewed prior to administering individual #303's medication. Review of the Medication Administration Book for Driscoll D found that all PNMPs' were located in a separate section of the Book. The monitoring team explained that for the PNMPs to be of value and readily accessible for review they must be in the front of the individuals' Medication Administration Record with the PNMP oriented to face forward. Review of the PNMP for individual #303 did not contain instructions for medication administration. • Medication administration observations were conducted on Fannin 504 for individuals #52, #293, #23, #185, #398, and #377. Two nurses took turns administering medication to these individuals using the same medication cart. Individuals were administered medications in a private room. The direct care professionals brought each individual to the nurse for medication. The nurses administering medication began telling the monitoring team the names and purposes of the medications they were administering. The monitoring team prompted the nurses to inform the individuals (rather than the monitoring team) the names and purposes of their medications, and the nurses promptly complied. The nurses failed to address individuals' SAM programs. During one medication pass, an individual dropped one of the pills. The nurse assisting checked the name of the medication with the Medication Administration Record and pulled another pill to give to the nurse administering medication. The monitoring team prompted the nurse that if he/she checked and pulled the replacement pill then he/she must administer the medication. The monitoring team asked the nurse administering the medication what was the procedure for disposing and replacing the dropped pill, and she explained the procedure correctly. The PNMPs were not referred to prior to administration of medication for the above individuals. All PNMPs' were located in a separate section of the Medication Administration Book. The monitoring team explained that for the PNMPs to be of value and readily accessible for review they must be in the front of individuals' Medication Administration Record with the PNMP oriented to face forward.	

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		• Review of the observed individuals' Medication Administration Records did not show any missing/undocumented doses of medications form January 1, through January 13, 2011. This was a positive finding. While there were significant improvements observed since the last tour there remained some areas that need continued improvement. The Nursing Department needs to continue improvements in the following areas of medication administration: • Work collaboratively with the Physical and Nutritional Management team to ensure that instructions for medications are included on the PNMP, • Ensure that individuals are maintained in correct positioning according to their PNMP before, during, and after medication administration, particularly individuals who receive medication enterally and/or those individuals who are deemed at risk for aspiration. • Ensure that SAM programs are consistently carried out according to the individual's plan. • Ensure that individuals are consistently informed of the medications they are receiving and their purpose. • Ensure that nurses follow good infection control practices. • Ensure that the PNMPs are placed in front of individuals' Medication Administration Record with the PNMP oriented to face forward for easy access. It was positive to find that two additional audits for medication administration practices were initiated since the last tour. The new audit tools were for Medication Administration Records and Medication Room Checklist. The monitoring team reviewed completed Medication Administration Records, October through November. The Quality Assurance Nurse completed a monthly audit of one home on each unit, except for the Cottages; two homes were audited on the Cottages. Review of 12 completed Medication Administration Records indicated that all 12 (100%) had numerous problematic issues identified. The completed audit tools with a detailed list of identified issues were attached to each tool and were sent to the Nurse Managers for retraining or corrective action with copies sent to the Nursing Operations Officer for review. There was no analysis of data available for review. There was no validation for corrective actions taken or spot checks completed the Nursing Operation Officer available for review. The monitoring team reviewed completed Medication Room Checklists, October through November, 2010. The Quality Assurance Nurses rotates the units on a monthly basis and audits all medication rooms of the selected units. The completed audit tools with a detailed list of identified problematic issues noted on each tool were sent to the Nurse	

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		Managers for retraining or corrective action with copies sent to the Nursing Operations Office for review. Review of the eight completed Medication Room Checklist audits indicated that all eight (100%) had numerous problematic issues identified. The completed audit tools with a detailed list of identified issues were attached to each tool and were sent to the Nurse Managers for retraining or corrective action with copies sent to the Nursing Operations Office for review. There was no analysis of data available for review. The Nursing Department and/or Quality Assurance Department need to develop and implement a database to capture, analyze, and trend data from Medication Administration Observations, Medication Administration Records, and Medication Room Checklists audits. This information needs to be integrated into the Medication Error Committee and Pharmacy and Therapeutic Committee meetings, as appropriate. It was apparent, since the last tour, from review of documents, records, observations, Nursing Management Meetings, Medication Error Committee Meeting Minutes, Pharmacy and Therapeutic Committee Meeting Minutes, and attendance of such meetings, that significant effort had been put forth to improve medication administration practices and to reduce medication errors. Improvements included but were not limited to: • In August, 2010 the Quality Assurance Nurse developed and implemented a new medication error database system to track, analyze, and trend medication error data. The system had undergone continuous modifications since the implementation as the nursing staff analyzed data extrapolated from the database. The system can analyze and trend data by: type of medication error, nurses committing the medication errors, classification of medication, Severity Indexes, ratios of errors in relation to number of medications administered by home, unit, and facility, make comparisons home to home, unit to unit, and facility-wide, and identify contributing factors causing medication errors, e.g., cross coverage, distractions, agency nurses, floating staff, staff inexperience, insufficient staffing, staff working over time. Medication Error Report can be produced in both tabular and graphic forms. As this system is refined it should produce reliable data to track, analyze, and trend medication errors in order to make further improvement in the management of medication errors. • The Medication Error Committee had developed Medication Error: Corrective Action Plan Guidelines. Corrective Actions included: o When a nurse has five errors with a Severity Index of "C" per month the Nurse Manager or designee will perform retraining and review of BSSLC [Medication Administration] Policy and Procedure. Medication Observations will be done once per month for three months. Observations	

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		will be done from beginning to end of the Med Pass and will be completed by the Nurse Manager or Nurse Shift Manager or designee. o When a nurse has two errors with a Severity Index of "D" per month. The Nurse Manager or designee will perform retraining and review of BSSLC Policy and Procedure. o When a nurse has one error with a Severity Index of "E" through "I" at anytime; that nurse will be removed from staffing. The Nurse Manager or designee will provide training and review of the BSSLC [Medication Administration] Policy and Procedure, administer a competency test and perform a Medication Administration Observation. All documentation of training and Medication Administration Observations will be submitted to the Nursing Operation Officer for review at the Medication Error Committee. This plan was still under review and refinement. • In order to improve documentation of PRN medications a contact note form was printed on the back the Medication Administration Records. • Since the baseline review the Nursing Department had arranged for space in which to administer medications that afforded individuals with privacy. The direct care professional assists the nursing staff during medication administration by bring one individual at a time to the nurse for medications. • The Clinical Pharmacist provided the nursing staff with training on adverse drug reactions in September, 2010. • Because of the high incidents of medication errors committed by the agency nurses, more intensive training will be provided to agency nurses by the Nurse Educator or designee along with competency-based testing. • Since the last tour the Chief Nurse Executive stated that there had been increased coordination and cooperation with the pharmacists. Pharmacists routinely attend Nursing Management Meetings and Medication Error Committee Meetings. • The Nursing Department now schedules a rotation in the Pharmacy during New Employee Orientation. • Since the last tour the Nursing Managers, Nursing Shift Manager, and Quality Assurance Nurses had consistently completed Medication Administration Observations quarterly as discussed above. In addition, new audits for Medication Administration Records and Medication Rooms had been formally added to the monitoring process, as discussed above. • Effective 12/1/10 an item to observe nurses' following PNMPs was added to the Medication Administration Observation Tool. This was a positive finding since the last tour. Although the PNMPs were placed in the Medication Administration Record Books, as reported above they were located in a separate section of the Book and not functionally available for the nurses to review at the time of medication administration. The monitoring team recommended to the Chief Nurse Executive	

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		and Nursing Operation Officer to place PNMPs with each individual's Medication Administration Record in the front and to orientate the PNMPs to face forward for ready access for the nurses to review before administering medications. The Chief Nurse Executive and Nursing Operations Officer were agreeable to the recommendation and will make the change in location of the PNMPs. According to the Facility Medication Error Summary Report for October, November, and December, 2010, there were a total of 255 medication errors for these months. This represented an 11% decrease from the three previous months. Omissions accounted for the largest percentage of errors at 78%, with the remaining percentages accounting for: wrong drug 2.4%, wrong dose 11%, extra dose 4%, wrong individual 0.4%, and other 4%. There were three variables cited as contributing factors; agency staff committed 84 errors or 33%, 47 or 18% were attributed to distractions, and 21 or 8% were committed by floating staff. The implementation of the new database had made it possible to extrapolate more specific data from the Medication Error Report form and made it possible to begin to analyze and trend data from a root cause analysis perspective. It provided the Facility with more specific data to analyze and trend for making clinical decisions for corrective action. As the new data collection system is refined and matures it should provide invaluable information regarding all aspects related to medication errors. According to discussion with the Chief Nurse Executive and Nursing Operations Officer, review of the Medication Error and Pharmacy and Therapeutic Committee Meeting Minutes, and Medication Error Reports, omission of medication was historically and continually responsible for the highest number of medication errors. It was theorized that the way that compound medication orders were printed on the Medication Administration Records contributed to omission errors. For example, a medication is printed on the Medication Administration Record for Prevacid 90 milligrams. The Pharmacy dispenses 60 milligram tablets and 30 milligram tablets to equal the 90 milligram dose. Both strengths of the tablets are placed, divided separately, in the individual's medication drawer. However, it is not printed on the Medication Administration Record to give one 60 milligram tablet and one 30 milligram tablet to equal the prescribed 90 milligram dose. Consequently, the potential for medication errors occur in which only one of the strength tablets is administered by the nurse. There was documentation reviewed from the State Nursing Coordinator regarding a meeting she conducted with the HHSC Medication Management Project Manager and vendor representatives from the WORx system that prints the Medication Administration Records. When the WORX system representatives were asked if compound medication order were written, such as the example above, could the WORx system accommodate compound order written into one box to read, "Medication name, 90 milligram twice a	

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		day, give one 60 milligram tablet and one 30 milligram tablet". The vendor representative agreed this could be done. The Chief Pharmacist explained that in order to print this additional information the pharmacy staff would have to manually enter it on the Medication Administration Record, which would increase time that the pharmacy staff did not have. Therefore, although the WORx system can accommodate the additional information, it was not done at the time of the tour as was validated through review of Medication Administration Records reviewed for individuals #303, #52, #293, #23, #185, #398, and #377. On these records instructions for the number of tablets to administer to equal the prescribed dose was handwritten by the nurse checking the Medication Record. For example, individual #303 was prescribed Carbamazepine 400 milligrams per G-tube three times a day; for seizures. The Pharmacy dispensed 200 milligram tablets. In the box the nurse had handwritten "(2-200 mg tab)". Adding the information to explain the number of tablets and strengths to administer to equal the total dose should be responsibility of the Pharmacy to ensure accuracy of the dose administered and to maintain quality control. While the nurses' handwritten instructions for the number of tablets and strengths to administer were reported helpful, they also had the potential to cause medication errors if the information was incorrect or written illegibly. The Nursing Department and Medication Error Committee needs to continue to work with the Pharmacy to resolve the way compound medication orders are written on the Medication Administration Record. For the medication error data entered into the database to be reliable for analyzing and trending, the Medication Error Reports must be complete and accurate. Review of the last 10 medication errors reported on the Medication Error Report form indicated the following: • One of 10 reports was not filled out completely. The Severity index was not marked on one report. The Medication Error Reports must be filled out completely in order to accurately provide data for analyzing and trending medication errors. • Two of 10 reports had medication errors occurring on two different days and were combined into one report. There should have been to two separate reports completed even if the error for the two days were discovered on the same day. Reporting multiple errors on one report results in under reporting and skews data for accurate accounting of incidents of medication errors. The Nursing Department needs to ensure that medication errors are reported separately, even if multiple errors are discovered at the same time. • Two of 10 reports had the Severity Indexes marked incorrectly. One error was graded as Category "B" (an error occurred but the medication did not reach the individual). The other error was graded Category "C" (An error occurred that reached the individual but did not cause the individual harm). These errors were a result of improper doses of Phenobarbital that resulted in the physicians ordering	

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		Phenobarbital blood levels. Both errors should have been graded as Category "D" (an error occurred that reach the individual and required monitoring to confirm that it resulted in no harm and/or required intervention). The fact that Phenobarbital blood levels were monitored meets the criteria for Category "D." One of the errors was not discovered for nine days, yet it was marked as causing no harm. It was questionable how a clinical decision regarding whether or not harm was caused nine days after the error occurred. Presently, the Nurse Managers or designees review the completed Medication Error Reports and grade the Severity Index. The Nursing Department needs to review the interpretation of the Severity Index Categories with the physicians and pharmacist to ensure that there is mutual agreement with the definitions of Severity Index Categories and that medication errors are graded appropriately and correctly. • Two of the 10 reported medication errors were not discovered within 24 hours of occurrence. It is vital that medication errors are discovered at least within 24 hours or less to accurately assess the risk of harm to individuals and to take immediate corrective action with nurses committing the errors to prevent further errors. The Nursing Department needs to ensure that medication errors are discovered timely and reported to accurately assess the risk of harm to individuals and to take immediate corrective action with nurses committing the errors to prevent further errors. • One of 10 reports on the section to complete for "Follow-up by Nursing Supervisor" contained corrective action with the nurse committing the medication error. Typically, in this section the supervising nurse made statements explaining the nature of medication errors but failed to include corrective action taken by the supervising nurse. The Nursing Department's Medication Error: Corrective Action Guidelines' section completed by the Nurse Managers simply stated, "Follow-up by the Nursing Supervisor" but failed to explain what the follow-up action entailed. The Nursing Department needs to provide a detailed explanation as to what Nurse Managers are to follow-up on in the Medication Error Record. The Nursing Operations Officer and/or the Quality Assurance Nurses need to monitor the completed Medication Error Report forms for completeness and accuracy, and take corrective action, as indicated. Although improvements had been made since the last tour, there remained several issues that continue to be problematic in completing the Medication Administration Record, as identified above. The Nursing Department needs to continue to make improvements in completing the Medication Administration Record to ensure that those medication errors are reported accurately, and that individuals on whom the error was committed are assessed timely for risk of harm. Areas in need of continued improvement include: • The Medication Error Reports must be filled out completely in order to accurately provide data for analyzing and trending medication errors.	

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		• The Nursing Department needs to ensure that medication errors are reported separately, even if multiple errors are discovered at the same time. • The Nursing Department needs to review the interpretation of the Severity Index Categories with the physicians and pharmacist to ensure that there is mutual agreement with the definitions of Severity Index Categories and that medication errors are graded appropriately and correctly. • The Nursing Department needs to ensure that medication errors are discovered timely and reported to accurately assess the risk of harm to individuals and to take immediate corrective action with nurses committing the errors to prevent further errors. • The Nursing Department needs to provide a detailed explanation as to what Nurse Managers are to follow-up on the Medication Error Record. • The Nursing Operations Officer and/or the Quality Assurance Nurses need to monitor the completed Medication Error Report forms for completeness and accuracy, and take corrective action, as indicated. The State Supported Living Center Nursing Workgroups presented draft Medication Administration Guidelines and Medication Variance Procedures at the statewide Chief Nurse Executive Meeting in November, 2010 ; these were finalized in December, 2010. These guidelines and procedures were awaiting final approval by the State Office. It was positive to find that a Medication Variance Procedure was drafted and in the final stages of review and approval. It could not be determined if other disciplines, particularly physician and pharmacist had input into the drafting of the Medication Variance Procedure. The Medication Variance Procedure should include the role and responsibilities of other disciplines that are responsible for safe medication administration practices, such as, prescribing, dispensing, and administering medications. Nurses are not the only discipline who may commit medication errors; therefore other disciplines who commit medication errors must be required to complete Medication Error Reports. However, standard medication variance procedures include more than just reporting medication errors, such as storage and handling of medications from the point of delivery through administration, prescribing, dispensing, administration, monitoring outcomes, and documentation. The Medication Error Committee needs to expand to include all medication variances, not just those limited to nursing services.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. The Nursing Department needs to ensure that nurses document the methods that temperatures are taken.
2. The Facility needs to ensure that standardized abbreviations are used. If additional abbreviations need to be added, they need to be reviewed and approved.

3. The Nursing Operations Officer or designee needs to conduct periodic observations of the Nurse Manager and Nurse Shift Managers to ensure the reliability of the Medication Observations performed.
4. The Facility needs to ensure their processes and practices for management of psychotropic are strengthened to meet compliance with the Settlement Agreement and Health Care Guidelines.
5. The Nursing Department needs to ensure that the nursing staff train the direct care professionals on care plans.
6. The Nursing Department needs to developed and implement a database to capture data in order to analyze and trend information for each of the following audits:
    - Post Sedation Chart Review. This audit began in November, 2010 and was completed by the Quality Assurance LVN III.
    - Care Plan Audits
    - Enteral Medication Administration Observation
    - Medication Administration Observation (oral intake)
    - Medication Room Checklist
    - Injury Report Follow Up
    - Medication Administration Record
    - Medical Chart Audit for Weight Management
7. The Nursing Department needs to ensure that all Nurse Managers and Nurse Case Managers receive competency-based training on Nursing Physical Assessment Training.
8. Because of the high incidents of tuberculosis in Texas, the Facility needs to ensure that all employees are current with tuberculosis testing/screening.
9. The Infection Control Nurse needs to ensure that the Facility follows CDC guidelines for treating intestinal parasites as well as including such training in the Infection Control Training Curriculum.
10. The Infection Control Nurse needs to prepare a quarterly summary of reportable infections by type and rate per unit as well as facility-wide to use in tracking and trending infections.
11. The Infection Control Nurse needs to establish procedures, criteria, sample size, and frequency for monitoring environmental issues and handwashing across campus.
12. The Infection Control Program needs to develop and implement a database for collecting, analyzing and trending environment surveillance and handwashing data to identify areas that may need plans of corrective action for environmental health and safety issues and handwashing. After this information is analyzed it needs to be incorporated into other Infection Control data to identify if there was a correlation with transmission and/or cross contamination with incidents of infectious diseases.
13. The Nursing Operation Officer needs to develop and implement a database to capture the Medication Administration Observation data, and analyze, trend, and develop plans of corrective action. These data needs to be incorporated into the Facility's Quality Assurance database.
14. When a database is developed to capture, analyze, and trend data from Medication Administration Observations, Medication Administration Records, and Medication Room Checklists audits, the information needs to be integrated into the Medication Error and Pharmacy and Therapeutic Committees meeting, as appropriate.
15. The Nursing Operations or designee needs to conduct periodic observations of the Nurse Manager and Nurse Shift Managers to evaluate the competency of the nurses performing the observation and to ensure inter-rater reliability of the Medication Observation performed.
16. The Nursing Department and Quality Assurance Department need to ensure that the nurses conducting Medication Administration Observations observe entire medication administration passes during the quarterly Medication Administration Observations.
17. The Nursing Department needs to continue improvements in the following areas of medication administration:
    - Work collaboratively with the Physical and Nutritional Management team to ensure that instructions for medications are included on the PNMP.

- Ensure that individuals are maintained in correct positioning according to their PNMP before, during, and after medication administration, particularly individuals who receive medication enterally and/or those individuals who are deemed at risk for aspiration.
- Ensure that the PNMPs are placed in front of individuals' Medication Administration Record with the PNMP oriented to face forward for easy access.
- Ensure that SAM Programs are consistently carried out according to the individual's plan.
- Ensure that individuals' are consistently informed of the medications they are receiving and their purpose.
- Ensure that nurses follow good infection control practices.

16. The Nursing Department and Medication Error Committee needs to continue to work with the Pharmacy to resolve the way compound medication orders are written on the Medication Administration Record. This issue will be followed up on the next tour.
17. The Nursing Department needs to continue to make improvements in completing the Medication Administration Record to ensure that those medication errors are reported accurately, and that individuals on whom the errors were committed are assessed timely for risk of harm. Areas in need of continuous improvement include:
    - The Medication Error Reports must be filled out completely in order to accurately provide data for analyzing and trending medication errors.
    - The Nursing Department needs to ensure that medication errors are reported separately, even if multiple errors are discovered at the same time.
    - The Nursing Department needs to review the interpretation of the Severity Index Categories with the physicians and pharmacist to ensure that there is mutual agreement with the definitions of Severity Index Categories and that medication errors are graded appropriately and correctly.
    - The Nursing Department needs to ensure that medication errors are discovered timely and reported to accurately assess the risk of harm to individuals and to take immediate corrective action with nurses committing the errors to prevent further errors.
    - The Nursing Department needs to provide a detailed explanation as to what Nurse Managers are to follow-up on in the Medication Error Record.
    - The Nursing Operations Officer and/or the Quality Assurance Nurses need to monitor the completed Medication Error Report forms for completeness and accuracy, and take corrective action, as indicated.

The following are offered as additional suggestions to the Facility:

1. The Nursing Department should consider evaluating all audit tools used in addition to the 12 revised monitoring tools and incorporate those audit tools into the 12 monitoring tools to improve the efficiency and effectiveness of the monitoring process.
2. The State should consider enhancing the Infection Control Nurses knowledge and skills by supporting membership to the local Texas Association for Professionals in Infection Control and Epidemiology (APIC),. As the infection Control Nurses work to revise the Infection Control Procedures and training, it would also be beneficial for the State to contract with an expert Infection Control Nurse to provide onsite technical assistance and mentoring.
3. The Medication Error Committee needs to expand to include all medication variances, not just those limited to nursing services.

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. BSSLC Plan of Improvement updated 12/29/2010 2. Medication Error Corrective Action Plan Guidelines (no date or policy number) 3. Medication Error Committee summary and minutes from June through December 2010 4. DADS Draft policy 011 Pharmacy Services, copy of section D, Drug Utilization Evaluation (DUE) dated August 31, 2009 5. Drug Utilization Evaluation: Risperidone, dated January 1, 2010 6. Drug Utilization Evaluation: Phenytoin, dated September, 2010 7. Drug Utilization Evaluation: Phenobarbital, dated October, 2010 8. Blank copy of a Medication Adverse Drug Reaction Reporting Form (no document form number, issue date, or reference) 9. Completed copy of the Medication Adverse Drug Reaction Reporting Form (pre-visit document) 10. Draft copy of the Adverse Drug Reaction (ADR) Policy, number 011, dated August 31, 2009 11. Training roster for formal training programs for reporting of ADRs, dated August 16, 2010 12. Minutes for Nurse Manager meeting, September 15, 2010 13. DADS Policy: Nursing Services, policy number 010, dated August 31, 2009 14. DADS Draft policy 011 Pharmacy Services, copy of section on tracking and monitoring of tardive dyskinesia, , dated August 31, 2009 15. A total of 70 DISCUS reports from 18 unique individuals (#42, #186, #417, #152, #379, #514, #86, #98, #375, #305, #65, #15, #61, #12, #420, #52, and #589) 16. Quarterly Drug Regimen Review (QDRR) forms and clinical records of the following individuals: #19, #98, #223, #399, #43, #597, #567, #519, #358, #92, and #474 17. DADS Draft policy 011 Pharmacy Services, copy of section on Drug Regimen Reviews, dated August 31, 2009 18. Data on reduction of Phenobarbital, phenytoin and atypical antipsychotics 19. Psychoactive Medication Oversight Committee Meeting minutes dated December 13, 2010 and November 29, 2010 20. Recent two QDRRS, current problem list, past 12 months of laboratory studies, past six months of progress notes, of individuals #568, #115, #269, #90 and #305 21. Drug intervention reports, medication list, physician orders and drug monographs for individuals #1, #375, #109, #79, #186, #481, #276, #496, #269, #24, and #561 22. Draft policy on new medications, no title or date provided **People Interviewed:** 1. Joe Williams, R.Ph. 2. Trey Knittel, Pharm.D.

	Meeting Attended/Observations: None
	Facility Self-Assessment: The Facility reported substantial compliance with provision N.1 for the following reasons: "Pharmacy policy was developed by the pharmacist and approved by the P&P Committee on 11/22/2010. Pharmacists review the of medication regimen when a new medication order is received. Pharmacists concerns are presented to the PCP and all interventions are documented and retained on an Intervention Log." The Facility reported substantial compliance with provision N. 2 for the following reasons: "Lab results are reviewed as part of all QDRRs and abnormal values are considered, noted and addressed in the QDRR. Emergent issues are communicated with the PCP and documentation is retained in the pharmacy. All QDRRs are reviewed by the PCP and psychiatrist as needed." The Facility reported that it remains out of compliance with provision N. 3 for the following reasons: "In the QDRR we they have placed a lot of emphasis on the review of anticholinergics with the results being a number of individuals seeing decrease in dose or discontinuation of offending drug. The first Psychoactive Medication Oversight Committee (PMOC) was held on 11/29/2010 and will be conducted monthly. During this meeting the essential committee members were identified, monthly agenda topics and the purpose of the committee was determined. The meeting on 12/13/2010 was a review of intraclass antipsychotic polypharmacy." The Facility reported substantial compliance with provision N. 4 for the following reasons: "PCPs and Psychiatrists are considering all recommendations from the Clinical Pharmacist's QDRR. Recommendations are either followed or justification is document in the QDRR." The Facility reported substantial compliance with provision N. 5 for the following reasons: "During the QDRR, the Clinical Pharmacist ensures the MOSES and/or DISCUS are up-to-date and notifies the responsible nurse if they are past-due." The Facility reported substantial compliance with provision N. 6 for the following reasons: Nursing has been trained by the Clinical Pharmacist on adverse drug reaction (ADR) reporting and policy. ADRs are presented to the Clinical Pharmacist for investigation. The Facility reported substantial compliance with provision N. 7 for the following reasons: Our The Clinical Pharmacist has presented a number of drug utilization evaluations (DUEs) including mood stabilizers,

	antiepileptic drugs (AEDs), and antipsychotics in the Pharmacy and Therapeutic Committee. The Facility reported substantial compliance with provision N. 8 for the following reasons: Medication Error Committee has expanded the reporting and trend analysis of medication errors After review of provisions N.1, N.2, N.5, N.6, N.7 and N.8, the Monitoring Team differs with the Facility self assessment of being in compliance and has determined that the Facility remains out of compliance with the provisions.
	Summary of Monitor's Assessment: The Monitoring Team recognizes that Pharmacy Services had accomplished many outstanding and important improvements that will significantly improve the lives of persons who reside at the Facility. In collaboration with physician and nursing services, Pharmacy Services developed a process and provided training that had essentially eliminated the writing of scripts, dispensing and administering of medications to persons with documented allergies. Another very impressive improvement is, under the direction of Pharmacy Services, and in collaboration with physicians, a methodical and clinically appropriate process was developed to review and provide on-going review of all persons on select classes of medications with the result of a significant reduction in the number of less desirable medication being prescribed. Under drug utilization review, the Clinical Pharmacist had provided high quality educational venues on three select medications. The result of this venue has been well received by physician services and has had a positive impact on prescribing practices at the Facility. When a pharmacy review of a physician order raised questions, and the pharmacist notified the physician of the concern, there was a lack of meaningful clinical follow-up of potentially serious adverse outcomes. The pharmacist did not request more details from the physician regarding his or her clinical rationale and/or did not offer or request from the physicians alternative pharmacologic treatments. The pharmacist simply documented what the physician's response was and dispensed the medication. Because of time constraint and the many other responsibilities the Clinical Pharmacist has, such as addressing ADRs and leading the utilization review process, he must significantly limit his review of each individual and does not have time to fully review the clinical record. The inability of the Clinical Pharmacist to complete a comprehensive review of the clinical record, assess the individual when necessary and meet with relevant staff, results in diminished quality of the review process. Specific to provision N. 4 of the Settlement Agreement, given the sample size, and the significant compliance on the part of physicians attending to the pharmacist's recommendations of the QDRRs, the Monitoring Team has determined that the Facility is in substantial compliance with provision N.4 at this time.

	The Facility did not have a formalized and specific policy in place for ADRs that includes current standard of care practices for monitoring and reporting of ADRs; had no documented training of physicians, pharmacists and direct care staff on ADRs and no regular competency based training of relevant staff; lacked a standardized means to collect and analyze data specific to ADRs; had no process for consistently reporting ADRs to the IDT and LAR; and had no specific documentation and follow-up on ADRs by physicians and nurses, other then completing an ADR reporting form.

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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 Facility reported that a policy was developed by the pharmacists and approved by P&P on 11/12/10 and that Pharmacists review of medication regimen, when a new medication order is received, raises appropriate concerns to the prescribing physician and documents the intervention on a drug intervention report. To assess compliance, the Monitoring Team reviewed 11 cases, which included review of drug intervention reports, medication lists, physician orders and drug monographs for Individuals #1, #375, #109, #79, #186, #481, #276, #496, #269, #24, and #561. The following is a summary of the cases reviewed. These findings do not imply that the physicians made decisions outside the standard of current, generally accepted practice. Instead, they provide examples in which there needed to be documentation of both clinical rationale and of the discussion between the pharmacist and physician. The Pharmacist has a responsibility to evaluate whether discussion beyond notice alone would indicate more intensive monitoring of effects and/or help the physician to ensure appropriate prescribing. • Individual #1 o The individual is prescribed clonazepam, carbamazepine, and Seroquel all for "aggression", which is not an FDA approved diagnosis for these medications. These medications are, however, clinically used when there is appropriate clinical justification and consent; however, as with all non-FDA approved uses for medications, their use must be justified. Prior to dispensing a new medication that is not FDA approved, the pharmacists, as part of their review should discuss its use with the prescribing physician and ensure that there is clinical rationale for its use and documentation. One of the important functions of having a clinical pharmacy on grounds of a developmental disability facility is to ensure appropriate and safe administration of medications. o A drug intervention report was generated on 1/14/11 stating that concurrent use of carbamazepine may result in decreased levels of quetiapine. This was brought to the attention of the physician who indicated that they would monitor effectiveness of Seroquel at monthly PTRs and on a PRN basis. The monitoring team finds this action	Noncompliance

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		appropriate. • Individual #375 o A drug interaction monograph was generated because of a severe interaction between medications; however, the pharmacist failed to generate a drug intervention report , which is required by Facility policy and is good practice. Despite not completing the drug intervention report, the Monitoring Team learned that corrective action was taken to avert the interaction on this occasion. • Individual #109 o A drug intervention report was generated on 1/4/11 because of a potential significant interaction between two medicines. The physician determined an alternative treatment. The Monitoring Team is satisfied with the outcome. • Individual #79 o An interaction report was generated on 12/17/10 because of a potential moderate drug interaction. The interaction would possibly decrease the effects of two antimicrobials that were prescribed for cellulitis, a potentially serious infection. Upon notification by the pharmacists, the physician responded by indicating that he would "monitor" and to continue with the medication. The pharmacist did not question the clinical rationale of the physician. The Monitor team has concerns over the clinical justification for the physician's "monitoring" of the issue. What parameters would the physician use to monitor the outcome? Clinical efficacy? Alternatively, the physician could have sought consultation with the clinical pharmacist to find possible alternate treatment, or enhanced dosing strategy. At a minimum, and if no alternative was available, the physician should have written orders for close monitoring of the individual, providing concise parameters for nursing and direct staff to monitor, such as measuring the lesion at least hourly, assess for streaking, edema, fever, or chills. No monitoring parameters were noted in the documentation provided. Cellulitis can result in loss of tissue, organs and lead to death if untreated appropriately. In this case, the information should have been provided to the PST so that nursing and direct care staff could monitor closely. • Individual #186 o A drug intervention report was generated on 12/16/10 because of a moderate interaction between an antimicrobial and an antipsychotic medication. The manufacturer of the antipsychotic recommends dosing adjustments to prevent possible toxicity. The physician did not adjust the dose but indicated that she would "monitor." The pharmacist did not	

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		question the clinical rationale. Alternatively, the physician could have sought additional recommendations by the pharmacist, or pharmacist could have independently recommended alternate dosing, or alternate treatment. If alternate dosing/treatment is not an option, then specific and clinically relevant monitoring by nursing and direct care staff should have been ordered. • Individual #481 o A drug intervention report was generated on 12/10/10 because of a contraindication for use of a medication. Upon notification, the physician concurred with the pharmacist's recommendation to use an alternate medication. The Monitoring Team is satisfied with the outcome. • Individual #276 o A drug intervention report was generated on 12/3/10 because of a moderate drug interaction between two medications, which would cause the absorption of Neurontin to be decreased. Upon notification by the pharmacist, the physician indicated that he would "monitor" and the medication was dispensed as prescribed without further follow-up on the part of the pharmacist. There was no documentation on the clinical rationale, alternative treatments or schedules that might have been considered, or specific parameters on what to monitor. • Individual #496 o A drug intervention report was generated on 12/2/10 because of moderate risk for QTc prolongation secondary to the combination of two medications, Azithromycin and Risperidone. The pharmacist recommended prescribing Levofloxacin, instead of Azithromycin because the individual was on that combination in the past and was without adverse side effects. Levofloxacin and Risperidone combination has the exact same risk as Azithromycin and Risperdal. In this situation, as with any combination of drugs that can cause potential serious outcome or death, the risk benefit must be seriously considered. If benefit weighs in support of using the medication, then prudent clinical monitoring, including specific clinically relevant instruction for observation and reporting by nursing and direct care staff along with other appropriate monitoring (in this case, possible serial EKG monitoring and checking magnesium and potassium levels) while the person is on the combination of the two drugs would be clinically warranted. • Individual #269 o A drug intervention report was generated on 11/12/10 because of a	

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		major interaction between two medications. The pharmacist recommended alternative treatment and the physician concurred. The Monitoring Team was satisfied with the outcome. • Individual #561 o No pharmacy intervention was initiated following the initiation of a new medication, Lasix. Lasix is a potent diuretic, which if not monitored closely, may cause severe dehydration. The pharmacist is expected to ensure that appropriate laboratory tests are obtained for all new medications. In this case, monitoring labs were ordered for one month after the medication was initiated. Whenever Lasix is prescribed to a patient, initial and more frequent monitoring of electrolytes is clinically indicated when starting the medication, as is prudent monitoring of clinical signs and symptoms for dehydration. No rationale was provided as to why electrolytes were not ordered sooner and more frequently, until the individual's response to the medication was determined. Following review of the 11 cases reviewed, the Monitoring Team noted lack of meaningful clinical follow-up of potentially serious adverse outcomes. The pharmacist did not request more details from the physician regarding his or her clinical rationale and/or did not offer or request from the physicians alternative pharmacologic treatments. The pharmacist simply documented what the physician's response was and dispensed the medication. Therefore, the Monitoring Team finds the Facility not in compliance with provision N.1. It should be noted and appreciated that the Facility had made significant improvement in the area of assessing allergies, prior to prescribing and dispensing of medications. Subsequent to the Monitoring Team's last review, the Clinical Pharmacist provided in-service training on addressing allergies more effectively to physician and nursing professionals. The pharmacy department continued to monitor for inappropriate orders secondary to known allergies and subsequent to the training, there have been no orders written for medications with known allergies. This is an extremely important accomplishment and demonstrates the commitment of improving outcomes for individuals served on the part of pharmacy, nursing and physician staff members.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	The Monitoring Team reviewed the records of five QDRRs, along with associated recent problem lists, recent last 12 months of laboratory values, and six months of progress notes of individuals #568, #115, #269, #90 and #305, to assess over quality of the QDRR process at the facility. The Monitoring Team also discussed the issue of Provision N.2, and the Facility's QDRR process with the Director of Pharmacy and the Clinical Pharmacist. The Monitoring Team	Noncompliance

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		was informed that review was limited to the use of the quarterly review tool, which does not require comprehensive review of the individual's health care needs. This may be, in part, because of time constraint and the many other responsibilities the Clinical Pharmacist has, such as addressing ADRs and leading the utilization review process, he must significantly limit his review of each individual and does not have time to fully review the clinical record. This can result in diminished quality of the review process. Following are examples of findings from the Monitoring Team review: • Individual #305: o QDRR dated 11/1/10 noted discrepancy between MOSES and DISCUS, secondary to gait disturbance being noted on the MOSES but not the DISCUS. The physician concurred with the pharmacist's recommendation and documented "monthly PTR." There is no evidence to suggest more frequent DISCUS/MOSES screening, no documentation relevant to abnormal movements in the progress notes, and the discrepancy between the DISCUS and MOSES was not addressed. Even if the discrepancy was not related to medication (that is, if another reason for abnormal movements is identified), the discrepancy should be addressed so that proper assessment can be done and so that the PST will be informed of medical conditions that might need to be addressed. • Individual #90: o QDRR dated 11/3/10 noted adequate HbA1c and low H/H but did not comment on moderate leukocytopenia with prominent neutropenia. These findings were also not addressed in the progress notes. Anemia was not listed on the problem list dated 11/18/10, however "leucopenia" and B-12 deficiency was added to the list by handwriting. Post marketing reports suggest that there is an association of Enalapril and bone marrow depression. This issue was not addressed. • Individual #269: o QDRR dated 9/8/10 commented on low H&H and previously low iron panel with the recent addition of iron supplementation on 8/12/10, while the ADRR dated 9/8/10 did not comment on the continued use of iron supplementation. Progress notes reviewed did not comment on this, nor did the problem list document the type of anemia and its etiology. Anemia requiring treatment must always be completely evaluated. • Individual #115: o QDRR dated 7/22/10 noted that the individual was prescribed oral folic acid for "decreased level",; however, review of historic records by the pharmacists indicated that a level was never decreased in the past, hence the folic acid was discontinued by the physician. Upon	

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		subsequent review by the pharmacist on 10/25/10, the pharmacist noted that the individual's MCV continued to increase (macrocytosis). The physician did not respond to the pharmacist's recommendation to restart the folic acid and at the time of this review, folic acid was not prescribed. There are multiple issues with this QDRR. First, whenever there is a macrocytosis, with our without actual anemia, the etiology must be explored to rule out serious medical conditions, such as B12 and/or folate deficiency. These conditions, if untreated, may lead to serious neurological disorders, including dementia and other central and peripheral nerve problems. Second, there was no follow-up on the pharmacist's recommendations to restart folic acid and the physician did not document a plan on the QDRR. • Individual #568: o Medication list dated 1/18/10, QDRRs dated 8/24/10 and 11/23/10, current problem list, past six months progress notes and past 12 months of clinical labs were reviewed. The problem list indicated that the individual has a diagnosis of tremor, which was not mentioned in the context of the QDRRs, despite the individual being on valproic acid, which is known to cause significant tremors. The individual was also on chronic therapy with ferrous sulfate for anemia, however, there was no reported etiology of the anemia, no iron studies, nor other evaluation for anemia noted in the records reviewed. Based on the review of the clinical records, including the most recent two QDRRs for each individual, the Monitoring Team determined that the Facility is not in compliance with provision N. 2 of the Settlement Agreement. It is essential in a DD setting that individual pharmacy reviews are inclusive of review of the clinical record, and when necessary, evaluation of the individual and meeting with relevant staff may be required. By simply reviewing laboratory values, one can easily miss necessary laboratory studies that are necessary, albeit not ordered. Importantly, the Facility does not have a mechanism in place to promptly follow up on recommendations to ensure that the Clinician attends to them; hence, abnormal labs and other serious issues may not be followed up upon until subsequent quarterly reviews. There is no reliability factor to ensure that the QDRR process actually meets the needs of individuals served. The Facility currently has 329 individuals who require quarterly pharmacy reviews. A comprehensive review takes on average two hours of dedicated time, hence, the Facility must provide at least 658 hours of dedicated clinical pharmacy time, to complete quarterly reviews, in addition to dedicated time for other necessary functions of the Clinical Pharmacists, such as addressing adverse drug reactions and the Facility's Drug utilization review process. The Monitoring Team has significant concerns of the amount	

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		of time offered the Clinical Pharmacist to perform the necessary functions at the Facility and to ensure that related process, such as drug utilization and adverse drug reaction process are sustainable with one Clinical Pharmacist.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	Provision N.3 of the Settlement Agreement requires the implementation of a collaborative effort among medical practitioners and pharmacists to ensure that "STAT" medications and chemical restraint are used in a clinically justifiable manner and to ensure that potent medications, including benzodiazepines, anticholinergics and polypharmacy, in general, are used prudently and only when clinically justified and other less restrictive therapies can not be employed. N.3 also requires close monitoring of metabolic and other endocrine risk associated with the use of antipsychotic medications. In addition to requesting policies, procedures and all materials available for provision N.3, the Monitoring Team discussed details of the Facility's compliance issues with the Facility's Director of Clinical Pharmacy and the Clinical Pharmacist. At the time of this review, the Facility had determined that is was not in compliance with provision N.3 of the Settlement Agreement. The issue of STAT medication and mechanical restraint had not yet been addressed by the Facility. Also, the Facility had yet to develop a process that will provide on-going monitoring for the use of STAT medications, chemical restraint, anticholinergics, benzodiazepines, and polypharmacy. The Facility had made impressive headway by developing a robust committee, the "Psychoactive Medication Oversight Committee," which has met on November 29, 2010 and December 13, 2010, and which will address issues related to provision L3 of the Settlement Agreement. Importantly, outside of a formalized process, the Clinical Pharmacist, in collaboration with physician staff, had made significant and impressive strides in reviewing, monitoring and carefully reducing risk in persons who received atypical antipsychotics, Phenobarbital, Phenytoin and other psychotropic medications. Specifically, during the past 12 months, the use of metoclopramide had been reduced by 48.8%, phenobarbital by 4.8%, primidone by 41.5%, phenytoin by 10.0%, trazodone by 48.6%, risperidone by 32.6% and olanzapine by 12.9%.	Noncompliance
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	The monitoring team reviewed ten examples of QDRRs that primary care physicians concurred with the clinical pharmacist's recommendations (#98, #223, #399, #43, #597, #567, #519, #358, #92, 474), and attempted to find ten samples of QDRRs that the primary care physicians did not concur with the Clinical Pharmacist's recommendation. During this review, the Monitoring Team could find only one example where the Physician and pharmacists did not concur with the pharmacist's recommended (#19). In that case the Clinical Pharmacist documented the physicians rationale onto the QDDR	Substantial Compliance

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	followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	and concurred with the physician's judgment. The Monitoring Team does question the validity of the documented clinical rationale; however, given the sample size, and the significant compliance on the part of physicians attending to the pharmacists' recommendations, the Monitoring Team has determined that the Facility is in substantial compliance with provision N.4.	
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.	Provision N.5 requires that the Facility monitor individuals closely for the development of Tardive Dyskinesia (TD) by means of validated scales for TD, such as the AIMS or DISCUS assessment tools. It is understood that the MOSES side effect scale cannot be utilized independently to diagnose TD but instead assesses other side effects of medication. The Facility reports substantial compliance with provision N.5 because they review DISCUS during the QDRR to ensure that they are current, and if not, they notify the responsible nurse if they are past due. The draft policy that includes requirements for the tracking and monitoring of TD, policy number 011, dated August 31, 2010 was reviewed by the Monitoring Team and was found to be insufficient. The policy comments on the use of the MOSES to diagnose TD, and is not specific to the Facility. The policy needs to address issues required to implement a standard of care monitoring process for TD. Standard practice dictates that a TD assessment process should include: regularly scheduled competency based training on how to use the DISCUS for all relevant staff, including physicians, clinical pharmacists, nurses and psychologists; regularly scheduled inter-rater and intra-rater reliability assessments of those who perform and those who review the DISCUS; TD, and other potential side effects must be assessed more frequently when every there is a dose change, when any medication, including a antipsychotic, is added or discontinued; when there is a change in functional capacity and/or behavior of the individual. All nursing, behavior health, and direct care staff must be aware and trained, through regularly scheduled competency based training, on important issues related to abnormal movement, such as what to monitor, how to document, and how to report their findings. Although the DISCUS will identify subtle changes in movement, staff should observe and report obvious changes in movement when they occur rather than waiting for assessment with the DISCUS. Similarly, other staff should be informed of other significant side effects to monitor and report whenever they occur in between MOSES assessments. Review of BSSLC Nurses' Training Database validated that 21 (81%) of 26 Nurse	Noncompliance

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		Managers, Nurse Case Managers, and Administrative completed refresher training (10/5/10) on MOSES and DISCUS assessments. Plans were projected for 100% completion by 1/31/11. The Monitoring Team reviewed 70 DISCUS reports from 18 unique individuals to assess completeness, timeliness and to ensure that more frequent monitoring was completed when there was a change in antipsychotic medication (added, or discontinued). All 18 unique individuals were reported by Pharmacy to have had a change of their psychotropic medications. The Monitoring Team noted the following: 1. Of the 70 DISCUS assessments completed, 69 were completed at the scheduled three-month evaluation time period. One report was completed one Month earlier. 2. There were no additional (more frequent) assessments completed for any of the 18 unique individuals, despite all of these individuals having a change of their psychotropic medications. 3. The Monitor Team found it interesting that only one of the 70 DISCUS reports demonstrated any sign of abnormal movement. 4. Of the one DISCUS report noting an abnormal movement and diagnosis of TD, the physician noted that more frequent monitoring would be necessary, and this was not completed. 5. Of the 70 DISCUS reports, 34 were not completed by the physician, as required and 29 did not have the nurse's signature, as required (name was typed but no signature). In addition to the MOSES and DISCUS assessment tools for monitoring medication side effects, physicians, nurses and direct care staff should monitor the person closely following any medication change, especially if there is noted change in behavior or medical condition of the Individual served.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The Monitoring Team reviewed the issue of monitoring and reporting of adverse drug reactions (ADRs) at the Facility. In addition, the Monitoring Team requested all policies, training materials and documents used for reporting ADRs and was provided with a blank copy of the ADR reporting form, draft copy of DADs general policy for Facilities for ADRs, a training roster documenting a training session for nurses by pharmacy on reporting ADRs and Nurse Manger minutes, dated September 15, 2010 which documented the training. Specific training materials were not provided. At the time of the review, the Facility assessed itself as in substantial compliance with provision N.6 of the Settlement Agreement based on their training of Nurse Managers on	Noncompliance

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		September 15, 2010 and because ADRs are presented to the clinical pharmacist for investigation, and pertinent ADRs are presented at Pharmacy and Therapeutics Committee meetings. At the time of this review BSSLC included the ADR reporting process in its Pharmacy Services policy. Training by pharmacy services was reported to be limited to Nurse Managers, who in-turn were to train nursing staff. There was no additional training offered for physicians, pharmacists, or direct care staff, specific to ADRs. The ADR Reporting Form has not been assigned a number or date issued. The form also lacks specificity, when compared to what is required by standard of care practices. All health care Facilities must have in place an effective and robust process that actively and efficaciously monitors for ADRs, ensures an efficient mechanism for reporting of ADRs, enables prompt evaluation by a physician who carefully reviews for signs and symptoms and documents their physical assessment, findings and recommendation of ADRs, maintains a database of ADRs for trend analysis by the Facility's Pharmacy and Therapeutics Committee, and provides continuing education for all staff involved in the process, including physicians, nurses, pharmacists and direct care staff. A reporting process for serious and/or unexpected ADRs to drug manufacturers, and the FDA (MEDWATCH Program) should also be a component of a Facilities ADR process; BSSLC, in the Pharmacy Services policy, defines this process and had reported one ADR to date. Essential information regarding an ADR includes review of all medications for side effects, allergic reaction, drug-drug reactions, and potential food and environmental allergies. Inspection of the skin and mucus membranes for rash, urticaria, and edema are important signs to evaluate, as is assessment of vitals signs, pulse oximetry, heart rate/tones, and lung sounds are essential components of a physical assessment for potential ADRs. Once an ADR is identified, specific monitoring instructions must be provided to nursing and direct care staff, until discontinued by a physician. As with any adverse outcome, the issue must be addressed by the PST process, with prompt notification to the LAR. Although the Facility did have a process for reporting ADRs, it is not in compliance with provision N.6 as a result of not having a formalized and specific policy in place for ADRs that includes current standard of care practices for monitoring and reporting of ADRs; having no documented training of physicians, pharmacists and direct care staff on ADRs and no regular competency based training of relevant staff; no process for consistently reporting ADRs to the IDT and LAR; and no specific documentation and follow-up on ADRs by physicians and nurses, other then completing an ADR reporting form.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18	The Monitoring Team reviewed the Facility's Drug Utilization Evaluation (DUE) process with the Facility's Director of Pharmacy Services and Clinical Pharmacist. The Monitoring team requested all policies related to DUEs and all other materials related to	Noncompliance

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	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 Facilities DUE process. The review team was provided with the following material for review: Draft policy 011, dated August 31, 2009; Draft policy 011, section D, Drug Utilization Evaluation (DUE) dated August 31, 2009, Drug Utilization Evaluation, Risperidone, dated January 1, 2010; Drug Utilization Evaluation, Phenytoin, dated September, 2010; Drug Utilization Evaluation: Phenobarbital, dated October, 2010. Provision N7 requires that the Facility develop and implement a DUE program. At the time of this review, the Facility did not have a functional or draft DUE policy and reported that they are awaiting finalization of a Statewide policy for their DUE process. The State policy reviewed by the Monitor Team was in Draft form from August, 2009. The Facility reported substantial compliance of section N7 based on its work on producing three DUE reports that provided educational materials on three drugs selected through the Physician and Therapeutic Committee and Physician Services. Current standard of care practice specifies that the main intent of a DUE program is to review and ensure the safety of medications used at a Facility. Typically, a drug or drug class is selected by a committee that should consist of pharmacists, physicians and nurses. Final selection of the drug or drug class is generally based on a retrospective analysis, secondary to concerns with clinical outcomes and safety. Following selection of a drug or drug class, one or more outcomes can occur, such as recommending more assertive use of a drug, discontinuing a drug from the formulary, recommendations for enhanced monitoring of side effects, development of specific policies for a drug and the provision of specific educational venues for staff. In addition, although outside the scope of the settlement agreement, economic issues may be included in the DUE process. Following the on-site review by the Monitor Team, it was understood that the Facility did not, at this time, employ a mechanism to conduct retrospective analysis of drug utilization, did not have a functional policy for their DUE process and did not provide longitudinal trends analysis to determine the efficacy of DUE educational training and recommendations. For these reasons the Monitor Team finds the facility not in compliance with provision N7. It should be noted, however, that the Facility had made significant strides in providing meaningful, clinically relevant educational programs for the use of risperidone, phenobarbital and phenytoin. These programs have significantly benefited individuals served at the Facility by reducing the use of these three medications, and by enhancing clinical awareness of clinicians on potential adverse outcomes and improved monitoring for the use of these agents. The Facility is to be commended on these important steps.	
N8	Commencing within six months of the Effective Date hereof and with	To assess compliance of N8, the monitoring team conducted a meeting with the Facility's Director of Pharmacy Services and Clinical pharmacist on January 13, 2010, and a	Noncompliance

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	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.	request for all policies and procedures, as well as committee minutes and examples of relevant materials was submitted. The Monitoring Team received and reviewed the following material: Medication Committee meeting minutes from June through December, 2010, Department of Aging and Disability Services Policy number 010, dated August 31, 2009, Medication Error Corrective Action Plan Guidelines (no date, no policy number). During discussion with the Director of Pharmacy Services and Clinical Pharmacist, the Monitoring Team was informed that at this time, the monitoring and reporting of issues specific to medication errors were conducted independently by each discipline. Following review of medication review committee minutes, it is evident that the only issues addressed related to medication administration. There was no documented evidence, such as minutes or trends analysis, to support a robust review process for medication errors conducted by physician services. Pharmacy issues were not included within the context of a comprehensive medication error monitoring process at the Facility. Standard of care practice for monitoring medication variances (errors) includes the following categories: Storage and handling of medications (at the pharmacy and living area – from the time the medications reach the facility until they are administered); prescribing; dispensing; administration; documentation; and monitoring of effects of all medications at the facility. A process must be in place to address all categories and include a mechanism for monitoring, reporting, on-going analysis, system improvement and remediation. Review of medication error trends reports, which were part of Medication Error Committee Summary Reports, revealed data that were significantly outside expected norms for long-term care facilities. Most impressive was the fact that in no instance was a "wrong time" documented as a medication error. The Monitoring Team interprets these data as likely to be flawed secondary to under reporting. The Facility's recently documented "Corrective Action Plan Guidelines" were specific only to nursing staff and not staff from other disciplines. The guideline comments on a severity index, which was not explained. Corrective action needs to be addressed across the spectrum of medication variances at the Facility. After reviewing the Facility's Medication Error Committee Meeting minutes from June through December, 2010, the Monitoring Team learned that on only one out of seven meetings did a participant from physician services attend this very important venue. The physician who attended the July meeting was a unit physician and not a member of	

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		leadership, such as the Medical Director. Medication errors are known to be one of the most significant causes of adverse outcomes within the Nations Health Care System and it is paramount that the Facility's Medical Director or at a minimum, a designated physician not only consistently attend but fully participate at this most important committee.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility must promptly develop and implement a policy for its DUE process, which is based on current practice standards. The DUE process must focus primarily on safety of drugs and/or drug class used at the Facility. The process must be data driven, usually in terms of a retrospective analysis of used, and outcomes must be assessed on-going for efficacy of recommendations and training.
2. Review of Medication variances should be inclusive of the following: Storage and handling of medications (from the time of delivery to the center through to administration); prescribing; dispensing; administration; monitoring outcomes; and documentation.
3. The Facility's Medication Error Committee should be more comprehensive in nature, and ensure that there is appropriate review of all medication variances: Monitoring for and review of medication variances; reporting practices of medication variances; ensure that trends analysis are completed for all medication variances; develop a mechanism to provide, evaluate and monitor system improvement issues and staff remediation.
4. Medication variance issues should be addressed in the context of an integrated process inclusive of all relevant disciplines, such as nursing, pharmacy and physicians services. The Medication Error Committee should address all variances, not just those of nursing services.
5. The "Corrective Action Plan Guidelines" should address all medication variances and associated disciplines at the Facility.
6. Physicians must ensure their full participation with medication variances, and all Medication Error Committee meetings should include physician representation. It is highly recommended that the Medical Director take an active role in this process.
7. Data presented at previous Medication Error Committee Meetings should be reviewed for possible under-reporting.
8. Immediately develop a comprehensive process, which is well documented by a formal policy, to address ADRs at the Facility The process should include robust monitoring for ADRs by all staff who routinely are in direct contact with individuals served, including direct care staff, nurses, physicians, pharmacists and others deemed relevant; there must be a process in place to track and analyze ADR data and analyze trends; physical assessment of ADRs and documentation practices must be significantly enhanced; and on-going monitoring of an individual expected of an ADR should continue until cleared by a physician following a physical assessment, and concise monitoring instructions must be provided to nurses and relevant direct care staff.
9. Physicians must determine the clinical manifestations of an ADR, differentiate between an allergic reaction and drug side effect,, and document as such.
10. It is imperative that all ADRs be reviewed by the PST and that the LAR be immediately notified of an ADR or suspected ADR.
11. As with all clinical judgment, when not complying with pharmacy recommendations, the physicians must well document clinical rationale, which should be supported by benefits that significantly out way risks.
12. It is essential that the PST is made aware of issues raised by the QDDR process, and in-turn reviews the issue, monitors outcomes and involves the LAR in the process. The LAR must be aware of potential adverse outcomes and risks of the individual served.
13. Continue efforts to evaluate risk and benefits of psychotropic medications and all forms of polypharmacy, including the use of anticonvulsants,.
14. Immediately develop a process to provide on-going evaluation and treatment for metabolic syndrome associated with medication use. In doing so, ensure to adopt standard of care practices that regularly assesses abdominal girth, BMI, glucose monitoring, blood pressure, HDL, and triglycerides. It is essential that all individuals identified as having glucose intolerance and other risk factors be assertively addressed by clinical staff and that the PST, including the LAR, is immediately notified of such risks and that they concur with the recommended clinical plan.

15. The Facility must assess its capability to adequately perform the necessary obligations of quarterly drug monitoring, independently and in the context of other necessary functions of a Clinical Pharmacist, including the drug utilization and adverse drug reaction process' at the Facility.
16. It is imperative that the quarterly drug reviews are comprehensive and require careful review of the clinical record, not purely a review of laboratory values.
17. When a pharmacist raises a clinical concern, such as in the case of a QDRR, ADR or when identifying an issue when reviewing a new medication order, the Physician must provide a clinically rational explanation of why he or she is not following the pharmacist's recommendation, as timely as possible.
18. The Monitoring Team recommends competency-based training for Physicians and Pharmacists for provision of, and a quality assurance process to assess outcomes of, its clinical processes for provision N.1, including assessing and managing potential adverse outcomes, with regard to medication management, consideration of alternative treatments, specific monitoring protocols, and the use of meaningful diagnostics and frequent assessment whenever there is a potential for a known or clinically suspected adverse outcome.
19. The PST, including the LAR, should be made aware of all potential adverse outcomes with for provision N1. as with all other relevant clinical issues.

The following are offered as additional suggestions to the facility:

1. Although, outside the scope of the settlement agreement, it is recommended that the Facility adopted a different terminology when discussing medication errors, and for the Medication Error Committee. Alternate terminology could include terms such as "medication variance", and "Medication Variance Committee". This terminology may help the Facility move toward a more comprehensive view of medication variance beyond medication errors.
2. A reporting process to the FDA (MEDWATCH program) for serious and/or unexpected ADRs should be considered.

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 #9, #54, #59, #60, #61, #78, #81, #95, #97, #126, #151, #284, #291, #305, #349, #422, #427, #450, #497, #576 2. Enteral Assessment reviews for Individuals #26, #53, #79, #83, #160, #138, #231, #272, #305, #343, #413, #437, #453, #461, #497 and #570 3. Monitoring Reviews of Individuals #50, #57, #95, #403, #449 and #475 4. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management (PNM) team members, including credentials. 5. Policies, procedures, and/or other documents related to Physical and Nutritional Management Policy #013 dated 1/31/2010 and #012 dated 1/31/2010) 6. Curriculum vitae (CVs) for Physical and Nutritional Management Team (PNMT) members 7. A list of continuing education sessions or activities participated in by PNMT members since 1/2010 8. Minutes, including documentation of attendance, for the following meetings for the past 6 months i. PNMT meetings, ii. Nutritional Management Team (NMT) meetings, and iii. Health Support Team (HST) meetings 9. Individual PNMT reports for individuals reviewed above 10. Tools used to screen and identify individuals' PNM health risk level. 11. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order. 12. Tools used to assess PNM status and needs. 13. A list of PNM assessments and updates completed in the last two (2) quarters. 14. PSPs for the individuals on the list above for whom PNM assessments and updates have been completed in the last quarter. 15. Completed Physical Nutritional Management Plans (PNMPs) for all individuals with identified needs. 16. Tools used to monitor implementation of PNM procedures and plans. 17. A list of individuals for whom PNM monitoring tools were completed in the last quarter. 18. Tools utilized for validation of PNM monitoring. 19. 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. 20. Nutritional management plan template and any instructions for use of template. 21. Dining Plan template. 22. PNM spreadsheets generated by the facility. 23. 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. 24. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation during the past year. 25. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials. 26. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans. 27. For the prior 12 months, a list of competency-based training sessions addressing foundational skills in PNM. 28. Information on percent of staff with responsibilities for the provision of direct supports who have completed competency-based training on foundational skills in PNM. 29. BSSLC Plan of Improvement (POI), dated 12/10 **People Interviewed**: 1. Kori Keim PT, Habilitation Therapy Director 2. Erin Pepper SLP 3. Donna Baron SLP 4. Direct Care Professionals on Childress, Driscoll, and Bowie **Meetings Attended/Observations**: 1. Daily activities on Bowie, Driscoll, Childress, and Program Services 2. Mealtimes on Bowie, Driscoll, Childress, and Program Services 3. Individuals #33, #35, #45, #70,#140, #151, #165, #330, #358, #406, #465, #473, #478, and #523 during meals
	Facility Self-Assessment: The monitoring team found agreement with areas found not to be in compliance. These areas included: • Development and Implementation of a Physical and Nutritional Management Team (PNMT) that

	addresses individuals who are at an increased level of risk. • Identification of individuals who are considered to be at an increased risk of decline related to PNM. • Maintenance and implementation of comprehensive PNMPs. • Safe staff practices relevant to PNM • Monitoring system that focuses on staff implementation and effectiveness of assigned interventions or strategies. • Proper assessment of individuals who receive non-oral means of nutrition.
	Summary of Monitor's Assessment: **Provision O.1:** This provision was determined to be not in compliance. A Physical and Nutritional Management Team (PNMT) had been formed that consisted of the appropriate members. A process that outlines the responsibilities of the team as well as their scope had not yet been developed. There was still no evidence that data regarding the occurrence of PNM triggers or outcomes are collected and that the team is reviewing these data to better identify system issues or respond to recurrent issues on a regular basis. On a positive note, the team had reviewed five individuals and the assessments reviewed were comprehensive and demonstrated active collaboration through multiple disciplines. **Provision O.2:** This provision was determined to be not in compliance. A new risk process had just been implemented and the monitoring team was only provided with two individuals in which to conduct a review of the new process. Overall, individuals' risk remained inaccurately identified. That being said, the new process showed progress and did accurately identify the two reviewed individuals level of risk. **Provision O.3:** This provision was determined to be not in compliance. PNMPs are not comprehensive due to the plans lacking information regarding oral care and medication administration. The risk of aspiration is not limited to just mealtime therefore there is a need to address all areas in which the risk may be increased. **Provision O.4:** This 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. Individuals as well as staff were observed poorly positioned and with safe dining strategies not implemented. Per interview, staff again was not knowledgeable of the plans and why the proposed strategies were relevant to the individuals' well being. **Provision O.5:** This 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. It should be noted that BSSLC was on the verge of implementing a new process in which staff would be required to undergo competency based training on two of the highest risk individuals in each PNMP category prior

	category prior to working on an unfamiliar home. **Provision O.6:** This provision was determined to be not in compliance. BSSLC had increased monitoring but there was no evidence that staff or the individual were being monitored in all aspects in which the individual was determined to be at increased risk. Over 90% of all monitoring focused only on oral intake and not other areas in which the risk of aspiration was increased. The risk of aspiration is not limited to just mealtime therefore there is a need to monitor all areas in which the risk may be increased. **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 in its infancy and had just started to be implemented. **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 and potential pathways to PO status. The assessment of the medical necessity of the tube has shown much improvement but the identification of potential pathways to resume intake remained absent. BSSLC was on the verge of taking significant strides in the overall PNM care. The new risk process has shown promise and the development of the trigger tracking forms will help the facility better identify issues earlier and more effectively. The PNM team has done an excellent job with their early reviews and assessments of individuals identified by the PNMT as being at an increased risk but need to expand their role to include data analyses regarding the occurrence of PNM related issues (choking, aspiration, pneumonia, skin breakdown, falls).

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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	BSSLC had developed a Physical and Nutritional Management Team (PNMT). The team consists of an Occupational Therapist (OT), Physical Therapist (PT), Speech-Language Pathologist (SLP), Physician (MD), Nurse (RN) and Dietitian (RD). In addition to the listed core members, ancillary members such as Psychology may be requested as indicated. The PNMT held meetings weekly (10 total) and as of this review had completed and reviewed five comprehensive assessments for five individuals. Selection of individuals for review was informally based on perceived degree of risk. Review of facility documentation (CV, copy of current licenses) submitted for each PNMT standing member demonstrated the following qualifications for PNM (NMT and HST) Team standing members: • In five of five licenses reviewed, a copy of the license was current.	Noncompliance

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	with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	• In five of five CVs reviewed, experience in respective field was documented. Based upon review of PNMT minutes from 9-9-10 to 11-17-10, minutes were found to vague and did not provide enough information to determine outcomes. For example: the meeting on 10-6-10 stated that further investigation is needed before report can be finalized but did not state what that investigation was or why it was needed. Other than the state policy, there is not a clear process in place that defines the roles and responsibilities of the PNMT and the collaboration that is intended to occur with the Personal Support Team (PST). There was not a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. Additionally, there was still not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences. Based on a review of 8 individual records, documentation supported that the PNMT 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. For example: • Individual # 305 had aspiration pneumonia on 10-17-10 and 12-28-10 with no evidence of discussion by the PNMT. • Individual #81 had aspiration pneumonia on 11-17-10 with no evidence of discussion by the PNMT. • Individual #78 had aspiration pneumonia on 10-20-10, 11-1-10, and 11-7-10 with no evidence of discussion by the PNMT. Currently, the responsibility to review individuals who have experienced a change in status had fallen on the PST; however, the review of these individuals should be the responsibility of both parties. Therapists did not actively participate in eight of eight PSP meetings although the individuals may have identified issues relevant to their field. Examples include PSPs for Individuals #33, #54, #60, #78, #81, #97, #305, and #349. Per the Habilitation Director, this is an area that should begin to show improvement by the next review secondary to the increased number of therapists and a focus on improved PST involvement.	
O2	Commencing within six months of	Based on a review of 21 individuals, 19 of 21 Individuals identified as being at an	Noncompliance

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	the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	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. Oral care and medication administration positioning remain missing from the assessment process. Additionally, 15 of 21 assessments reviewed did not contain the rationale behind many interventions listed in the PNMP. For example: • Individual #151 requires ¼ of a cup during mealtime but the reasoning behind this strategy was not listed in the OT/PT assessment. • Individual #330 was provided with only a ½ teaspoon of food per bite and only a ½ glass but the rationale for why this must occur was not clearly listed in the OT/PT assessment. • Individual #33 requires alternating liquids and solids but no rationale was listed as to why this strategy must be utilized. Review of 21 records revealed: • In 21 of the 21 records reviewed (100%), there was no documentation of PNM (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: o Oral care o Medication administration o Oral Motor Abilities o Mealtime strategies in a method that is clear as to why the strategies are relevant. o Rationale and justification of Head of Bed Elevation Additionally, the oral motor section of the assessments overall continued to be vague and did not provide clear objective information regarding swallow status but per review of more recent assessments (within the last 2 months), two of two assessments contained measurable data that lends itself to comparative analysis. Examples of this improved oral motor section may be found in individuals #450 and #95 habilitation therapy annuals. This is a positive step with regards to this section. Two of seven individuals reviewed for having increased or decreased BMI did not have nutritional assessments. Examples of individuals who did not have their nutrition adequately assessed: • Individual #9 had a BMI greater than 40 but had no formal nutritional assessment.	

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		• Individual #61 had a BMI greater than 35 but did not have an assessment. Per interview with the Director of Habilitation Services, all nutritional assessments should be updated or completed by March 31, 2011. Additionally, the expectation of BSSLC was that all assessments will be completed annually. Individuals who are at an increased risk of physical and/or nutritional decline remained not accurately identified. The system that was in place incorrectly identified individuals who are at an increased risk. Examples of individuals not being appropriately identified include: • Individual #97 had a choking incident on 9-2-2010 but was listed as being at a "low risk." • Individual #33 had aspiration pneumonia three times over the past year but was listed as being at a "medium risk" of aspiration. • Individual # 305 had aspiration pneumonia on 10/17/10 and 12/28/10 but was listed as being at a "medium risk" of aspiration. • Individual #576 had seven falls occurring from 10-1-10 to 12-26-10 but was listed as being at a "medium risk" of injury BSSLC did have a new risk process but the risk process and its accuracy in identifying those individuals who are at an increased risk could not be fully assessed at this time due to the risk process just being implemented at BSSLC and only two individuals being provided with the new process; therefore, this area will need to be reviewed again at the next visit to determine if compliance has been established The monitoring team did have the opportunity to observe a risk meeting as well as review two individuals who had undergone the new risk process. Records were reviewed for individuals #59 and #138 along with risk levels and two of two accurately identified the level of risk. The meeting observed contained active collaboration and brainstorming regarding factors that affect the level of risk and is a significant improvement over the previous format. However, there was no physician at the meeting and therefore medical issues were unable to be discussed which was a significant portion of the agenda. Forty eight individuals were routinely being provided with enteral nutrition while positioned in recliners. Recliners 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	

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		elevation to prevent reflux aspiration. Examples of individuals using recliners include Individuals #54, #59, #78, and #305. The ability to maintain an appropriate position for intake is greatly reduced when utilized devices that are not made to provide optimal support (i.e., recliners).	
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 21 individual records, individuals were not provided with a comprehensive PNMP as evidenced by: o In zero of 21 records reviewed (0%) strategies for medication administration were included. o In zero of 21 records reviewed (0%) positioning of staff during medication administration and oral care were included. o In zero of 21 records reviewed (0%) strategies for oral hygiene were included. o In zero of 21 records reviewed (0%) instructions for positioning for personal care were included. o In zero of 21 records reviewed (0%) communication strategies were included. Examples of where individuals were not provided with a comprehensive PNMP included: o Individual #305's PNMP did not contain information on oral care or medication administration o Individual #33's PNMP did not contain behavioral strategies to address PICA behavior. o Individual #284's PNMP stated this individual's primary method of communication but did not provide any information regarding strategies staff may have used. Positives noted through review of the same 21 PNMPs included: o In 21 of 21 records reviewed (100%) individual adaptive equipment was included. o In 21 of 21 records reviewed (100%) bathing/showering positioning and instructions were included. o In 21 of 21 records reviewed (100%) positioning instructions for wheelchair and/or alternate positions instructions were included. o In 21 of 21 records reviewed (100%) transfer instructions were included. o In 21 of 21 records reviewed (100%) the mealtime/dining plan included intake strategies for mealtime and snacks o In 21 of 21 records reviewed (100%) the mealtime/dining plan included diet consistency.	Noncompliance

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		o In 21 of 21 records reviewed (100%) positioning of individual during medication administration and oral care were included. PNMPs were not formally developed with input from the PST, home staff, medical and nursing staff. In 0 of 19 records reviewed (0%), 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 #427's PSP where recommendations were read with no discussion provided by the PST. Examples of where individual PNMPs were not developed with input from the IDT included: o There was no evidence of staff participation during the development of PNMPs for Individuals #33, #54, #81 and #305. o No discussion of PNMP by the PST during Individual #427's PSP meeting. In 21 of 21 records reviewed (100%), there was documentation that the PNMPs were reviewed annually at the PSP meeting but based on observation of PSP meetings, there was no active discussion of the plan.	
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.	Three 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 prevent swallowing difficulties and/or increased risk of aspiration in the following areas: • In seven of 15 individual observations, staff was following mealtime plans. • In four of six individual observations, staff was following wheelchair positioning instructions. Positive observations included: • In five of five observations staff was following alternate positioning instructions. • In three of three observations staff was following transfer instructions, and • In three of three observations, staff was following tooth brushing instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: o Individual #486 was observed eating at an unsafe rate when her plans called for her to eat at a slow pace. o Individual #330 was observed receiving whole spoonfuls of food and a full glass	Noncompliance

#	Provision	Assessment of Status	Compliance
		of liquids when the plan called for ½ teaspoon and the glass to be half-filled. o Individual #45 was not provided with cues to swallow between bites o Individual #523 was not provided with cues to avoid overstuffing. o Individual #33 was provided with thin/nectar liquids when plan called for Honey thick liquids Additionally, staff at Program Services was often seen standing over individuals and walking around the room during dining resulting in a distracting dining environment. A dining room that is loud, or contains a large amount of distractions results in an increased risk of choking and or aspiration secondary to the decreased ability to maintain focus on the meal itself as well as implementing strategies. Additionally, staff standing up will result in an increased risk of unsafe head and neck positioning.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	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. Staffs 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 curriculum revealed that it did include adequate PNM training in the following areas: o Body mechanics o Handling techniques o Optimal alignment and support in seating systems and alternate positions o Mechanical lift transfers o Manual transfers approved by facility policy o Mealtime positioning o Food and fluid consistency o Safe presentation techniques for food and fluid o 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed competency-based training specific to the individual. Per interview with Habilitation Director, a workgroup is currently developing a process that will focus on ensuring all staff are trained on the most medically or physically complex individuals for all sections of the PNMP for their assigned sister home. (Childress-Fannin and Bowie-Driscoll). This process will be reviewed at the next visit.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	The monitoring process provided to the monitoring team consisted of how to complete the monitoring form but did not indicate frequency of monitors or list the individuals responsible for completing the monitors and the areas of monitoring in which they were responsible. Lack of specificity resulted in the majority of monitors focusing primarily on mealtime and not other areas (i.e., oral care and medication administration). Per monitoring database, 3194 monitors were completed utilizing the comprehensive monitoring form during the months of November 2010 and December 2010. A review of Facility monitoring reports from 11/2010 to 12/2010 documented that staff were not being monitored in all aspects in which the individual was determined to be at increased risk. Per review: o 2865 of 3194 monitoring forms focused on oral intake (meals and snacks). o 329 of 3194 monitoring forms focused on bathing. The risk of aspiration is not limited to meals but also often occurs during bathing, personal care, oral care, medication administration, and when in bed. Lack of monitoring in these areas does not give an accurate picture of status or ensure implementation across all settings in which the risk is increased. Additionally, monitoring results showed greater than 97% accuracy in implementing goals. This percentage did not match that of the monitoring team during this review which showed less than 50% implementation compliance.. Per Habilitation Director, Oral care and Medication Administration will begin to have monitoring conducted and data acquired by the next review.	Noncompliance
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	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. The new risk process did include a monitoring component where the PST determined through an action plan if increased monitoring was needed but the process was informal and as stated in O.6 did not contain clear directives on what areas would be monitored. Due to this informality, it was unclear as to who was responsible for what monitoring	Noncompliance

#	Provision	Assessment of Status	Compliance
	as appropriate.	area (i.e., meal, bathing, snack, oral care). While the PNM status is scheduled to be regularly reviewed during the PST quarterly meetings, there was no clear indicator that status is reviewed by the team in the event of a change in status. See Section O.1. Additionally, information about five of six individuals who experienced potential aspiration indicators noted during monitoring was not shared with nursing or Habilitation Therapies. For example: • Individuals #50, #57, #403, #449, and #475 experienced multiple coughing events during a meal but there was no evidence of nursing or habilitation therapy notification. A positive practice that was in the process of being developed and implemented was the use of an "Aspiration Trigger" data sheet. The trigger data sheet will allow nursing and professional staff the ability to respond more quickly to potential indicators associated with PNM decline. It will also allow for better tracking of positive outcomes by determining the occurrence or absence of pnm triggers.	
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 16 individual records, 16 of 16 who were enterally nourished revealed these individuals did not receive an annual assessment that addressed potential pathways to PO status. Examples of individuals who received enteral nutrition and did not receive an appropriate annual assessment: o Individuals #26, #79, #305, #83, #453, #343, #413, #570, and #461 received an assessment but no discussion or plan for possible pathways to oral (PO) intake or increased PO intake. 16 of 16 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 16 of 16 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: o It was mentioned in the PSP that Individual's #26, #79, and #305 were tolerating tube feedings but did not specify why enteral nutrition was	Noncompliance

#	Provision	Assessment of Status	Compliance
		appropriate or possible pathways to PO intake. A policy did 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: The following recommendations are offered for consideration by the State and the Facility:

1. 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.
2. Recliners do not provide proper support to maintain an adequate position while receiving enteral nutrition. Other positions should be investigated by BSSLC.
3. Formalize the PNMT and its process by developing a policy/procedure that clearly defines roles and responsibilities of not only the PNMT but the expected relationship and referral process between the PST and the PNMT.
4. Integrate into the PNMT process a method for data analyses and review.
5. Capture PNMT minutes in a manner that clearly shows events and outcomes within the meeting.
6. Ensure that a system of monitoring is implemented for individuals and that it is based on level of risk rather than only the general dining room monitoring currently in place.
7. Ensure there is validation process integrated into the monitoring process to ensure accuracy and validity of findings.
8. Incorporate findings from monitoring into the PNMT reviews to bring greater depth of information necessary for decision-making and problem solving.
9. 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.
10. PNMPs must 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.

The following are offered as additional suggestions to the facility:

1. A trigger tracking sheet should be developed to allow for the daily occurrence or nonoccurrence of PNM triggers (i.e., coughing with struggle). This type of data should be gathered along with other data such as bowel movements, and intake. This would allow nursing as well as other clinicians a quick and easy method to review occurrences throughout the week and month.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: **Review of Following Documents**: 1. Record reviews for Individuals #9, #19, #24,#33 #50, #57, #78, #81, #86, #121, #138, #151,#196, #249, #291, #305, #330, #403, #404, #449, #475, #576 2. Policies, procedures and/or other documents related to the provision of OT/PT supports and services (Policy 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 (June 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 (6-2010 to 12-2010) 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 12/29/2010 **People Interviewed**: 1. Kori Keim PT Director of Habilitation Services 2. Direct Care Professionals on Bowie, Driscoll, and Childress **Meetings Attended/Observations**: 1. Daily activities on Bowie, Driscoll, and Program Services 2. Mealtimes on Bowie, Driscoll, Childress, and Program Services
	Facility Self-Assessment: BSSLC's POI indicated the facility was not in compliance with any of the provisions in the OT/PT section. Based upon the review, the monitoring team is in agreement with the facility's findings.

	Areas of improvement noted by BSSLC include: • Approval to hire an additional OT and PT • New PSP process that should improve integration • Additional training regarding lifting techniques • Increased monitoring of implementation
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. BSSLC has two positions for PT and OT, 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 (i.e., falls). **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. Additionally, therapy services were not consistently integrated into the PSP. Another area of concern was noted with the PST's response to potential indicators of risk or status changes. 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. However, for individuals receiving direct services, there was evidence that each individual receiving direct services was reviewed at least monthly for OT/PT Status for six of six individuals reviewed. Furthermore, following assessments, plans were developed within 30 days of the date of the assessment/update. **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. Staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan. **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. This is an area that OT/PT was in the process of addressing during the visit. Per interview with Habilitation Director, a workgroup is currently developing a process that will focus on ensuring all staff are trained on the most medically or physically complex individuals for all sections of the PNMP for their assigned sister home. (Childress-Fannin and Bowe-Driscoll). This process will be reviewed at the next visit. BSSLC has openings for an additional OT and PT, which when filled will assist BSSLC in better being able to respond to changes in status as well as improve the ability to participate in all facets of care. The

	assessments continue to be comprehensive with the exception of information regarding oral hygiene and medication administration intake as well as positioning strategies for this activities and the lack of clinical justification for recommendation.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The facility had approval to hire an additional PT position and an additional OT position. As of this review, both positions remain open. Lack of available therapists resulted in participation in all facets care lacking. For example: • Individual #576 had multiple falls occurring throughout the months of October, November, and December without a meeting to discuss the etiology, nor was there evidence of OT/PT assessment or follow through to determine root cause of the falls or implementation of a care plan to address the change in status. 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. Based on review of OT/PT tracking spreadsheet, all individuals had received an OT/PT assessment and/or screening. This was validated via review of 12 records for completed OT/PT assessment/screening. Assessment/screening indicated whether or not the individual required OT/PT supports and services for 22 of 22 records reviewed. If receiving services, direct or indirect, six of six 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; d. Independence Based on record review of individuals who had experienced a change in health or physical status, five of eight individuals had not received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. For	Noncompliance

#	Provision	Assessment of Status	Compliance
		example: • Individual # 305 had aspiration pneumonia on 10-17-10 and 12-28-10 with no evidence of discussion by the PNMT. • Individual #81 had aspiration pneumonia on 11-17-10 with no evidence of discussion by the PNMT. • Individual #78 had aspiration pneumonia on 10-20-10, 11-1-10, and 11-7-10 with no evidence of discussion by the PNMT. • Individuals #576 and #249 had multiple falls occurring throughout the months of October 2010 to December 2010. There was no evidence of OT/PT assessment or follow through to determine root cause of the falls or implementation of a care plan to address the change in status. While OT/PT was responding to referrals within an appropriate timeframe, issues were not consistently being identified and brought to the attention of Habilitation Services. Examples of this include: • Individual #576 and #249 had multiple falls occurring throughout the months of October 2010 to December 2010 but there was no evidence of OT/PT notification. • Individual #249's headrest was not effective in supporting his head in an upright manner but there was no evidence of a referral. • Individuals #50, #57, #403, #449, and #475 experienced multiple coughing events during a meal but there was no evidence of habilitation therapy notification. The system was informal and there was 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. Twenty-two of 22 assessments reviewed (100%) contained probes that identified the need for additional assessment. Individuals who were identified as needing modification of equipment were provided with the needed assessments. Based on review of 22 OT/PT assessments, 100% showed collaboration between the disciplines and included signatures and date of both OT and PT. Based on review of 22 OT/PT assessments, two of 22 were comprehensive with content from each discipline as indicated. The summary did not address: • Oral care • Medication administration • Oral Motor Abilities	

#	Provision	Assessment of Status	Compliance
		• Mealtime strategies in a method that clear as to why the strategies are relevant. • Rationale and justification of Head of Bed Elevation Based on review of 22 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 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.	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for 22 individuals receiving OT/PT services, 22 of 22 had plans that 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. Please refer to Provision P.1 regarding assessments in response to a change in status. Intervention plans were not based on objective findings in the comprehensive OT/PT assessment or updated with analysis to justify specific strategies for 22 of 22 individuals reviewed. For example: • Individual #151 requires ¼ of a cup during mealtime but the reasoning behind this strategy was not listed in the OT/PT assessment. • Individual #330 was provided with only a ½ teaspoon of food per bite and only a ½ glass but the rationale for why this must occur was not clearly listed in the OT/PT assessment. • Individual #33 requires alternating liquids and solids but no rationale was listed as to why this strategy must be utilized. Per the Habilitation director, providing rationale for the recommendations listed in the PNMP was a priority and justification for such interventions should be more noticeable during the return visit. Based on reviews of PNMPs and other positioning plans for 22 individuals, equipment was specified for 22 of 22 plans reviewed. 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 six of six individuals reviewed. Individuals not receiving direct services were not consistently reviewed by OT/PT should there be a change in status. Please refer to Provision P.1 for additional information	Noncompliance

#	Provision	Assessment of Status	Compliance
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 seven of 15 individuals reviewed in the sample. This indicates that staff were not trained to competence on implementing these plans. Examples of components of plans not implemented included positioning and use of adaptive equipment. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan: o Individual #486 was observed eating at an unsafe rate when her plans called for her to eat at a slow pace. o Individual #330 was observed receiving whole spoonfuls of food and a full glass of liquids when the plan called for ½ teaspoon and the glass to be half-filled. o Individual #45 was not provided with cues to swallow between bites o Individual #523 was not provided with cues to avoid overstuffing. o Individual #33 was provided with thin/nectar liquids when plan called for Honey thick liquids o Individuals #291 was leaning significantly to the left in his wheelchair 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 six of six 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 four DCPs: o In two of four interviews with staff, staff could describe individual-specific strategies outlined in the plan. o In one of four interviews with staff, staff could describe the schedule for implementation of the OT/PT plans. o In two of four interviews with staff, staff stated they had received individual-specific training for OT/PT intervention/support plans. o In four of four interviews with staff, they were able to identify the location of the OT/PT plans. Examples of direct support professionals who were not able to describe the rationale for OT/PT interventions and recommendations: • DCP at Program Services was not able to identify reasoning for positioning schedules.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• DCP on Childress was not able to describe rationale for maintaining appropriate elevation.	
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 monitoring forms, a system exists that is designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. Per POI, all staff were 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. A system did 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. Per interview with Habilitation Director, a workgroup is currently developing a process that will focus on ensuring all staff are trained on the most medically or physically complex individuals for all sections of the PNMP for their assigned sister home. (Childress-Fannin and Bowe-Driscoll). This process will be reviewed at the next visit. 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. For example: • Five of six individuals who experienced potential aspiration indicators noted during monitoring were not consistently shared with nursing or Habilitation Therapies. o Individuals #50, #57, #403, #449, and #475 experienced multiple coughing events during a meal but there was no evidence of nursing or habilitation therapy notification. Per POI, there is no formal process to ensure data collection method is validated by the program's author(s). Currently, the clinician follows only individuals receiving direct therapy services.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. BSSLC should ensure that OT and PT participation in all facets of care in which there expertise is warranted. Areas include change of status

meetings, PSPs, and meeting to discuss sentinel events such as falls.

2. The OT/PT evaluation should include clear rationale and justification for recommendations. The benefit to implementing the recommendations should also be clearly stated within the assessment.
3. Current therapy services being provided to individuals should be integrated into PSP skill acquisition programs to provide multiple opportunities for incidental teaching, formally and informally.
4. Inter-rater reliability checks should be built into the monitoring process to ensure accuracy of monitoring.
5. 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.
6. 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, and choking, and/or neurological event). The action taken by OT/PT should be clearly documented and followed to resolution.
7. Policies/procedures should be developed for the OT/PT monitoring system, with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of PNMPs and related equipment, and OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability, and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans, as well as activity plans. There should be established thresholds for staff re-training; identification, training, and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement updated 12/29/2010 2. List of individuals who require intravenous sedation for dental procedures 3. List of individuals who are pending dental services because of service limitations for intravenous sedation 4. Training material/policy slide presentation: At Risk Individuals (no date, no number) 5. Draft copy of recently developed Daily Dental Report form (no form number or date) 6. Annual Dental report form (new form, no number or date) 7. List of individuals who are determined to be at high risk for aspiration pneumonia 8. Annual Dental Exam and Assessment form (new form, no number or date) 9. Annual Dental Exam and Assessment form (older form, no number or date) 10. Peer reviewed article: Defining oral neglect in nursing homes; Geriatric Dentistry; June 6, 2010 11. Medication lists of individuals prescribed Prolia, Alendronate, and Boniva **People Interviewed:** 1. James Ligon, D.D.S 2. Julie Weidemann, RDH **Meeting Attended/Observations:** None
	Facility Self-Assessment: At the time of this review, the Facility determined that it was not in compliance with provision Q of the Settlement Agreement. The Facility reported the hire of a full-time dentist; the monitoring team confirmed that a new Director of Dental Services had begun working at the Facility. The Facility reported that the Annual Dental Exam and Form had been revised and that revision of other forms was in process. Since the hire of the new Director of Dental Services, the Facility reported that significant improvements will be developed and implemented over the course of the next six month period.
	Summary of Monitor's Assessment: During the review of dental services, the Monitoring Team conducted an extensive interview with the Facility's newly hired Dentist, Dr. James Ligon, who will serve at the Facility's Director of Dental Services. The Monitoring Team also met with Julie Weidemann, who is assisting Dr. Ligon with policy development and implementation. Although there had been some development by dental services, such as identifying individuals who are at

	risk for aspiration and enhancing the use of suction tooth brushing at the living area, to reduce aspiration pneumonia, and by identifying individuals who are at risk for osteonecrosis of the jaw, the Facility had yet to develop the necessary policies, procedures, and standard of care practices to comply with the Settlement Agreement. It is important to note that following the meeting with the new Director of Dental Services, the Monitoring Team was, at the time of the review, confident that significant progress would made in development and implementation of policies and practices by Dental Services, over the course of the subsequent six month period.

#	Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	The Facility had yet to provide necessary evidence to support compliance with provision Q.1 of the Settlement Agreement. The Facility had hired a new full-time dentist to serve as dental director. Under the new leadership of Dr. Ligon, the Facility is in the process of reviewing and developing a strategy to fully comply with the provision. Although not formalized, the facility was able to provide emergency services by triaging individuals to local emergency rooms and community dentists, as necessary. Guidelines promulgated by the American Dental Association for persons with developmental disabilities will be reviewed and adopted into the facilities standard of care practices for dental services. With regard to providing timely dental services, the Monitoring Team was not presented specific data, however, when asked about possible delay of treatment, Dr. Ligon commented that the Facility does experience a back-log secondary to scheduling limitations with their current arrangements for TIVA. Dr. Ligon did assure the Monitoring Team that all dental practices, timeliness of treatment, scheduling and policies would be reviewed, subsequent to his taking a leadership position as Director of Dental Services.	Noncompliance
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	The Facility had made significant strides in working with direct care staff and employing the use of suction tooth brushing at the living areas to assist in the reduction of aspiration pneumonia. This is critical work that will enhance the lives of individuals served by the Facility. The Facility had also identified individuals at risk for osteonecrosis of the Jaw and is developing treatment strategies to ensure safe and effective dental services for such individuals. The Facility had also revised its forms for dental examinations and assessments and had developed a daily dental report that will efficiently share dental issues, such as persons scheduled for dental services and outcomes, with relevant staff. This process will help ensure that persons are served more promptly by Dental Services. Specific to the issue of "Pre-treatment sedation" please refer to section Provision J4 of this report.	Noncompliance

#	Provision	Assessment of Status	Compliance
	desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.		

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Ensure a well documented process for triaging dental emergencies for all reasonable scenarios, such as off hours and holidays. Ensure the services meet standard of care practices, and that there is documentation.
2. Ensure that direct care staff are provided regularly scheduled competency based training, supervision, and resources to enable the delivery of daily oral hygiene.
3. Ensure that efficacy of daily oral hygiene is regularly monitored and assessed.
4. Ensure a process that enables clinical and direct care staff the ability to efficiently report dental concerns of individuals served.
5. When developing new clinical processes, it is essential that all clinical information is shared in a meaningful way with the PST and that the PST clearly understands the impact of dental services for the individual served.
6. Ensure that the Facility's dental professionals are actively involved in the total care of the persons served, including behavioral management and primary care serves issues. It is paramount the dental professionals are included as an important member of the clinical team at the Facility.
7. All necessary resources must be provided to ensure that individuals served receive prompt, standard of care dental treatment. Prolonged delays secondary to resource issues are not acceptable.
8. Ensure that all persons who experience behavioral challenges that limit their participation with dental care are assertively assessed through the team process and that active and on-going supports are provided to assist the person in receiving necessary treatment.
9. Always ensure that all risks, and benefits of treatments, including no treatment are assessed and discussed with the PST, with full participation by the LAR.
10. Ensure robust policies and procedures that ensure standard of care practice for the use of all forms of chemical, mechanical, and physical restraint during dental procedures and for the use of all forms of sedation used for clinical purposes. Many individuals with developmental disabilities require more prudent assessment and monitoring prior to and following all forms of sedation because of the higher risk of aspiration, secondary to even mild forms of sedation.

The following are offered as additional suggestions to the facility:

1. Ensure that the delivery of dental services employs current standard of care practice and whenever possible, adopts standards promulgated by the American Dental Association for Persons with Developmental Disabilities.

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 #13, #33, #50, #59, #61, #64, #86, #121, #160, #191, #196, #249, #255, #272, #305, #358, #339, #404, #412, #419, #434, #473, #475 2. PSP and PBSP for Individual #427 3. Communication services and supports (Policy 016 dated 10/7/2009) 4. A list of people with Alternative and Augmentative Communication (ACC) devices 5. AAC screening forms. 6. AAC evaluation and Speech Language assessment template 7. Five (5) most current AAC and SLP assessments conducted by each therapist, and corresponding PSPs 8. Monitoring tools template for ACC and SLP programs 9. Completed monitoring forms 10. Communication dictionaries for individuals identified as having decreased communication 11. AAC-related spreadsheets 12. List of individuals receiving direct speech services, and focus of intervention 13. BSSLC Plan of Improvement (POI), dated 12-29-2010 **People Intervied**: 1. Kori Kelm Director of Habilitation Services 2. Erin Pepper SLP 3. Donna Baron SLP 3. Direct Care Professionals on Bowie, Driscoll, Program Services and Childress **Meetings Attended/Observations**: Daily activities on Bowie, Driscoll, Childress, and Program Services
	Facility Self-Assessment: Based on the Monitoring Team's review, the Facility was not in compliance with some of the components of the SA with which the Facility indicated it was in compliance. Examples of areas that were rated in compliance, but noncompliance was found by the Monitoring Team included: • The POI for Section R.1 documented compliance stating that BSSLC had an adequate number of SLPs or other professionals. • The POI for Section R.1 documented compliance stating that BSSLC had a process for identifying individuals who would benefit from AAC. The monitoring team found agreement with areas found not to be in compliance. These areas included: • Integration of Communication strategies into the PSP • Monitoring system that addresses presence, working, condition and effectiveness of communication supports.
	Summary of Monitor's Assessment:

	Provision R.1: This provision was determined to be not in compliance. BSSLC has filled all of their positions but remained not compliant due to lack of the SLPs' presence in all facets of care in which their expertise was needed. For example, 15 of 23 records indicated no participation by the SLP in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP. **Provision R.2:** This provision was determined to be not in compliance. Individuals identified as having decreased communication have not consistently been provided with the needed assessments. Programs in place to assist some individuals are not being consistently implemented. Additionally, Individuals who are listed as having severe speech handicaps had not received a comprehensive assessment that investigates the possibilities of AAC. On a much more positive note, many individuals are beginning to be provided with trials of communication equipment. Additionally, the newer assessments (completed in the last few months) were much more comprehensive and did a better job at identifying potential benefits of AAC. **Provision R.3:** This provision was determined to be not in compliance. AAC devices were not consistently portable and functional in a variety of settings. DCPs interviewed were not knowledgeable of the communication programs. For example; Staff were observed walking by devices with no effort given to utilize devices to communicate to individuals or have individuals attempt to initiate conversation. Additionally, communication programs were not integrated into the PSP. Lack of integration into the PSP results in isolation of the target behavior (in this case speech or use of device) as it is only taught once daily. This frequency is not conducive to generalization of the goal or its overall progression. **Provision R.4:** This provision was determined to be not in compliance. BSSLC was in the process of developing a monitoring process to address the presence and working condition of the AAC devices but were not monitoring whether or not the device was effective and or meaningful to the individual. Additionally, there was not a formal process that ensured monitoring occurred across all relevant locations and activities. Monitoring must occur throughout activities and should focus not only on the presence but the effectiveness of the device. Individuals with AAC devices as well as communication related objectives should be followed by the SLP to ensure the program and/or device remains effective in improving speech and/or language. BSSLC had hired two additional SLPs, which has brought their total number to five therapists. Although the numbers have increased, SLPS were not actively involved in all facets of care in which their expertise was needed. Among these areas included: • lack of attendance at PSPs • lack of consultation or authoring of communication related goals • lack of PSP integration • lack of follow through to ensure goals and objectives meet the individuals' needs.

	Positives noted during the review included some improvement in the presence of SLPs during the annual PSP meeting and improved investigation of AAC with the most recently completed assessments.

#	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.	As of this review, BSSLC had five full-time Speech-Language Pathologists in addition to the augmentative communication specialist. This represents an increase of two therapists since the last compliance visit. Based on a review of CVs for each therapy clinician (5) 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. The addition of the two staff may result in the ability to conduct assessments; develop, implement, and monitor programs, and provide staff training. As indicated in the examples below, there had been improvement in completion of assessments, but development and implementation of programs did not yet indicate that this provision is met. As the new staff carry out their responsibilities, the Facility may (or may not) be able to demonstrate that the number is adequate. The Facility should analyze caseloads to determine appropriate assignments of these staff and to evaluate whether there are enough to meet the requirements of the provision. Although the number of therapists has increased, therapists continue to pass the development of programs to individuals who lack the expertise needed to write functional and sequential goals. Through the PST 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. Examples of goals not being written appropriately include: • Individuals #412's communication goal states that prompting should be Hand over Hand when teaching sign language. The goal then asks the staff what level of prompting staff provided. Because levels of prompting were not defined in the goal, this resulted in documentation that was sporadic and did not provide a consistent approach to the stated goal. SLPs did not actively participate in all facets of care in which communication is relevant. For example:	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Fifteen of 23 records indicated no participation by the SLP in the PSP process outside of providing the required assessments. This resulted in communication issues being discussed without the presence of the SLP. An example is Individual #475's PST discontinued the communication dictionary without the presence or involvement of the SLP. Decisions regarding an individual's communication program should include the professional who was considered to be the expert in the field.. Based on a review of 23 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 #255 had decreased expressive language skills. The SLP stated to encourage sign language but no direction was provided or goal developed. • Individual #475 had decreased receptive language and unintelligible speech yet the PST discontinued the communication dictionary. • Individuals #160, #86, #434, and #473 had severe language disorders, had not received a comprehensive evaluation and did not have communication goals. • Two cases had the nurse writing a health maintenance plan for impaired communication when there was no health related issue • Observations on Bowie A, and B, Childress A, and B, and Driscoll A revealed no interaction with individuals using the available general area communication boards. On a positive note, many individuals were in the process of having trials conducted that focused on the use of speech-generated devices. Many of these trials resulted in devices being ordered for the individual. Based on a review of five records, two of five records indicated the Speech Language Pathologist(s) were not actively involved in the care of individuals with identified speech/language and behavioral difficulties. Examples of individuals with dual difficulties not receiving active SLP collaboration: o Individuals #196, and #121 had a history of SIB and Aggression but there was no evidence of SLP collaboration with psychology to determine interventions relevant to communication	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and	Fifteen of 23 records reviewed indicated individuals identified with severe expressive/receptive language did have AAC investigated as part of the assessment process.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	In 15 of the 23 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. The above represents a significant improvement in the comprehensiveness of the provided Speech assessments. SLPs conducting trials of Speech Generated Devices (SGD) were not documenting the trials with sufficient detail to clearly demonstrate progress or preference with presented devices. For example: • The SGD reports for Individuals #475 and #249 only stated what device was recommended and the integrated progress notes only stated that the session went "great" or referenced a SGD but did not state the specific type of SGD. BSSLC has a communication master plan designed to indicate when the comprehensive communication assessment would be due. The communication master plan only outlines the initial completion of the comprehensive assessment and not the future schedule of assessments. Additionally, many individuals identified by BSSLC as having severe language deficits were not scheduled to be provided with comprehensive assessments that fully investigate AAC until as late as 2013. This results in a significant delay of services to those who need them most. For example; Individuals #160, #86, #434, #191 were all listed as having severe language impairments but have not received a comprehensive assessment. Per interview with Habilitation Therapies director 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. On a positive note, the communication department is in the process of developing a new policy that will outline the above concerns. Programs, goals and objectives related to the acquisition or improvement of speech or language were not written by the SLP or followed by the SLP at a minimum quarterly to ensure continued appropriateness. For example: • In 23 records reviewed; 100% of individuals with goals/objectives related to language acquisition, did not have goals/objectives/outcomes written and followed by the SLP on a monthly basis if service is direct and quarterly if indirect. Goals were written by the QMRP and resulted, as stated in the finding	

#	Provision	Assessment of Status	Compliance
		for Provision R.1, in less than appropriate goal development.	
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 were 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 into the PSP results in missed opportunities for additional training and lack of opportunities for generalization to occur. Zero of 23 records reviewed had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated: o SLP stated in the assessment that Individual #50 should use his communication binder and it should be integrated into daily activities but no further information is supplied. o Individual #358 had an objective that focused on the use of the talking photo album but there is no mention in the PSP how the device can be utilized outside of specified training. o SLP stated in the assessment that Individual #196 would benefit from staff describing objects to him but there was no evidence of this recommendation being integrated into the PSP or its action plans. o For Individual #427, the team members, other than the direct contact employee who routinely works with the individual, were grossly unaware of the individual's use of spoken language while at school and the communication programs implemented at the school. DCPs interviewed were not knowledgeable of the communication programs as evidenced by: o In two of five interviews, direct support professionals were not able to locate adaptive equipment. o In four of five interviews with staff, staff could not describe individual-specific communication strategies. o In five of five interviews with staff, staff could not describe the schedule for implementation of communication strategies. Instances in which individuals' communication plans were not able to be described by staff included: • DCP on Childress A was not able to locate Individual #50 Communication Binder or describe strategies listed on the plan.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• DCP on Bowie A was not able to state Individual #475 primary method of communication • DCP on Childress C was not able to describe communication strategies to use with Individual #412 Five of five 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.	
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.	There was no formal monitoring process that outlined persons responsible or frequency in which the monitoring should occur. Per review of the November monitoring data, there was no documentation to identify time of monitors or activity in which monitoring was completed. A review of 21 Facility monitoring reports from November 2010 documented that staff were not being monitored in all aspects of AAC utilizations: This included: • In 21 of 21 reports reviewed, the presence of the AAC was documented • In 21 of 21 reports reviewed, the working condition of the AAC was addressed • In one of 21 reports reviewed, the implementation of the device was addressed • In one of 21 reports reviewed, the effectiveness of the device was documented Additionally, there was no evidence of validation checks built into the monitoring process.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Many of the current assessments lacked adequate justification for the recommendations for specific AAC as well as for recommendations that communication supports (other than the Communication Dictionary) were not indicated. This must be addressed for the assessments not yet completed, but must be also addressed for those assessments already done. This is a key element to a comprehensive assessment that meets generally accepted professional standard of care.
2. When an update is completed subsequent to a strong baseline assessment, reference to the comprehensive assessment should be made in the update and the comprehensive assessment should not be purged until a new comprehensive assessment is completed. This is critical to ensure continuity and to permit tracking of decision making and clinical reasoning by SLPs.
3. A process should be developed that ensures individuals who have been identified by the therapists as having severe language impairments are provided with comprehensive assessments that fully investigate the potential use or pathway to expanded language through the use of AAC or other methods of enhancement. This process should ensure that all individuals with severe speech handicaps are provided with such assessments during their annual PSP

4. Many recommendations appeared to be left to the PST for the development and implementation of plans. It is critical that SLPs be involved at least in a consultative model to ensure that the plans, materials and implementation are within the scope of the individual's abilities and/or promote enhancement and skill development, as well as modeling and coaching for staff. SLPs should be utilized in the development of instructional plans in a variety of settings to ensure that they are individualized with regard to the communication strategies incorporated into these plans.
5. Communication Goals should be followed by the SLP on a monthly basis if service is direct and quarterly if indirect.
6. The focus of monitoring for AAC systems should address effectiveness and implementation versus only availability and condition. This will require professional staff to conduct more frequent and thorough monitoring in addition to that conducted by the PNMP Coordinator.
7. Validation checks should be built into the current monitoring process to ensure accuracy of acquired data.
8. Ensure improved consistency of how communication abilities and effective strategies for staff use are outlined in the PSP. Ensure strategies and goals are not only listed but integrated into all aspects of daily programming.
9. The Facility should analyze caseloads to determine appropriate assignments of these staff and to evaluate whether there are enough to assess individuals; develop, implement, and monitor programs, and train staff.

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:** 1. RSSLC Plan of Improvement (POI) 2. RSSLC Outline of Section's Presentations (01/10/2011) 3. Documents that were reviewed included the annual PSP, PSP updates, Special Program Objectives (SPOs), Positive Behavior Support Plans (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, task analyses, and behavioral and functional assessments. All documents were reviewed in the context of the POI and Supplemental POI and included the following individuals: #1, #3, #4, #7, #8, #9, #11, #12, #15, #20, #21, #38, #51, #61, #62, #65, #66, #118, #121, #139, #173, #196, #206, #229, #231, #252, #261, #314, #316, #337, #349, #399, #411, #417, #424, #425, #427, #467, #484, #488, #490, #493, #504, #513, #528, #556, #559, and #576. **People Interviewed:** 1. Terry Hancock, PhD – Chief Psychologist 2. Shawn Cureton, MS – Psychology Manager 3. Kathleen Williamson, MEd – Psychology Manager 4. Melissa Waters, MBS – BCBA 5. Kim Littleton – ADOP 6. Tammy Bryant – Residential Director – Childress Terrace 7. Philip Carnagey – Residential Director – Cottage Estates 8. Melissa Abston – Residential Director – Driscoll Gardens 9. Vickie Morgan, MD – Psychiatrist 10. Andrea Miller – Program Services 11. Juanita Taylor – QMRP Coordinator 12. Michael Doebler – Vocational Services 13. Cheryl Powell – HRC 14. Stephanie Tyrone – Active Treatment Monitor 15. Shanitra Dennis - Active Treatment Monitor **16.** Direct Care Professionals in the Program Services classrooms, the on-campus and off-campus workshops, and at the Childress, Cottages, Driscoll, and Fannin residences **Meetings Attended/Observations:** 1. Psychology Peer Review Committee 2. PTR – Bowie 3. PSP – Individual #427 (Fannin)(1/11/2010) 4. Human Rights Committee (1/13/2011) 5. Observed training at Program Services and off-campus vocational workshop

	6. Observed active treatment, staff performance and environmental characteristics in the Childress, Cottages, Driscoll, and Fannin residences.
	Facility Self-Assessment: The Facility. none of the three provisions was in substantial compliance. The Monitoring Team is in agreement with the Facility regarding the self-assessment. For Provisions S. 1 and S.2, the Facility reported that staff had been trained in the new PSP process, a BCBA had begun to provide consultation to program services on skill acquisition programs, and a pilot had begun to implement the Murdoch program. All of these have the potential to improve services but had not yet progressed to a point of compliance. Furthermore, only PSP training addresses the issue of improving assessment in the areas of living, working, and engaging in leisure activities; more will need to be done to establish useful assessment that can contribute to PSP planning. For Provision S.3, the Facility reported an increase in training opportunities for community integration. Although some initial promising steps had been implemented, there had not been an increase in formal training on community living skills occurring in community settings.
	Summary of Monitor's Assessment: At the time of the site visit, observations and a review of documentation clearly indicated that the facility had made little progress toward compliance with the SA. Efforts at staff training were observed to have provided minimal benefit. Attempts to revise skill acquisition programs offered improvements but were unlikely to effectively enhance the skills of people living at the facility. There was a continued lack of skill assessment while awaiting completion of the ongoing review of assessment strategies by DADS. From a facility-wide perspective, there was no reason to expect the individuals living at the facility to be better trained, possess more robust skills, or have developed greater independence than was seen at the beginning of the SA process. **For Provision S.1:** The provision was determined not to be in compliance. BSSLC indicated that 79% of staff had received training on the new PSP process. Observations of the PSP process and materials, however, revealed minimal changes over the pre-training PSP. Although the Facility was making an effort to improve skill acquisition programs through use of the Murdoch Center Program Library, attempts to modify existing skill acquisition programs using these materials had so far produced only minimal improvement. **For Provision S.2:** The provision was determined not to be in compliance. The assessment process continued to languish while DADS reviewed options for assessment tools and instruments. Without valid and reliable assessments, there can be no meaningful improvement in skill acquisition programming. **For Provision S.3:** The provision was determined not to be in compliance. No individuals were employed in Supported

	Employment or Competitive Employment jobs. Training on community skills lacked the formalized components necessary for learning to occur.

#	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.	The Facility indicated that the process of training staff on the new PSP was 79% complete. Although the Facility may be accurate as far as the number of staff to whom the curriculum had been presented, observations completed during the site visit reflected numerous limitations in the PSP process. • Individual #19 o When asked where he would like to live, identified a church he had attended with his family member, the LAR. The LAR stated that she would not be able to care for him if he moved to her home and that she felt he was best served at BSSLC. No further discussion of other living alternatives was held. Several barriers to movement to a more integrated environment were discussed, including his advancing dementia, which the PST indicated would mean he could not be served in a community setting. There was no discussion of investigating the availability specialized dementia services, nor was there discussion of how this would affect selection of leisure activities. The PST did plan return to work following recuperation from an injury. • Individual #20 o Individual #20 is a teenager whom the monitoring team has observed over the course of the past year. Considerable progress in the areas of appropriate social behavior and communication was evident during this year's meeting. The individual expressed a number of desires and preferences during the PSP meeting which the team did not adequately address. ▪ The individual expressed a desire to attend the Boys and Girls Club. The team agreed later in the meeting to look into it. No member of the team expressed any awareness that this was discussed and included in last year's PSP as an Action Plan. A review of the individual's record later revealed no action taken other than a single note that a referral to Program Services had been made on 1/22/10. ▪ Similarly, the PST discussed whether swimming might be of interest to the individual and suggested it would obtain a swimming assessment. The team expressed no awareness that a water safety assessment had been complete in 12/09. A review of the record also revealed the individual went	Noncompliance

#	Provision	Assessment of Status	Compliance
		swimming at the aquatic center with peers and staff on 8/10/10. The eventual outcome of this PSP was that most of the action plans were the same or a slight variation of the past year's plan. ▪ The circumstances for Individual#20 reflected that the team was unfamiliar with the current and previous requests offered by the individual, and was poorly prepared to make relevant decisions about future training and supports. A thorough review of the individual's historical record combined with a thorough assessment of personal strengths and needs for support could have eliminated many of the shortcomings noted in the PSP. Without such review and assessment, the members of the team were unable to develop the individualized and specific training programs and resource opportunities that the individual needed for further development, independence and community access. o For Individual #20, there was no discussion in her PSP meeting of the IEP or the specific goals and objectives, nor was there a representative from the school present. ▪ The IEP in the individual's BSSLC record indicated objectives in the areas of, and that the individual has attained considerable skills in, areas such as: keeps area neat, has good social skills; follows directions; cares for materials; attends to task for periods of 10 minutes; adds and subtracts with a calculator; reads aloud and answers questions about story; writes in complete sentences; and has personal interests and hobbies. ▪ These skills and goals and objectives were not reinforced at all in the PSP developed for this individual. The team did not ask the individual directly what she was working on or learning in school. At one point the individual stated she would like to attend a certain university, but no one on the team responded to this assertion. Toward the conclusion of the PSP meeting, the parents were asked if there were any other things they would like the individual to work on, and the mother suggested some of the things being worked on at school, such as reading a menu. The PST did not provide any further discussion nor develop any action plans in this regard. ▪ As indicated previously, the acquisition of skills and the development of opportunities for learning, community access and independence require the PST to be fully familiar with the individual. In addition, data derived from thorough assessment	

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		are critical to the development of necessary and relevant training programs. In regard to Individual #20, the PST had neither conducted the review and assessment necessary to recognize current abilities, nor had they specified any plans to do so. As a result, there was a very low probability that any recommendations offered by the PST would be relevant to or helpful for the individual. • For Individual #427, the team members, other than the direct contact employee who routinely works with the individual, were grossly unaware of the individual's use of spoken language while at school and the communication programs implemented at the school. Furthermore, although the Individual was to complete school within 5 months, the team members had not included post-education plans into the assessments or training programs. • For Individual # 490, there was no IEP information available at the 30-Day meeting. It was reported that a new IEP was to be developed in the near future, but there was neither team discussion as to the individual's previous experience in school, nor any input as to recommendations for the upcoming IEP. No member of the team asked the individual about her educational or vocational goals. • For Individual #513, there was no mention of the IEP or the individual's experiences at school, other than one mention that the individual did not like to make her bed before leaving for school. For any training to be considered successful there must be an indication or measure of how well those completing the training were able to demonstrate mastery of the skills taught. This is true in regard to teaching individuals living at BSSLC, as well as providing training to the employees of BSSLC. One such measure of the efficacy of training is the ability to apply the skills included in the training. Observations conducted of facility staff throughout the site visit consistently reflected an inability of the PST members to adequately complete the PSP process. Therefore, it was clearly evident that staff had not developed mastery and the training process was incomplete. During the July 2010 site visit, the conditions presented immediately below were documented. The facility provided no indication at the January 2011 site visit that the actively implemented skill acquisition programs reflected any change from what was observed 6 months previously. Therefore, the facility provided reason to believe, and data from sampling of 32records supported that the July information remained accurate and valid. • 0 of 32 records reviewed contained plans that reflected development based	

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		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 • 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. Prior to the current site visit, the facility had begun a process of revising existing skill acquisition programs using examples from the Murdoch Center Program Library. Approximately 50 programs had been revised, but none were implemented. Although the Murdoch Center Program Library is a widely accepted tool, its use is predicated upon a formal task analysis. BSSLC had not conducted a task analysis or any other additional assessment. Instead, a system of accommodation or adaptation was used. 1. Specific program(s) recommended will be sent to Program Services Department to the employee who coordinates this process. 2. BSSLC assessor's team will meet with the employee who coordinates this process to discuss the specific programs. 3. Assessors will meet with each Individual's QRMP for specific details regarding the programs recommended. 4. The employee who coordinates this process will generate the programming with the Murdoch Library of Programs. 5. For programs that cannot be generated using the Murdoch Library of Programs, it will be the QMRP's responsibility to develop these programs. 6. All programs generated by the Program Services Assessment Team, will be	

#	Provision	Assessment of Status	Compliance
		delivered to the QMRP along with the completed program data sheet, and training instructions by the assessor for final approval and signatures. 7. After the QMRP has signed off on the program it shall be returned back to the employee who coordinates this process. 8. The employee who coordinates this process will meet with the "Individual assigned Assessor. " The program will be reviewed for clarifications prior to training staff. The noted plan of implementation was unlikely to produce effective skill acquisition programs due to the lack of assessment and individualization. BSSLC submitted a sample of the eleven "best" revised programs for review. These plans had been developed but not yet implemented. The results of that review are presented below. • 0 of 11 plans (0%) reflected development based upon a task analysis. • 11 of 11 plans (100%) included a behavioral objective. • 2 of 11 plans (18%) included operational definitions of a target behavior. • 6 of 11 plans (55%) included a description of teaching conditions. • 2 of 11 plans (18%) described a schedule of implementation with sufficient trials for learning to occur. • 11 of 11 plans (100%) included relevant discriminative stimuli. • 9 of 11 plans (82%) included specific instructions for implementation. • 2 of 11 plans (18%) included specific consequences for correct response. • 2 of 11 plans (18%) included specific consequences for incorrect response. • 0 of 11 plans (0%) included a plan for maintenance and generalization that included assessment and measurement methodology. • 2 of 11 plans (18%) described a specific documentation methodology. Apart from the lack of adequate assessment, it was evident that the revised skill acquisition plans, although they reflected improvement, did not contain all the components considered to be current, generally accepted practice and shown to be effective for training. The status of the revised plans provided an example of how even highly valuable program development tools do not ensure adequate programs when used ineffectively. Tools such as the Murdoch Center Program Library are valuable, but must be applied by staff who possess demonstrable skills in applied behavior analysis and learning, as well as following careful and comprehensive assessment. When the Murdoch templates were implemented at BSSLC without the full integration of individualized assessment results and careful planning, the product did not meet accepted standards for skill acquisition training. programs	
S2	Within two years of the Effective	At the time of the site visit, the Facility offered no indication regarding compliance with	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	this Provision. Information regarding limitations in the assessment process is discussed in Provisions K5, K6, K7 and S1. The monitoring team was informed during the current site visit, as it had been informed during previous site visits, that DADS was developing an assessment tool that would be implemented at all SSLCs. As indicated in S1, the delay created by the ongoing development process for this tool was a substantial impediment upon progress toward compliance with the SA. A format for assessment had been recently submitted to the SA Monitors for review. However, a year after the baseline visit, BSSLC was no better prepared to conduct skill assessments than it was at the very beginning. Staff had not been trained as there was no tool or process upon which to base the training. Because there was not yet an improved skill assessment in place, there had been no opportunity to revise goals and training programs based on such assessment.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:	At the time of the site visit, the Facility offered no indication regarding compliance with this Provision.	Noncompliance
	(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 programs 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. Observations were conducted of training activities in the Adult Program Services classrooms, as well as at Childress, Cottages, Driscoll, and Fannin residences. No formal teaching programs were noted during these observations. BSSLC Active Treatment Monitors conducted observations at the Adult Program Services C and D classrooms prior to and during observations. Prior to the arrival of the Active Treatment Monitors, the following conditions were observed.	Noncompliance

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		• Seven clients and three staff were present: One staff member immediately left the room. The only activity was 1 staff reading to the clients. All clients were engaged in stereotypic behavior. No interruption or redirection was offered in response to stereotypic behavior. • One individual was observed with his head down while he bit himself and struck his head against the window. Staff offered no interruption or redirection. • Seven individuals were observed during scheduled "Active Treatment". One staff member was present. The only productive activity was 1 client who was sorting cards. The six other clients in the room were engaged in stereotypic behavior. • A staff person offered one individual who was visually impaired interaction. Although the client was visually impaired, the staff member offered no cue to alert the client to when she departed or returned. When the Active Treatment Monitors arrived at classrooms D2 and D3, staff behavior reflected a measurable change. Interaction with clients increased and staff were observed to use the Bumble Bee style of interaction whereby they moved about the room offering interaction with several individuals. Although interaction was observed to increase, there was no observed increase in formal training. • The Active Treatment Monitor in classroom D2 rated all individuals as engaged. The Active Treatment Monitor noted no undesirable behaviors, and available activities were described as including reading, table activities, puzzles and informal training. Documentation completed by the SA monitor reflected less than 50% of the individuals were engaged in activities. Several displays of stereotypic behavior were also observed. • The observations recorded by the Active Treatment Monitor in classroom D3 were substantially more accurate. The Active Treatment Monitor correctly documented that roughly only 1/3 of the individuals were engaged at any point by staff. The Active Treatment Monitor also captured the fact that staff in the classroom never offered choices to the clients, but simply had walked around offering occasional interactions. In addition to the poor reliability of at least one Active Treatment Monitor, these circumstances revealed that direct contact staff lacked the motivation and/or skills to conduct formal training or to intervene when undesired behavior was displayed. The basic skills required to strengthen desired behavior and weaken undesired behavior can and should exist regardless of the quality of written training programs. BSSLC should aggressively act to increase these skills in all direct contact staff.	
	(b) Include to the degree	Increased community opportunities are highly desired. However, acceptable practice and	Noncompliance

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	practicable training opportunities in community settings.	successful compliance require 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. As of November 2010 (the latest information provided by the facility), there were 110 clients of BSSLC working in various workshops, 2 individuals involved in Client Worker Program on campus and 18 individuals employed off-campus in programs maintained by the facility. No individuals living at BSSLC were working in Supported Employment or Competitive Employment. Competitive Employment was being sought by BSSLC, but as of the site visit no opportunities had been finalized. At the time of the site visit, BSSLC had implemented a series of Community Awareness classes during twice-weekly community outings. The curriculum for the Community Awareness classes included twelve topics. • You've Got Mail- Class about United State Postal System • The Green Team- Class about Recycling • Store Savvy- Class about all interaction required when in a store shopping • Dining out Made Easy- Class about dining and what how to order from a menu • Laundry 101- Class about washing and drying clothing • Group Options- Class about different types of group home options • Electronics Review- Class about learning how to operate small electronics • Room Maintaining- Class about learning how to perform basic cleaning • Restaurant Etiquette- Class about manners when in a restaurant • Street Sense- Class about traffic safety • World Wide- Class about learning how to use the internet • Community Options- Class about different community jobs Although the content of each class varied somewhat based upon which group of individuals was involved, the examples below offer a representation of the actual training curriculum. 1. Store Savvy • PERFORMANCE OBJECTIVE: • Individuals will learn appropriate behavior while shopping in stores. Individuals will learn to look at items in a store without touching them, talk at an appropriate volume level while in the store, and wait in line to purchase items. Making grocery/shopping lists will also be discussed	

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		• MATERIALS NEEDED:
		  • Instructional dvd on shopping
		  • Picture cards to make grocery/shopping lists
		• ACTIVITY SUGGESTIONS:
		  • Have residents visit the store inside Program Services. They will look at items in the store and talk quietly while inside the store. Using picture cards have each person make grocery/shopping lists. Plan outings to King Dollar, Dollar Tree, CVS, and Wal-Mart for residents to find items listed on their lists.
		2. Clean Sweep
		• PERFORMANCE OBJECTIVE:
		  • Individuals will learn the importance of keeping their living area clean.
		  • Learn basic cleaning skills (vacuum carpet, sweep with a broom and dustpan, dust with a feather duster, and use a Swiffer mop on non-carpeted floors).
		• MATERIALS NEEDED:
		  • Broom
		  • Dustpan
		  • Vacuum and vacuum bags
		  • Feather duster
		  • Swiffer mop and refills for it
		  • Instructional DVD on keeping house
		• SUGGESTED ACTIVITIES:
		  • Take out the vacuum and discuss the parts to it, how to plug it in, turn it on, use it safely and put it away after use.
		  • How to put the mop wipe on a Swiffer mop and use it to clean non-carpeted floors
		  • Watch the DVD on housekeeping and discuss the importance of keeping our home clean
		  • Take turns using the feather duster to dust items
		  • Take turns using the broom and dustpan
		
		Although these activities could be enjoyable and held the potential for providing some increase in skills, there were no elements for formal training or documentation included. Furthermore, there was no indication provided as to how individuals of varying needs and skill levels were accommodated within the classes. Therefore, it was highly improbable that the classes were increasing the skills needed for a successful transition	

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		into the community by people living at BSSLC.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Although decisions are pending in State Office, there exist skills that staff will be required to possess regardless of which assessment strategy or tool is eventually selected. For example, the implementation of skill acquisition programs requires that the staff implementing those programs possess knowledge regarding positive reinforcement, the skills to deliver reinforcement, and the ability to document displays of behavior with objectivity and reliability. 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.
2. BSSLC and DADS must act with urgency and diligence to resolve the lack of a skill assessment instrument or resource. Without a valid and reliable means of assessing individual skills, it will not be possible to achieve progress in this area.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: Document Review: 1. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), dated 12/29/10 2. BSSLC's Outline of Sections Presentation, dated 1/10/11 3. BSSLC Policies on Admissions, Transfers and Reassignments, and Personal Support Plan Process 4. Since July 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 5. Since July 1, 2010, a list of all individuals who have requested community placement, but have not been referred for placement 6. Since July 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" 7. Since July 1, 2010, a list of all individuals who have been discharged pursuant to an alternative discharge 8. A current list of all alleged offenders committed to the facility following court-ordered evaluations 9. Since July 1, 2009, list of all individuals who have been assessed for placement since, date of assessment, and resulting recommendation(s) 10. Community Placement Report, dated 1/1/10-12/16/10 11. 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 12. Since January 1, 2010, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 13. Personal Support Plans (PSPs) for 13 individuals: Individuals #1, #33, #38, #53, #151, #249, #273, #358, #386, #465, #492, #513, and #573 14. Personal Focus Assessments (PFA) for six individuals: #20, #151, #294, #513, #457, and #490 15. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for four individuals: Individuals #89, #231, #249, and #465 16. Revised Community Living Discharge Plan instructions and format, undated 17. Completed CLDPs for 11 individuals: Individuals #64, #70, #99, #180, #209, #298, #311, #378, #395, #438, and #559 18. Partial CLDPs for eight individuals: Individuals #9, #100, #139, #189, #196, #386, #420, and #557 19. CLDP Attendance Signature Sheets for 12 individuals: Individuals #64, #70, #99, #180, #209, #298, #311, #374, #378, #395, #438, and #559 20. Pre-Move Site Review document for Individual #374, dated 10/29/10 21. MRA Continuity of Care Pre-Move Site Review Instruments for ten individuals: Individuals #64, #99, #180, #209, #311, #374, #378, #385, #438, and #559 22. Community Placement Obstacles report, dated 12/14/10

	23. DADS Obstacles Report for the State Supported Living Centers, dated 10/10 24. Completed Post Move Monitoring (PMM) checklists for 17 individuals: Individuals #10, #64, #71, #99, #116, #180, #182, #209, #311, #374, #378, #385, ##421, #438, #559, #569, and#581 **People Interviewed:** 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Sherri Gilliland, Post-Move Monitor (PMM) 3. Juanita Taylor, QMRP Coordinator 4. Cheryl Powell, Rights Protection Officer 5. Brandi Rutan, Liaison for the children's pilot project **Meetings Attended/Observations**: 1. PSPs for three individuals: Individuals #20, #294, and #457 2. Personal Focus Assessment (PFA) meeting for Individual #411 3. Post Move-Monitoring Visits for Individual #374 4. CLDP Meeting for Individual #229 5. Self-Advocacy Meeting 6. Interagency Meeting 7. 30-day Meeting for Individual #490
	Facility Self-Assessment: The Monitoring team reviewed the BSSLC POI. Overall, the Facility indicated it was not in full compliance with any of the provisions of Section T. **For Provision T1**, the Facility indicated that it believed it was in compliance in several sub-sections, including the provision of adequate education about available community placements, the provision of the Community Placement Report and certain aspects of Community Living Discharge Plans and post-move monitoring. It also noted a number of actions it had taken since the previous site visit, including the creation of a new position to serve as Liaison with the MRAs to complete Permanency Plans and work with children and their families for possible alternate placement outside BSSLC. The POI also noted the development of new policies and processes related to transition and discharge. For T1g, related to the responsibility for developing a "comprehensive assessment" of identified obstacles to individuals' movement to more integrated settings, the Facility indicated it was using the PALS assessment and would implement a new Comprehensive Functional Assessment once approval had been received. This suggested there may have been a misunderstanding on the part of the Facility as to the expectation of "comprehensive assessment" for purposes of this section, such that a pertinent plan will need to be developed to implement this component. **For Provision T2**, the Facility stated it was in compliance with implementing and having an appropriate record of the PMM process, and adequately identifying that the essential and non essential supports prescribed by the CLDPs were in place at the time of the PMM visits. **For Provision T4**, the Facility indicated it believed this provision was not applicable, although it reported a draft policy and procedure related to this provision was under revision.

	Summary of Monitor's Assessment: BSSLC indicated that it was not in compliance with any of the provisions of this Section, but did reported it had achieved some level of compliance in three key component areas, those being the CLDP process and the Community Placement Report under Provision T1and PMM process under Provision T2. The monitoring team reviewed a 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:** This 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 Facility also reported it was in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The Facility was in substantial compliance with this component, but the monitoring team notes there was an agreement with DADS to add a category of individuals who were not referred solely due of LAR choice in future publications of the report. On a very positive note, the monitoring team was gratified to learn of the recently implemented pilot to encourage and assist the children living at the Facility to move to an integrated setting and appreciated the leadership exhibited by the administration at BSSLC and by DADS in this important matter. **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 Post-Move Monitoring (PMM.) The monitoring team found that the PMM Checklists were being completed in a timely manner. The potential for PMM visits to be missed when the process takes place across catchment areas was an area of concern during the site visit in 7/10, but this appears to have been resolved through a tracking system devised and maintained through DADS state office. Although the PMM Checklists reviewed were being completed in a timely manner, the process used to complete them was not yet thorough or adequate to be able to state with certainty that the essential and non-essential supports were actually in place. A single PMM visit observed during the compliance visit appeared to be more thorough than those observed during the previous site visit, but not every support was methodically observed and documented. **Provision T3:** This provision does not require a compliance review as it merely acknowledges that certain

	individuals who are at the Facility for court-ordered evaluations are exempt from the provisions of Section T. **Provision T4:** This provision was determined to be not in compliance. The Facility did not 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. The APC noted that a workgroup of her cohorts from SSLCs around the state were preparing a draft policy and procedure to satisfy the requirements of this provision.

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T1	**Planning for Movement, Transition, and Discharge**	This Provision was found to be not in compliance.	Noncompliance
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.	BSSLC had undertaken a number of initiatives that were intended, at least in part, to assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. • BSSLC had recently implemented the new statewide PSP process. Training in the new Supporting Visions curriculum had been ongoing at the Facility since September, 2010. According to the Report to Monitors provided at the entrance meeting, 352 staff had been trained in the new process. It remains to be seen whether this new process will result in any enhancement to the ability of PSTs to assess the supports and services needed by individuals in the most integrated setting. The QMRP Coordinator and Lead QMRPs had been providing coaching and training, and development of facilitator skills. • The Facility had also begun monitoring the PSP process. Please refer to Provision F2g for additional detail. • The Facility continued to hold a regular Interagency Planning Meeting with Richmond SSLC and the MRAs in their respective catchment areas to discuss and coordinate transition and placement issues. • BSSLC had recently begun a pilot to encourage and assist the children living at the Facility to move to an integrated setting consistent with the commonly accepted standards of practice that children should be served in family homes. The Facility had dedicated a staff position to implement this pilot, and was engaged with an advocacy organization, Every Child, Inc, to find appropriate family home matches for children living at BSSLC. The monitoring team was very gratified to learn of this project and appreciated the leadership exhibited by the administration at BSSLC and by DADS in this important matter. This pilot is in its early stages and the monitoring team will be eager to review its results in	Noncompliance

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		future visits. It is recommended that the dedicated staff person work very closely with the APC and be included in all activities related to transition and admissions for all children, including tours and meetings that occur prior to the time a decision is made for admission. The most effective approach to providing services to children in the most integrated setting will be to divert admissions through early planning. For this reason, it is also recommended that the dedicated staff person regularly attend the Interagency Planning Meeting described immediately above, particularly since the MRAs in attendance at the meeting indicated most of their potential referrals were for children, and engage with the Community Resource Coordination Groups in the area, which are interagency entities charged with the coordination of resources available for children with complex needs across multiple sources. These are positive steps, but none of these initiatives had been implemented long enough to be able to adequately assess their eventual impacts on compliance with the overall requirements of this component. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports; education for community awareness; transition and discharge planning; and, post-move monitoring indicated the Facility could not be said to be effectively assisting and encouraging individuals to move to the most integrated setting yet. In one such example detailed in Section F, Individual#20, a teenager with a guardian, stated several times throughout the PSP meeting the desire to live in a group home or family foster home. The parents were opposed. PST did not have any discussion with the individual about why this living environment was preferred, nor discuss the potential living options or Permanency Plan with the parents. The PST did not identify any obstacles, yet agreed that BSSLC was the least restrictive environment.	
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. The Facility had developed several new policies related to transition and discharge processes, including Admissions, Transfers and Reassignments and Personal Support Plan Process. These were generally consistent with state-level most integrated setting policies.	Noncompliance
	1. The IDT will identify in each individual's ISP the protections, services, and	The PSTs at BSSLC continued 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	Noncompliance

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	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.	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 and the supports and services needed at BSSLC, and in their understanding of their responsibility to complete a professional assessment of an individual's most integrated setting appropriate to his or her needs. This is described in detail under Provision F above. The new PSP process was predicated on beginning with a vision for the individual as the basis for identifying the supports and services 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. This vision was intended to be developed through the Personal Focus Assessment (PFA), completed by the individual, family and PST during the third quarter preceding the annual PSP. This revised PFA had not yet been implemented to an extent that would allow for it to be adequately assessed. The monitoring team looks forward to observing this process as it moves forward. As described in Provision F1c above, the PFA process was not currently implemented in a manner that was particularly meaningful to the individual nor likely to elicit information about the vision for the individual's future. The PFA should not be seen as a singular vehicle for envisioning an individual's future, or preparing an individual to participate in his or her own planning in a meaningful way. Individuals with intellectual disabilities may benefit from repeated and ongoing experiential activities as opposed to once or twice a year. The State and Facility should consider how it might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning. The monitoring team attended three PSPs and one 30 day PSP, and reviewed 13 PSPs completed using the new process and format for the purpose of evaluating this component. Consistent with the findings under Provision F, the PSTs did not exhibit proficiency in the assessment of the appropriate most integrated setting, the identification of needed supports and services in that setting other than those being provided at the Facility, or of the obstacles and/or strategies to overcome those obstacles. Examples included: • For Individual #457, the PFA indicated the individual enjoyed environments that were not loud, to the point that ensuring a quiet environment was what was needed most when the individual became angry or upset. Community outings were described on several occasions as the individual's favorite things. Going home to visit family was the "most fun" the individual had. During the PSP meeting, it was revealed that the family lived a number of hours away and could not visit as often as they would like to. The PST did not engage in any discussion	

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		about how a community living option might serve the desires for a quieter environment, more community participation and the likelihood that a community living option closer to the family would promote more frequent family visits. This was true even though the individual's mother stated she would be willing to look at community living materials. • For Individuals #20 and #513, both teenagers, the PSTs did not address the goals of the Permanency Plans for community living. • For Individual #490, the PSP began with the premise that the individual wanted to return to her mother's home and that the purpose of the meeting was to develop strategies to facilitate this. The mother attended the meeting and asked on several occasions when she could expect the individual to be ready to come home. Yet when the team addressed living options, they focused on the type of group home that would meet the individual's needs and did not discuss the supports that would be needed to facilitate living in the family home. Once this was brought to the team's attention by the monitoring team, they were very responsive.	
	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 and interviewed the APC and Post-Move Monitor. From 8/10/10-11/9/10, 16 individuals had participated in tours of community homes and programs, according to the documentation provided. Since this information was provided as a part of the document request in mid-December, this would appear to represent at least most of the opportunities provided over the past six months. The Facility reported that it had begun scheduling CLOIP tours every other Tuesday and Thursday, which should result in significantly more opportunities for individuals to gain awareness of community living options. Preparing Facility staff to engage individuals, families and LARs in discussions about community living is another essential ingredient in the provision of adequate education of these options, and the Facility had also begun to maintain documentation on the participation of staff in these tours as recommended during the previous site visit. According to the documentation provided, 19 staff had attended the CLOIP tours, with a two staff having attended more than once. BSSLC also provided Mandatory Living Options Training on 11/12/10, which is held on an annual basis. The purpose of this training was to provide information to team members about their roles in the community referral process. The attendance rosters provided documented that only 56 staff attended. It was not specified who the mandatory attendees should be, but if the target population was PST members, it would have been expected that more than 56 staff would attend. The Facility should make a determination as to what staff should be expected to attend the training and ensure they	Noncompliance

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		participate as required. The annual MRA CLOIP process continued to be an important part of the Facility's overall plan for education and awareness but perhaps should not be seen as the primary vehicle. The monitoring team reviewed a small sample of CLOIP Worksheets and found that for four of four, the MRA Service Coordinator documented the individual had no response and/or didn't seem to comprehend the materials or information being offered. This would suggest that there should be some consideration given to assessing how the materials and information should be modified to better meet the needs of the individuals. In one PSP meeting held during the site visit, an MRA Service Coordinator was present. During the living options discussion, the individual's mother was asked if she would be interested in receiving information on living options. She indicated that she would be. Rather than taking advantage of this opportunity, the MRA Service Coordinator noted that she had spoken to the mother earlier who had told her she was not interested in obtaining additional information. At that point, the mother agreed that this was so and the topic was closed. This was a missed opportunity to continue a conversation about community living. MRA CLOIP staff may benefit from additional training in recognizing such opportunities and how to appropriately address them. BSSLC is taking some actions to increase education and awareness, but these do not appear to have been well thought-out with clear goals in mind. The APC was not aware of any curriculum regarding most integrated setting in BSSLC's 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, the Competency Training and Development department at the Facility, the Contract MRA and other MRAs, with input from self-advocates at the Facility. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.	
	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	The Facility continued to take 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 who had been assessed for placement from 7/1/10-12/9/10 using this definition. Another 168 individuals were reported to have been assessed in this same process in the previous six months. If the Community Living Options discussion was implemented in such a manner that it could be considered an effective assessment for placement, the Facility would have fulfilled this requirement. From observations and document reviews as described in F1e, T1a and T1b above, this did not yet appear to be	Noncompliance

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	of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	the case. 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 clarification and additional training for PSTs on their responsibility, as qualified professionals, to assess each individual for the most integrated setting appropriate to their needs as called for by the ADA and the Olmstead decision • A focus on the ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning. This will require considerable staff training and mentoring.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	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 placement within the 180 day timeframe required by Texas DADS SSLC Policy: Most Integrated Setting Practices 018.1, 3/31/10. The monitoring team reviewed the Community Placement Report, dated 12/16/10. Or the 18 community placements that had occurred since 7/1/10, ten exceeded the 180 day timeframe. Of the 19 current referrals, six had already exceeded the 180 days. 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. The Facility was phasing in a new and expanded CLDP process and format, a process reported to have begun in late October, 2010. The CLDP instructions for completion require that: 1. Development of the CLDP should begin at the time of the referral for alternate community placement and should continue past the transition date. 2. The CLDP should be completed using the person directed planning philosophy. PSTs will meet at various stages of the community transition process. Deliberations from these meetings will be captured in the CLDP. 3. Direction from the individual and/or LAR (if applicable) should be solicited and documents at each stage of the process As the Facility has only recently begun to phase in these improvements to the process, it was not possible to adequately assess compliance at this site visit. The monitoring team will look forward to reviewing the Facility's progress at the next visit.	Noncompliance
	1. Specify the actions that need	The CLDP process is a continuation of the Facility's responsibility to assess the needs of	Noncompliance

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	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.	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. The monitoring team attended the single CLDP meeting held during the site visit, for Individual #229. While the meeting and process demonstrated continued improvement over previous visits in terms of thoroughness, the PST still failed to identify important issues in its listing of essential and non-essential supports. For example, Individual #229 had a vagus nerve stimulator (VNS) for seizure management, and the essential supports did not identify this as needed equipment, nor did it identify a requirement for staff training in its appropriate use. The listing of essential and essential supports did not always adequately capture basic requirements for a successful transition. Examples included: • For Individual #70, it is documented in the assessments and elsewhere in the CLDP that the individual requires a VNS. This information was not included in the listing of essential and nonessential supports. • For Individual #559, the only staff training specified as needed was behavioral training in-services, yet the individual has other needs related to use of adaptive equipment. The PST did not indicate training to be accomplished in these areas. • Individual #298 was scheduled to transition to community living on 1/18/11. The individual had GERD, required assistive dining techniques, must remain upright after meals for one hour and had a PNMP. The only related support listed was elevated head of bed, and this did not specify the degree of elevation needed. The individual has a history of PICA, but no staff training regarding precautions was listed. The Speech and Language Discharge Summary, dated 1/3/11 stated the individual needed to have a communication dictionary developed to assist new staff and others to understand how the individual communicates. This was not included in the listing of supports needed.	

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	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 each of the essential and non-essential supports. For the one CLDP observed during the site visit, the PST did not identify Facility staff to be responsible for each action that was specified during the meeting. 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, that CLDPs should 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. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff.	Noncompliance
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	The monitoring team reviewed the attendance signature sheets of 12 completed CLDPs for evidence that the individual and, as appropriate, the LAR had participated in the CLDP. For eight of 12, there was no documentation that the individual had participated. For nine of 12 there was no documentation that an LAR or advocate had participated. The new CLDP format and process calls for solicitation and documentation of direction from the individual and/or LAR (if applicable) at each stage of the process. The Facility had recently begun to use the Community Living section of the CLDP to document the community exploration and trial visits the individual had been offered and, at times, information regarding family/LAR involvement in the process. This was a positive step . This practice may provide a basis for documenting compliance with this component in the future if it consistently includes a comprehensive and accurate summary of all actions the PST had taken to inform the individual and LAR and solicit their input and direction.	Noncompliance
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. Obtaining updated assessments from various professionals and ensuring they are available at the CLDP and for the use of the selected provider is an important step. However, as described in T1c1 above, these were not being integrated into a comprehensive assessment in a manner that allowed for the CLDP to accurately reflect the needs and supports to be provided in the community setting. For six of 12 CLDPs, the Facility did not include in the materials given to the monitoring team the assessments that are an integral part of the CLDP for review. In the future, it is recommended that the Facility ensure the CLDP is maintained as a complete document, including all the referenced assessments, at all times.	Noncompliance

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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. The monitoring team requested and received documentation of the MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for 10 individuals who had transitioned to the community since 10/10. These generally appeared to have been completed in a timely manner following the CLDP and prior to the actual transition date, per the completion date. In one instance, however, the MRA Pre-Move site review for Individual #209 was completed on 9/21/10, and the eventual transition date was not until 11/3/10. For the purposes of ensuring continuity of care, given that environmental conditions can change in over a month's time, it would be necessary to repeat the visit after that length of time had elapsed. It would also not have been possible to ensure the provider had a copy of the most recent CLDP, since the most recent version, while undated in the copy made available to the monitoring team, referenced a date of 11/1/10 as the most recent IDT review of current summaries and assessments. The instrument also calls for the MRA to attest it has verified the provider is in good standing with DADS, using the DADS Quality Reporting System website, and to attach the printed verification. These were not attached to any of the instruments made available to the monitoring team for review. BSSLC should ensure that complete documentation is kept as required, and should ensure that pre-move site visits are made closely enough to the date of move to provide adequate assurance of continuity of care. The revised CLDP process calls for the Facility to also complete its own pre-move site visit prior to the individual's transition date. In its presentation at the site visit entrance, BSSLC indicated it had incorporated the additional pre-site visit to Providers before an individual leaves the Facility. The Facility had completed only one such visit, for Individual #374. At least four individuals have transitioned to community living since that initial pre-move site visit was completed, so it is not clear why the pre-move site visit was not completed for these individuals. The document for Individual #374 provided very little information. It listed the essential and non-essential supports, the responsible person, the required evidence and the due date of on or before October 29, 2010. The document did not indicate whether the supports were in place or, if they were not, the status or plan for ensuring their availability. On the second page of the document, there were a series of questions related to the environment, the day program, transportation availability, activity schedule, the status of in-service training and the provider's last life-safety code certification.	Noncompliance
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans	This component was found to be not in compliance. The Facility did not have quality 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 by the APC that a group of APCs	Noncompliance

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	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.	from across the SSLCs were working on the development of quality assurance processes and that they have asked DADS state office to assist them by providing a tool. The monitoring team looks forward to reviewing progress in this area at the next site visit. 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 routinely 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 developmental disabilities. To the	This component was found to be not in compliance. The Facility provided a 2 page document, entitled Community Placement Obstacles, dated 12/14/10, covering the period from 4/1/09-12/14/10. It listed identified obstacles for 62 individuals who had a preference for community placement but were not recommended for placement by their PST. The identified obstacle for 82.3% of these individuals was LAR Choice, while for 9.7% the obstacle was MRA Not Present. 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 identified by the PST during the assessment for placement and reflected in the annual PSP Living Options Discussion of the PSP • Barriers perceived and/or encountered by individuals, families and LARs, as documented by the PSTs and through Parents and Self-Advocacy groups	Noncompliance

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	extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	• Post-Move Monitoring Checklists could be analyzed and common issues identified. DADS had issued its first annual Obstacles Report for the State Supported Living Centers in October 2010, which provided guidance to the Centers as to the methodology and categories of obstacles to be used in order to ensure the State Office receives comparable and consistent data from each one. The monitoring team found the report to provide excellent guidance to the Facility regarding the types of obstacle data to be collected, such that they may be collated to provide an accurate picture of the obstacles to be addressed both in the catchment areas and the state as a whole. In terms of methodology, the process continued to rely heavily, as appropriate, on the PSTs to identify the obstacles on an individualized basis for each person. It also referenced the newly revised PSP process that was currently being introduced to the facilities, and stated that specific direction would be given to the PSTs under this new process to address the content of the Living Options discussion to include both the individual's and his/her LARs awareness, experience, and exposure to alternate living arrangements. The revised process was also described as including "a Personal Focus Assessment that will provide the PST with the individual's interest in pursuing alternate community placement, along with a geographic location for possible future placement, prior to the annual planning meeting. This will provide the PSTs with three months to explore the identified geographic location for obstacle identification prior to the Living Options discussion at the annual PST meeting." The PSTs will need further training to adequately perform these tasks that form the basis for obstacle identification.	
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	BSSLC indicated that it was in substantial compliance with this component and the monitoring team concurred. The Facility issued a Community Placement Report on 12/16/10, covering the period of 1/1/10-12/16/10. The report was in the standardized format as prescribed by DADS State Office. It listed 39 community placements, 19 current referrals, nine rescinded referrals, and six listed as not referred, but expressed preference of community. Of the 39 community placements listed in the report, 17 had occurred since 7/1/10. The monitoring team remained concerned that guardianship may on occasion be seen primarily as a vehicle for preventing transition to the most integrated setting when that has been deemed by the PST to be community living. At least one guardianship obtained since the last site visit resulted in rescinding of an individual's referral for transition to community living, despite the assessment of the PST that the most integrated setting appropriate for these individuals was community living. (Please refer to Provision U2 for additional information.) Given this, the monitors have also requested that DADS add a	Substantial Compliance

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	purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	category to the Community Placement Report of individuals who have indicated an interest in community placement but have not been referred solely due to LAR Choice. DADS had agreed to add the additional category, and the monitoring team will look for that in upcoming reports. This information is currently captured in the Community Placement Obstacles report (see T1g above), assuming these are comprehensive data.	
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.	Noncompliance
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	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. The monitoring team reviewed the PMM checklists for 17 individuals, including 12 individuals monitored by the BSSLC Post-Move Monitor and five individuals from BSSLC who were monitored by the Post-Move Monitor from another Facility. The monitoring team found that the PMM Checklists were being completed in a timely manner. The potential for PMM visits to be missed when the process takes place across catchment areas was an area of concern during the site visit in 7/10, but this appears to have been resolved through a tracking system devised and maintained through DADS state office. Although the PMM Checklists reviewed were being completed in a timely manner, the process used to complete them was not sufficiently thorough to be able to state with certainty that the essential and non-essential supports were actually in place. The Post-Move Monitor did not routinely visit each of the sites in which supports were to be provided. The PMM process was designed to be intensive during the critical 90 day period following transition. The Post-Move Monitor did observe the individuals in their new home environments at all 7-day visits, but in some instances did not visit the day program until the 90-day visit. The Post-Move Monitor must personally ensure that	Noncompliance

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	support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	supports are available and being provided in the appropriate and prescribed manner in all sites in which the supports are called for at each of the required visits. It was not possible to determine the sites visited in all instances from the documentation on the older PMM Checklist. The recently implemented newer version calls for the Post Move Monitor to document the sites visited. This is an improved process. In general, the use of the PMM Checklist provided 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 #581 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. There were many instances in which the Post-Move Monitor failed to document carefully and/or follow up as needed. Examples included: • For four of 12 individuals, including Individuals #99, #182, #311 and #421, the Post-Move Monitor noted that documentation of staff training in all required areas was not available for review. The stated plan to ensure this was completed was to follow up at the 45-Day visit. The potential risk to the individual of having staff who are not trained to meet their needs in the first 45 days after transition is unacceptable. Staff training documentation, and verification by staff interview, must be completed at the 7-Day visit to ensure health and safety. • For Individual #311, the Post-Move Monitor documented a need to follow up with the PST at BSSLC regarding a medical question at the 7-Day visit. No further documentation was made regarding this follow-up. • For Individual #438, an essential support was paid employment at BPS. The 7 and 45 Day Checklists indicated the support was not available and that the provider was attempting to obtain a contract. The 90-Day Checklist indicated the support was still not available, but no justification or follow-up was noted. The monitoring team interviewed the Post-Move Monitor and the APC regarding these and numerous other issues related to follow-up and documentation. In some instances, these staff had taken some actions and found emails that would document some follow-up. In other instances, no documentation existed. In addition to ensuring that all necessary follow-up is completed, the Post-Move Monitor should carefully document the follow-up by filling in the Action/Follow-up section of the Checklist, including date and	

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		response to action taken. Emails and phone logs related to the follow-up should be attached. During the interview, the APC raised a question as to how long and where this documentation should be maintained. It is recommended that DADS state office incorporate its expectations regarding this documentation into its statewide policy and procedure.	
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 90-day monitoring visit for Individual #374. Prior to the visit, the CLDP and previous PMM Checklists were reviewed. The PMM visit observed was more thorough than during the previous site visit, but not every support was methodically observed and documented. For example, the list of essential supports included ear plugs. The Post-Move Monitor inquired as to whether the ear plugs were available but did not ask to see them nor ask staff for what purpose the plugs were used. Given that the staff were the same as on a previous visit, the Post-Move Monitor may have checked their knowledge on a previous visit, but this was not documented on the 7 or 45 Day Checklists. In any event, the presence of the support and a verification of its appropriate use should be personally verified by the Post-Move Monitor.	Noncompliance
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	BSSLC stated that it had no alleged offenders committed to the facility. This provision does not require a compliance review as it merely acknowledges that certain individuals who are at the Facility for court-ordered evaluations are exempt from the provisions of Section T.	
T4	**Alternate Discharges -**		

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	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 since the last compliance visit pursuant to an alternative discharge as defined in the Settlement Agreement. Therefore, this provision was not rated. 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. The APC noted that a workgroup of her cohorts from SSLCs around the state were preparing a draft policy and procedure to satisfy the requirements of this provision.	Not Rated

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. It is recommended that the dedicated staff person for the children's pilot project work very closely with the APC and be included in all activities related to transition and admissions for all children, including tours and meetings that occur prior to the time a decision is made for admission. It is also recommended that the dedicated staff person (1) regularly attend the Interagency Planning Meeting with Richmond SSLC and the MRAs described in Provision T1a, particularly since the MRAs in attendance at the meeting indicated most of their potential referrals were for children, and (2) engage with the Community Resource Coordination Groups in the area, which are interagency entities charged with the coordination of resources available for children with complex needs across multiple sources.

2. The PFA should not be seen as a singular vehicle for envisioning an individual's future, or preparing an individual to participate in his or her own planning in a meaningful way. Individuals with intellectual disabilities may benefit from repeated and ongoing experiential activities as opposed to once or twice a year. The State and Facility should consider how it might expand on the PFA process to be an ongoing process that truly supports individuals to be active participants in their own planning.
3. There should be some consideration given to assessing how the CLOIP materials and information should be modified to better meet the needs of the individuals. MRA CLOIP staff may benefit from additional training in recognizing opportunities to continue a conversation about community living and how to appropriately address them.
4. The Facility should make a determination as to what staff should be expected to attend the Mandatory Living Options Training and ensure these staff participate as required.
5. The Facility should develop a comprehensive strategic plan for education of individuals, LARs and families and facility staff on community living options. The strategic plan should include assigned responsibilities, timelines and outcome measures. PSTs should receive additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs.
6. 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.
7. BSSLC should ensure that complete documentation of the CLDP process is kept as required, and should ensure pre-move site visits are made closely enough to the date of move to provide adequate assurance of continuity of care.
8. The Facility should ensure the CLDP is maintained as a complete document, including all the referenced assessments, at all times.
9. Facility policy and procedure should specify the expectations that Facility staff have responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff.
10. The PMM process 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. The Post-Move Monitor must personally ensure that all supports are available and being provided in the appropriate and prescribed manner in all sites in which the supports are called for, and at each of the required visits. Staff training documentation, and verification by staff interview, must be completed at the 7-Day visit to ensure health and safety.
11. In addition to ensuring that all necessary follow-up is completed, the Post-Move Monitor should carefully document the follow-up by filling in the Action/Follow-up section of the Checklist, including date and response to action taken. Emails and phone logs related to the follow-up should be attached. It is also recommended that DADS state office incorporate its expectations regarding this documentation into its statewide policy and procedure.
12. DADS state office should incorporate its expectations regarding documentation of PMM visits into its statewide policy and procedure, including how long documents should be kept.
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 12/29/10 2. BSSLC's Outline of Sections Presentation, dated 1/10/11 3. Prioritized list of 70 individuals who are in need of an LAR, dated 12/21/10 4. List of individuals for whom a Legally Authorized Representative (LAR) had been obtained since 8/1/10 5. Personal Support Plans and Rights Assessments for eight Individuals: Individual #38, #81, #144, #273, #334, #406, #513, and #573 6. Guardianship documents for Individual #334 7. Draft DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) dated 6/11/10 8. Draft BSSLC Policy on Human Rights and Protection **People Interviewed:** 1. Debra Green, Admissions/Placement Coordinator (APC) 2. Cheryl Powell, Rights Protection Officer **Meeting Attended/Observations:** 1. PSPs for three individuals: Individuals #19, #20, #294, and #457
	Facility Self-Assessment: The Monitoring team reviewed the BSSLC POI. BSSLC indicated it was not yet in compliance with any of the provisions for Section U. The monitoring team concurred with this assessment. The POI indicated that the DADS State Office workgroup is continuing to work on development of statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the SA, and that it was awaiting this final guidance prior to implementing significant changes. The POI listed some of the actions the Facility had taken or was planning to take to address recommendations made at the time of the last monitoring visit, but these reported actions were not always consistent with the information obtained during interviews during the site visit. The POI stated that the APC and Human Rights Officer (Rights Protection Officer) had been reviewing and updating the prioritized list of individuals in need of an LAR on an ongoing basis since 8/10, but during interview the APC noted that the only updating of the list that was ongoing was when individuals obtained or lost guardians. No updating of prioritization was being made.
	Summary of Monitor's Assessment: The monitoring team reviewed a 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 further action in these provisions. The findings are as follows:

	Provision U1: This provision was determined to be not in compliance. The Facility did maintain a list of individuals needing an LAR, but there was still no standardized approach to assessing and determining the actual need for an LAR on an individualized basis that was consistent with commonly accepted professional standards of practice. The list was updated on an ongoing basis as guardianships were obtained, renewed or lapsed. The list originally assigned a prioritization to each individual, but the prioritization process had been discontinued until the new DADS policy has been issued. The Facility provided a draft policy on Human Rights and Protection that was reported to be based on the draft statewide policy. For the purposes of this provision, however, it did not address guardianship in any substantive way. While it did address the philosophical basis for informed consent and the responsibility of the PST in supporting the ability of individuals to make informed decisions, it did not address the standardized tools or methodology PSTs would use to assess and prioritize the need for an LAR, nor the process for making a referral for a guardian. **Provision U2:** This 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, other than maintaining a standard agenda item for the parents' association meeting to encourage family members to consider becoming guardians. It remained 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. Future compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite. The draft Facility policy on Human Rights and Protection did address the roles, responsibilities and recruitment of personal advocates in some detail, which the monitoring team commends, but it did not describe the criteria the Facility planned to use when soliciting guardians, nor did it address its understanding of its roles and responsibilities in education, or assuring the education, of guardians and potential 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	BSSLC did not have a policy and procedure describing its processes for developing and maintaining 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. The Facility indicated that it planned to take action in these areas once the DADS Policy Number: 019 Rights and Protection (including Consent & Guardianship) is implemented. The monitoring team reviewed the Facility's draft policy on Human Rights and Protection that was reported to be based on the draft statewide policy. For the purposes of this provision, however, it did not address guardianship in any substantive way. While it did address the philosophical basis for informed consent and the responsibility of the PST in	Noncompliance

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	decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	supporting the ability of individuals to make informed decisions, it did not address the standardized tools or methodology PSTs should use to assess and prioritize the need for an LAR, nor the process for making a referral for a guardian. BSSLC had maintained a list of individuals who did not have a current guardian. The list was dated 12/21/10 and included the names of 70 individuals. Each person was assigned a priority as follows: 32 individuals were assigned priority 1, No Family/Correspondent-Needs Guardian; four individuals were assigned priority 2, Medication-Behavioral Support Plan; and 34 individuals were assigned priority 3, Active Family/Correspondent. This process of prioritization, which was not based on any standardized assessment methodology, had been discontinued until the new DADS policy has been issued. Rather, the list was being simply updated on an ongoing basis as guardianships were obtained, renewed or lapsed. The PSTs were not using 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. The monitoring team reviewed seven PSPs and accompanying Rights Assessments that had occurred from 8/10-11/10. Six of the seven individuals had LARs. For seven of the seven PSPs, there was no specific discussion of an individualized assessment of need for an LAR. PSTs also did not routinely develop action plans to assist individuals to maintain or improve decision-making capacity. In only a few instances were there specific action plans to address the individuals' capacity to make informed decisions, most often related to providing community tours to increase knowledge of community living options. Examples include: • For Individual #406, the Rights Assessment, Section J: Give or Withdraw Informed Consent, indicated the individual was unable to give informed consent in all five of the consent areas, including medical, programmatic, financial, restrictive/intrusive practices, media/photo and release of records. The only PST comment was "Guardian gives consent." The PSP further documented that the individual has some reading skills, can communicate most of his personal information, manages his own leisure time and is able to express opinions and desires related to his residential and work options. The PST did not have any further discussion about what would assist him to be better prepared to participate in decision-making, nor did it document any discussion with the LAR about how he might have more opportunity to participate in significant decisions. • For Individual #144, an adult without a guardian, the Rights Assessment, Section J: Give or Withdraw Informed Consent, indicated the individual was unable to give informed consent in all five of the consent areas. The PST comments were that the individual is unable to give informed consent and that the team would	

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		make the decisions on the individual's behalf. There was no further discussion in the PSP about how it was determined the individual could not give consent, nor of any action plans to assist the individual in developing decision-making skills. The only documented discussion indicated the individual's parents were interested in seeking guardianship and that the team would send a referral to the APC to provide information on the process. The PST did not provide any assessment of whether this was an appropriate avenue, nor provide any justification for such a step. • For Individual #38, the Rights Assessment, Section J: Give or Withdraw Informed Consent, indicated the individual was unable to give informed consent in all five of the consent areas. The PST comments indicated the individual had a guardian of person and estate who provided informed consent on the individual's behalf. The PSP does not provide any discussion of the individual's capacity to participate in decision-making. • For Individual #273, the Rights Assessment, Section J: Give or Withdraw Informed Consent, indicated the individual was unable to give informed consent in all five of the consent areas. The PST comment agreed that the individual needs assistance in all of these areas "per his PALS Assessment." The PALS is not a standardized instrument for the determination of level of ability to participate in decision-making; but, if it were, the PST still did not reference any specific findings in this regard in the PSP, nor did they develop any action plans to address decision-making capacity. Facility PSTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished 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 appeared to incorporate approaches in these areas. Once the statewide policy and assessment process has been finalized, BSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements.	
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	BSSLC reported it had drafted a policy and procedure on Human Rights and Protection to implement portions of this provision of the SA. It reported it was awaiting the final version of the statewide Policy Number: 019 Rights and Protection (including Consent & Guardianship) before finalizing this policy. The monitoring team reviewed the draft. It did address the roles, responsibilities and recruitment of personal advocates, which was to be commended. It did not describe the criteria it planned to use when soliciting guardians, nor did it address its understanding of its roles and responsibilities in education, or assuring the education, of guardians and potential guardians. If the Facility	Noncompliance

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	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.	plans to actively solicit 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. From August 2010 to December 2010 there have been six new Guardianships obtained at the Facility. At least one of these guardianships resulted in rescinding of an individual's referral for transition to community living, despite the assessment of the PST that the most integrated setting appropriate for these individuals was community living. • For Individual #334, the PST recommended during the annual PSP on 6/4/10 that the individual be referred for community living and the Designated Mental Retardation Authority (MRA) concurred. The PSP noted that the individual had completed three community home tours during the previous year, and that no objections had been noted. A Personal Support Plan Addendum (PSPA), dated 7/29/10, indicated that a trial visit to a community provider home had been made, with concerns about body odor and not eating well. The PST recommended that the individual visit two additional homes, which would have been an appropriate response. On 8/25/10, the individual's advocate obtained guardianship and rescinded the referral for community living, with no additional visits to community homes offered. The monitoring team remained concerned that guardianship may on occasion be seen primarily as a vehicle for preventing transition to the most integrated setting when that has been deemed by the PST to be community living. As the policy and procedure for this section is developed, DADS and the Facility should give consideration to: • 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. BSSLC did not report any additional organized efforts or planning to obtain LARs for individuals lacking LARs during this review period, other than maintaining a standard agenda item for the parents' association meeting to encourage family members to consider becoming guardians. It was appropriate that the Facility had 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. It is also appropriate that no large-scale effort to solicit guardians is made until the Facility has	

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		further developed policy and procedure regarding the criteria for and education of potential guardians as described above. Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

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, which will require expansion on the policy on Human Rights and Protection currently in draft.

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.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 6. BSSLC Plan of Improvement updated 12/29/2010 7. BSSLC Outline of Section's (sic) Presentations dated 01-10-2010 8. DADS Policy #020 Recordkeeping dated 9/28/09 9. BSSLC Policy Unified Record Keeping Practices, approved 12-17-2010 10. Record Order and Maintenance Guidelines templates (tables of contents) for use with two, three, four, and five binders dated 10/28/10 11. Master Folder Filing Instructions 12. Complete Active Records for Individuals #19, #513, and #595 13. Chart Audits from the Month of November 2010 and their findings 14. Record Audits from the Month of December 2010 and their findings 15. Blank Chart Audit Form to be completed by program auditors 16. Monthly Chart Audit Score by Question report for 2010-11 17. Individual Active Records for Individuals #19, #513, and #595 18. List of "Approved policies for BSSLC" with approval dates from 9/22/2010 through 12/17/2010 19. List of DADS SSLC policies dated 12/9/2010 20. BSSLC Policy Dental revised 10-18-2010 21. BSSLC Policy Medical and Dental Restraint revised 12-10-2010 22. BSSLC Policy Quality Assurance/Quality Improvement Council revised 09-30-2010 23. BSSLC Policy Protection from Harm—Abuse, Neglect, and Incident Management undated 24. BSSLC Policy Personal Support Plan Process revised 11-22-2010 25. BSSLC Policy Physician Procedures and Best Practice Guidelines approved 10-18-2010 26. Minutes of Policy and Procedure Committee meetings from 09-22-3010 through 12-17-2010 **People Interviewed:** 1. Margaret Zwerneman, Unified Records Coordinator 2. Deborah Borah, Unified Records Coordinator 3. Kim Littleton, Assistant Director of Programs (ADOP) 4. Jackie Gertman and Michael Appling, Program Auditors, and Program Audit clerk Karen Koester 5. Jill Quimby, RN, Quality Assurance Nurse and Brandy Todd, LVN III, QA 6. Sammie Donald, QMRP, Fannin 7. Direct Care Professionals (DCPs) at Fanning and Cottages **Meeting Attended/Observations:** 1. Entrance Presentation by Facility Staff 1/10/11 2. QA/QI Council 1/12/11 3. PSP meeting for Individual #19, #20, and #294
	Facility Self-Assessment: The Facility reported that it had established a unified record for each individual consistent with the

	guidelines in Appendix D of the SA. The Facility reported noncompliance with the other provisions of this section, including development and revision of all policies necessary to implement the SA, implementation of quality assurance procedures to ensure individual unified records are consistent with Appendix D, and use of records in making treatment decisions. The Facility reported that it had revised its policy and procedure format and developed a process to track policy and procedure from development to completion. The monitoring team noted development of a number of policies. The Facility accurately pointed out that record audits had begun, with audits completed in November and December 2010, but that no formal process to review finding, other than presentation to the QA/QI Council, were yet in place. The Facility listed the new PSP process as a step in utilizing records to make decisions. However, review by monitors did not verify that information from the records was actively used in preparing annual updates of PSPs.
	Summary of Monitor's Assessment: Conversion to the new unified record format was completed. BSSLC policy is consistent with DADS policy. The Active Record and Individual Notebooks (called All About Me books) were in place for each individual. Training had been provided to all staff. Active Records were usually kept in two binders but the record for an individual could have up to five binders. A Record Order and Maintenance Guidelines provided a standard table of contents for each number of binders required. Labeling on the outside of each binder made it easy to find the binder that included the information needed. Records were generally neat and legible. There were numerous examples of documents that were not filed in the correct location or order, and a few documents were missing. There were a few examples of gaps between entries. Records were accessible to staff. However, there were two cases during the visit in which binders were not found immediately and therefore were not accessible to staff. The Facility has, in addition to the record, a Share drive on the computer network, set up by Unit, Home, and Individual. This drive provides a location for electronic files of assessments and other information. The information on the drive is available to clinicians on an individual's PST. This accessibility has the potential to improve interdisciplinary process by making information easily accessible. The Unified Record Keeping policy does not address this share drive and the records kept on it. The Facility should, in some manner, address this system in policy. The Facility has at least three separate processes for auditing records. These include audits by the Unified

	Records Coordinators of at least five records monthly (the audits required by the Unified Record Keeping policy), audits by Program Auditors, and audits by nurses of nursing documentation. Although this is a good process for ensuring that a great deal of auditing is done, these three processes are not coordinated. Staff carrying out one of these processes do not know what is audited by the other audit processes, there is no intentional overlap of items checked, and there is no sharing of data to provide information on trends. These processes provide a valuable opportunity to identify trends, to ensure that different auditors reviewing the same records agree on presence or absence of documents and on quality of documentation (when that is part of an audit), and to provide information that helps improve documentation and recordkeeping. The Facility should take advantage of this extensive auditing by developing a means to coordinate the audits. Findings from the audits by the Unified Records Coordinators are sent to residence directors for corrective action. There was no procedure requiring confirmation that corrective actions have been done. Trending of the types of deficiencies had not begun for these audits. The Facility had developed or revised numerous policies. The Facility developed a process to review and revise policies and to approve newly developed policies. A Policy and Procedure Committee met regularly to carry out this responsibility. This list of new and revised policies shows significant progress, although not all necessary policies are yet in place. Many of the policies were recently implemented, and implementation was not yet complete or entirely accurate. The Facility did not have a system to assess utilization of records in making decisions. The BSSLC Unified Record Keeping policy (Step I.D) requires that information from the unified record be used at PSP and PST meetings in developing the individualized programs and services to be provided to individuals. However, examples found throughout this report demonstrate that this did not always occur.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Conversion to the unified record format to comply with requirements of Appendix D was completed November 26, 2010, with the Individual Notebooks (All About Me books) implementation completed December 1, 2010. The two Unified Records Coordinators trained staff including DCPs on all shifts. Training included review of the index; where and under what headings documents should be filed; and what contents would be found in the program record binder, medical record binder, and individual record. Review by the monitoring team verified that all records have been converted. Recordkeeping is to follow the BSSLC Unified Record Keeping policy. This BSSLC policy provides information specific to that Facility and is consistent with DADS Policy 020.1 Recordkeeping except that: • The definition of Master Record includes only documents thinned from the Active Record and not documentation regarding the individual's legal status as	Noncompliance

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		required in DADS policy 020.1 Recordkeeping. • The BSSLC policy does not include the statement from DADS policy 020.1 that "Only authorized persons with a need to know may view the individual's record. The individual is always authorized to review his/her record." Active Records were usually kept in two binders. One binder is the Program record; the other is the Medical record. In some cases, records for an individual were too voluminous for two binders. For example, most individuals residing in Driscoll homes required two Medical binders. A few people require more than three binders, but this was not common. A Record Order and Maintenance Guidelines template provided a standard table of contents for each number of binders required; the use of this template as the table of contents provided consistency in the order of documents and in where the binder contents were divided when more than two were required. The outside of each binder is marked to identify whether it contains the Program or Medical record and, if more than one of these, which one (e.g., Medical 1, Medical 2). This made it easy to find the binder with the information needed. Review by the monitoring team verified that this was consistently done. Policy permits a variety of designated staff to file documents. Some units have all filing done by a clerk; in others, a clinician or QMRP may do some filing. There is no documentation of who is designated to file other than file clerks. Because the Record Keeping policy appropriately requires competency based training for all individuals responsible for maintaining Active Records, the Facility should keep a record of all individuals who are designated to file documents and check that against training records. The Unified Records Coordinators reported that the QMRP and Nursing staff thin the Active Record at the time of the annual PSP meeting, based on the purging schedule. Because this is done at the time of the PSP meeting, documents may be in the record longer than identified in the Record Order & Maintenance Guidelines. Furthermore, nurses may thin records throughout the year if the records are becoming too large. It would be advisable for the Facility to clarify this in procedures and develop a process to ensure that all thinned records are sent to Central Records to be filed in the Master Record. Overflow records are sent, per DADS procedure, to an outside storage, where they are kept until the retention period (for most documents, 10 years) is over and are then destroyed. The Unified Records Coordinators report they can get those records usually within a day of requesting them if they are still within the retention period. Data collection and observation notes are entered into the All About Me book. Each month, the QMRP is responsible for moving the prior month's data and observation notes	

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		to the Active Record. Review of two Individual Records and Active Records for the same individuals confirmed that this was done for two out of the two records, except as noted below in examples of items missing from Active Records. Three records were reviewed in detail to audit completeness and accuracy of filing. In addition, all members of the monitoring team gathered information on completeness and accuracy of records as part of review of documents. Although most components required for a usable and accurate record were available, none of the three records reviewed in detail met all standards of Appendix D or the Record Order and Maintenance Guidelines. The following are a few examples of missing or incomplete documentation or documents misfiled. • Three of three unified records reviewed included an active record. • Two of three unified records reviewed included an individual notebook. • For three of three records, the records were legible throughout. • For three of three records, the record had a table of contents (the Record Order and Maintenance Guidelines). • None of the three records had all required documentation in the correct order. In addition, problems were found in other records reviewed by the monitoring team. Following are a few examples: o In all three records, the PSPA-Rights Restriction and HRC Review form(s) completed since the Rights Assessment had been done were filed in front of the Rights Assessment. This made sense but did not match the Record Order. However, for Individual #595, some of these forms were filed behind the Rights Assessment. o For three of three records, the order in the Specific Objectives/Progress Notes did not match the Record Order. o Consents for Medication for Behavior Support documents for Individuals #19 (1/11/10) and #513 (10/4/10) did not include the back of the page, which lists side effects. o For Individual #19, the Personal Focus Assessment was filed in the Assessment tab, although that document is not listed in the Record Order. According to Margaret Zwerneman, this was not to be filed in the Active Record. o For Individual #19, there were missing data sheets for some Specific Service Objectives (SSO) and Specific Program Objectives (SPO). o The PSP dated 11/22/10 and the current SPOs for Individual #358 were not in the record. o PSPs were not in the Active Record for Individuals #13 (11/23/10) and #121 (11/1/10). o A consultation for Individual #312 was filed in the record for Individual	

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		#19. o The current Acute Health Management Plan for Individual #19 was not in the record. o For Individuals #19 and #513, Neuro checks were filed in the MAR/TOR tab instead of the Nursing tab as indicated in the Record Order. o For Individual #513, there was no photo in the Program binder and no photo or profile sheet in the Medical binder. o For Individual #513, the Social History tab, Rights tab, PSP tab, and Habilitation Therapy tabs were empty of documents. The Functional Skills Assessment tab had none of the required documents but did have a diet record sheet for January 2011. o The SLP assessment for Individual #50 and the OT/PT assessment for Individual #576 were missing. o For Individual #513, the Diet Record sheet for November 2010 was filed in the Nutrition tab; for Individual #595, the Diet Record sheets for October and November 2010 were filed in the Nutrition tab. o For Individuals #513 and #595, there was no psychological evaluation, although Individual #513 did have in the record a behavior plan evaluation with data on challenging behavior, and Individual #595's record did include a Behavioral Services Review Summary of 7/02/009. o For Individual #595, a PNMP was filed in the midst of SPOs in the SPO tab. o For Individual #595, a PSPA for TIVA was filed but there was no Pre-Sedation Assessment in the Restraints tab. o For Individual #595, there were no Observation Notes from 9/19/10 until 11/410 and none since 11/4/10. o For Individual #595, the All About Me book did not have a data sheet for the SPO with the goal to "manipulate instruments." • Three of three records had all documentation typed or using non-erasable pen. • For three of three records, signatures or initial legends were consistently provided. • In three of three records, there were examples of gaps between entries. These were not common, but they each had blank lines at the bottoms of one or more pages, and Individual #595 had a half-page gap following a 12/27/10 Physician's Order. • Three of three records were in chronological order. • None of the three records had any indication of falsification. There were no instances of data recorded before the correct time period. • Three of three Active Records were accessible to staff. However, records of other individuals were not easily found when requested by the monitoring team.	

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		o The second Medical binder for Individual #576 was not immediately found. o The Program chart for Individual #13 was not immediately found. • Except in the case of Individual #513, DCPs were able to find All About Me books for each individuals checked. They were able to point out where in each book they were to find program and service instructions and to enter data and notes. Not all documents that had been in the records prior to conversion are still found there. It was unclear whether instructions had been provided to QMRPs to indicate where those documents should be filed or maintained. Furthermore, some documents that were filed in the record were not listed on the Record Order, which may have accounted for some of the variability in where documents were filed. The Facility might wish to survey QMRPs and clinicians to identify any documents for which filing instructions should be provided. BSSLC maintained a share drive in which assessments and other documents were placed to make them accessible to PST members. This drive, which is set up by Unit, Home, and individual, has a behavioral section, social section, nursing/medical section, programming section, consent section, risk assessment section, personal preferences section, and staffing (annual PSP and PSP Addendums) section. Any discipline has access to all sections. DCPs do not have access to this drive, but most documents are also in the Active Record. This accessibility has the potential to improve interdisciplinary process by making information easily accessible. The Unified Record Keeping policy does not address this share drive and the records kept on it. The Facility should, in some manner, address this system in policy.	
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 continued to develop and revise policies. DADS provided a listing of policies in development and revision that included implementation dates. Review of policies during this visit found the listing to be accurate. Several policies remain in development or were recently implemented. For example, the policy on At-Risk Individuals was implemented 1/1/11. The policy on Consent is in process of review prior to final approval. Three important policies have been developed, been approved by facility management, and are in the process of being implemented: BSSLC Policy Quality Assurance Process (11/22/10), BSSLC Policy Quality Assurance/Quality Improvement Council (10/5/10), and BSSLC Nursing Peer Review Policy (12/10/10). Some policy development or revision is waiting for final approval of statewide DADS policies. For example: • As reported in Provision U1, prioritization of need for guardianship is awaiting approval of the DADS Guardianship policy.	Noncompliance

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		• Many of the nursing policies, procedures, and protocols were still in draft waiting for final approval from the State Office. • The Facility did not have a functional or draft DUE policy and reported that they are awaiting finalization of a Statewide policy for their DUE process. The Facility developed a process to review and revise policies and to approve newly developed policies. A Policy and Procedure Committee met regularly to carry out this responsibility. Minutes of 11 meetings held from 09-22-2010 through 12-17-2010 were provided to the monitoring team. The Facility Director, Medical Director, and Settlement Agreement Clerk attended every meeting. Other regular attendees included the CNE and ADOP (who began attending while serving as QA Director and still covers that role pending filling the vacancy in that position). The minutes list attendees, policies reviewed, outcome of the review (approved, resubmit, tabled, terminated) and comments (such as "Will make minor corrections" or the date that a tabled policy will be brought back for review). The Facility has reviewed numerous policies since this process began. According to the list of Approved Policies for BSSLC, 76 policies were approved between 9/22/10 and 121710. The list does not indicate which policies were newly developed, which were revised, and which were approved without revision. The monitoring team reviewed a number of policies that were necessary to implement Part II of the SA. This list indicates the Facility was actively developing and revising policies to meet the requirements of this provision. This list shows significant progress, although not all necessary policies are yet in place. • Dental, a new policy, was approved 10-18-2010. • Medical and Dental Restraint has a revision date of 12-10-2010. • Physician Procedures and Best Practice Guidelines, a new policy, was approved 10-18-2010. • Quality Assurance has a revision date of 11-22-2010. • Quality Assurance/Quality Improvement Council has an approval date and a revision date of 09-30-2010. • Protection from Harm—Abuse, Neglect, and Incident Management did not have an approval or revision date. The approval date of 12/10/2010 was listed on the Approved Policies for BSSLC. • Personal Support Plan Process had an approval date of 12-10-2010 and no revision date (indicating it was a new policy), but the Approved Policies list had an approval date of 12-17-2010. • Restraint for Behavioral Crisis has a revision date of 11-22-2010.	

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		Reviews of these policies and of how they were being implemented can be found in relevant sections of this report. Many of the policies were recently implemented, and implementation was not yet complete or entirely accurate. The Facility needs to develop procedures to ensure that policies are trained and are implemented accurately.	
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.	BSSLC had begun the process of audits. In fact, the Facility had several types of audits—the unified records audits developed to meet the requirements of this provision and at least two other audits. This was an excellent beginning that could be enhanced by coordination of those different audit processes. The BSSLC Unified Record Keeping policy includes a requirement for auditing a minimum of five records monthly. The policy states, "Noted deficiencies will be monitored for corrective actions." The Facility has at least three separate processes for auditing records. These include audits by the Unified Records Coordinators of at least five records monthly (the audits required by the Unified Record Keeping policy), audits by Program Auditors of three active records per month for each of three auditors and of an individual's record within five days following each unusual incident (or 24 hours following a DADS-reportable incident), and audits nurses of nursing documentation in the Active Records by nurses from other units (all of which are reviewed by the QA nurse). Although this is a good process for ensuring that a great deal of auditing is done, these three processes are not coordinated. Staff carrying out one of these processes do not know what is audited by the other audit processes, there is no intentional overlap of items checked, and there is no sharing of data to provide information on trends. These processes provide a valuable opportunity to identify trends, to ensure that different auditors reviewing the same records agree on presence or absence of documents and on quality of documentation (when that is part of an audit), and to provide information that helps improve documentation and recordkeeping. The Facility should take advantage of this extensive auditing by developing a means to coordinate the audits, including identifying which components should be reviewed by each auditing process, which components should be reviewed by more than one of the auditing processes, and determining what information should be shared among the auditing processes and used to identify trends and areas for which corrective and improvement actions should be planned. The audits by the Unified Records Coordinators began in November 2010. The QA nurse also has information from audits beginning in November 2010, but new audit tools were put into place in January. Program auditors have been auditing for at least three years, but two of the auditors have been in this position only since October 2010. Because the Unified Records and nursing audits began recently, tracking and trending of the data has	Noncompliance

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		not begun. This should begin following review of January audits for the unified record audits. As a coordinated audit process is put into place, more comprehensive trending should be possible. Summary reports of record audits by the Unified Records Coordinators were provided for November and December 2010. The reports list the date, reviewer (often both coordinators), Unit/Home, Individual whose record was audited, portion of the "chart" reviewed (in all cases, this was listed as "Entire"), and "Comments" (which listed missing documents, signatures or legends needed, items which should not be filed in the record, documents filed in wrong places, items needing thinning from the record, and items noted as "thinned and taken to Records." The Unified Records Coordinators reported that the SAC sends emails to residence directors with findings so they can get with discipline staff to make corrections by the 10th of the following month. The Facility has not developed a process to confirm that corrections have been completed. A report was prepared monthly listing the items needing correction for each record. This is to be presented monthly to the QA/QI Council for review and possible action. No procedure for trending this information had yet been developed. At the QA/QI Council meeting observed by the Monitoring Team, and confirmed by the minutes, there was mention that procedures for trending will be developed. The program auditors used a completely different "Chart Audit Form" that reviewed different items. While there was some overlap (for example, the Chart Audit Form checked whether the assessments for self-administration of medication and for water safety were filed), the audit by the program auditors checked content of several items (such as whether all action steps are reviewed in Monthly Reviews and whether data sheets show that the number of sessions needed to meet criteria were offered). The two audits (by the Unified Records Coordinators and the program auditors) have the potential to combine into an effective and useful system that could provide one model for how other facilities could audit both presence of documents and quality of services and documentation. However, there were some conflicts between the requirements of the Chart Audit Form and the Active Record Order and Maintenance Guidelines. For example, the Chart Audit Form checked whether there were six months of data sheets on file for active SPOs, whereas the Maintenance Guidelines specified there should be Progress Notes (which serve as the data sheets) from one PSP quarterly review to the next. The Facility needs to resolve any such inconsistencies between the two audits. Program auditors reported that information from their audits was provided to the QMRP Coordinator, the Lead QMRP for the appropriate unit, and the individual QMRP. Although the program auditors had trending information, there was no indication provided to the monitoring team of any actions taken as a result of information on	

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		trends.	
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.	The Facility did not have a system to assess utilization of records in making decisions. The BSSLC Unified Record Keeping policy (Step I.D) requires that information from the unified record be used at PSP and PST meetings in developing the individualized programs and services to be provided to individuals. Examples in which the PST was unaware of information in the record or did not use that information in PSP planning include: • Individual #20 is a teenager whom the monitoring team has observed over the course of the past year. Considerable progress in the areas of appropriate social behavior and communication was evident during this year's PSP meeting. The individual expressed a desire to attend the Boys and Girls Club. The team agreed later in the meeting to look into it. No member of the team expressed any awareness that this was discussed and included in last year's PSP as an Action Plan. A review of the individual's record later revealed no action taken other than a single note that a referral to Program Services had been made on 1/22/10. Similarly, the PST discussed whether swimming might be of interest to the individual and suggested it would obtain a swimming assessment. The team expressed no awareness that a water safety assessment had been complete in 12/09. A review of the record also revealed the individual went swimming at the aquatic center with peers and staff on 8/10/10. The eventual outcome of this PSP was that most of the action plans were the same or a slight variation of the past year's plan. • For Individual #294, who had numerous medical conditions on the active problem list, a physician was not present at the annual PSP meeting. The PST was unaware of several of the medical conditions, including a history of intestinal parasites that could be related to rectal digging. Without the presence of the physician or recognition of the potential contribution of parasites to rectal digging, a PBSP for that behavior was initiated. There were some abbreviations used in the documents that were not in the Facility's standardized abbreviation list. The use of abbreviations not included on the Facility's standard abbreviation list limits the interpretation of the clinical data for disciplines not familiar with the abbreviations used. As noted in Provision M6, the PNMPs at Driscoll D, PNMPs were filed in a separate section of the Medication Administration Book rather than in the MAR, which made them less accessible and less likely to be reviewed when administering medication. As reported in Provision K4, behavior data graphs were reviewed on a monthly basis in	Noncompliance

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		some context. It was not clear, however, that the interdisciplinary team was involved in this review process, or that the review produced meaningful changes in intervention strategies or behavior. As noted in Provision K11, a Flesch-Kincaid Grade Level was obtained for the direct service staff instructions in the five most recently written PBSPs. Microsoft Word 2010 was used to obtain readability statistics. The measures revealed that direct service staff instruction consistently fell within the 7th to 8th grade reading level. Interviews with direct service staff, as well as residence administrators, indicated that staff infrequently experienced problems understanding PBSPs.	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. Because the Record Keeping policy appropriately requires competency based training for all individuals responsible for maintaining Active Records, the Facility should keep a record of all individuals who are designated to file documents and check that against training records.
2. Clarify procedures to ensure guidelines for thinning records are consistent and develop a process to ensure that all thinned records are sent to Central Records to be filed in the Master Record. Ensure that the same guidelines are used as standards for all records audits.
3. Address in policy the Share Drive system and its relationship to the Unified Record.
4. Develop procedures to ensure that policies are trained and are implemented accurately.
5. Develop a formalized system to ensure corrective actions are completed for deficiencies found in unified records audits. The system should include checks of a sample of corrections to ensure accuracy of notice of completion.
6. Coordinate the multiple systems for auditing records, including identifying which components should be reviewed by each auditing process, which components should be reviewed by more than one of the auditing processes, and determining what information should be shared among the auditing processes and used to identify trends and areas for which corrective and improvement actions should be planned.
7. Begin tracking and trending of information on deficiencies identified in unified records audits. As the multiple audit systems are coordinate, determine which information should be trended.

The following are offered as additional suggestions to the facility:

1. The Facility might wish to survey QMRPs and clinicians to identify any documents for which filing instructions should be provided.

List of Acronyms Used in This Report
Brenham State Supported Living Center
January 10-14, 2011 Compliance Visit

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ACP	Acute Care Plan
AED	Anti-Epileptic Drug/Automated External Defibrillator
ADHD	Attention Deficit/Hyperactivity Disorder
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BPH	Benign prostate hyperplasia
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CBC	Criminal Background Check
CDC	Centers for Disease Control and Prevention
C-Diff	Clostridium Difficile
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
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
CSO	Campus Supervision Overnight
CTD	Competency Training and Development
CV	Curriculum vitae (resume)
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
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/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FFA	Face to Face restraint assessment
FBASE	Fundamental Behavior Analysis Skills Evaluation
FIRM	Facility Integrated Review of Medication
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
HIV	Human Immunodeficiency Virus
HMP	Health Maintenance Plan
HOB	Head of Bed
HRC	Human rights committee
HO	Human Rights Officer
HST	Health Support Team
IBW	Ideal Body Weight
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Notes
ISP	Individual Support Plan
i.v.	Intravenous
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

MRP	Medication Response Profile
MRSA	Methicillin-resistant Staphylococcus Aureus
NA	Not Applicable
NANDA	North America Nursing Diagnosis Association
NCP	Nursing Care Plan
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NP	Nurse Practitioner
OCD	Obsessive Compulsive Disorder
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
O2Sat	Oxygen saturation
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics Committee
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCD	Planned Completion Date
PCP	Primary Care Physician
PDB	Physically Disruptive Behavior
PDD	Pervasive Developmental Disorder
PDP	Personal Development Plan
PFA	Personal Focus Assessment
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMOC	Psychoactive Medication Oversight Committee
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PNM	Physical and Nutritional Management
PNMC	Physical and Nutritional Management Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth, oral
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
PTM	Psychotropic Medication
PTR	Psychiatric Treatment Review
PTSD	Posttraumatic Stress Disorder
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
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SFA	Structural and Functional Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center
SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SPOI	Supplementary Plan of Improvement
SQRA	Standard of Quality for Risk Assessment
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
TIVA	Total Intravenous anesthesia
TD	Tardive Dyskinesia
TURP	Post transurethral prostate resection
UIR	Unusual Incident Review or Unusual Incident Report
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus