United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
July 25-29, 2011

Date of Report: October 12, 2011
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Introduction

Background

In 2009, the State of Texas and the United States Department of Justice (DOJ) entered into a Settlement Agreement regarding services provided to individuals with developmental disabilities in state-operated facilities (State Supported Living Centers), as well as the transition of such individuals to the most integrated setting appropriate to meet their needs and preferences. The Settlement Agreement covers 12 State Supported Living Centers (SSLCs), including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) component of Rio Grande State Center.

Pursuant to the Settlement Agreement, the parties submitted to the Court their selection of three Monitors responsible for monitoring the facilities' compliance with the Settlement. Each of the Monitors was assigned responsibility to conduct reviews of an assigned group of the facilities every six months, and to detail findings as well as recommendations in written reports that are submitted to the parties.

In order to conduct reviews of each of the areas of the Settlement Agreement 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.

Although team members are assigned primary responsibility for specific areas of the Settlement Agreement, the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members share information routinely and contribute to multiple sections of the report.

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

Methodology

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

(a) **Onsite review** – During the week of the 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. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(c) **Observations** – While 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, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the facility.

Organization of Report

The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement, as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement. The report addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement. This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;
c) **Summary of Monitor's Assessment:** Although not required by the 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:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the facility to move toward compliance, obstacles that appear to be impeding the facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

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 and 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.

The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Susie Johnson, and for the assistance provided by Chelsea Howard. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations the Monitoring Team needed. In addition, the following people worked closely with specific Monitoring Team members to ensure efficiency of the whole process of review: Jackie Gertman, Juanita Taylor, Caitlin Connor, Melissa Moehlmann, Brandy Todd, Tammy Pavlu, and Michael Appling.

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 the Facility 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.

Given the number of issues identified during the baseline review, it was expected that the change processes would take time. During this review, it was clear that the staff at the Facility had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas, progress had been made. In other areas, the foundation had been laid for change. In some areas, concerted efforts need to be made over the next six months to make the necessary improvements.

Population of the Facility at the beginning of the compliance visit was 317 individuals, a reduction of 17 individuals since the last compliance visit.

General Comments

Changes in Key Staffing. The Facility demonstrated significant improvement in many areas of the Settlement Agreement requirements. In some areas, progress was slower. Staff turnover and vacancies in key positions, such as Medical Director and

Director of Quality Assurance were limiting factors. As those positions are filled, the Monitoring Team would hope to see greater progress across all Sections.

Facility Self-Assessment. The Self-Assessment and Plan of Improvement could be revised to be more effective at both assessing and reporting status and at doing and documenting effective planning to meet the requirements of the Settlement Agreement. For the most part, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit. The POI should describe, in addition to the self-rating of compliance:

- The activities the facility engaged in to conduct the self-assessment of the provision. This might include sampling, observations, implementation of their self-assessment tools, etc.
- How the facility used the findings from these activities to determine substantial compliance or noncompliance.

Separately in each Section of the POI, the Facility also provided a list of action steps to be done. Some of these steps build on each other and were presented in an appropriate order. Others were simply additional tasks to be done. It would be helpful if the Facility were to plan actions to accomplish specific goals and requirements, and present them in a way that shows an organized approach that can be tracked. These, along with measures of outcome, could provide the framework for reports of status. The Facility should consider how it may use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

Following are specific findings for each Section of the Settlement Agreement:

Restraints

Significant improvements had occurred in management of restraints, including policy revision and staff knowledge of policies, quality and accuracy of documentation, and review of restraints. At this time, however, use of restraints for crisis intervention was trending upward. Nevertheless, the Facility demonstrated a commitment to reducing the use of protective restraint.

- Positive Practices and Improvements Made
  - Since the last review BSSLC revised both policies that govern restraint use: Restraint for Behavioral Crisis Policy (6/8/11) and Medical and Dental Restraint Policy (6/18/11) consistent with recommendations made by the Monitoring Team. Both policies are comprehensive and are directed to the practices necessary to achieve compliance with the Settlement Agreement.
  - The quality and accuracy of the documentation associated with episodes of physical and chemical restraint improved significantly since the last review. Staff were more knowledgeable of restraint policies and procedures.
  - The Facility had taken the initiative to create an electronic version of the State-required Restraint Checklist and Face-to-Face Assessment/Debriefing documents (FFAD). This facilitated improved internal review of restraint

documentation by the Facility, and external review by the Monitoring Team. The Facility is to be commended for this initiative.

- The Facility restraint review process was more extensive and comprehensive than observed at the last review, including a process of post restraint review by a psychologist that is more extensive than that recorded on the FFAD by the restraint monitor. This review by a psychologist is more clinically oriented and occurs soon after the restraint episode ends. It provides important data that is not recorded on the FFAD. The Facility is to be commended for this initiative. Additionally, the Facility is piloting an additional review process that would occur several days after a restraint episode. This review process would have a psychologist review the restraint episode with those staff involved in the restraint in a more reflective, collaborative, and integrated manner than what typically can happen in the immediate aftermath of a restraint episode. The Facility is to be commended for this initiative.

- Improvements Needed
  - Restraint use for crisis intervention at BSSLC is trending up. Despite this there were individuals for whom the frequency of restraint was significantly less during this review period than the last review period. The Facility needs to identify the reasons for the upward trend and determine whether to establish a plan to reduce restraint use.
  - Little improvement in the management processes associated with medical restraint was observed by the Monitoring Team. Little data was being tracked and trended. The Facility was unable to produce an accurate list of individuals who had medical restraint. Treatments or strategies to minimize or eliminate the need for medical restraint were not implemented consistently or not at all. Significant improvement is needed in this area.

<u>Abuse, Neglect and Incident Management</u>

The Facility revised policy and had taken steps to ensure staff are aware of policy, including reporting abuse, neglect, and exploitation. Investigations were thorough and documentation from the investigations was reviewed at management levels. Allegations of abuse and neglect were trending up; this could be a result of the additional training and of the availability of the cameras monitoring activity in public areas rather than an increase in abuse or neglect, as the number of unusual incidents and injuries had decreased during the same time; this will require further review by the Facility. According to the 6/30/11 Trend Report, abuse/neglect allegations were trending up. For FY2011 there was an average of 18 allegations/month in quarter one, 23/month in quarter two, 28/month in quarter three, and 28 in the first month of quarter four. According to the 6/30/11 Trend Report, UIRs (other than A/N) were trending down. For FY2011 there was an average of 12 UIRs/month in quarter one, 10/month in quarter two, 7/month in quarter three, and four in the first month of quarter four. According to the 6/30/11 Trend Report, injuries were trending down. For FY2011 there was an average of 291 injuries/month in quarter one, 256/month in quarter two, 262/month in quarter three, and 243 in the first month of quarter four.

- Positive Practices and Improvements Made

- Since the last review the BSSLC has revised its Abuse/Neglect/Incident Management policy to reflect recommendations from the Monitoring Team. The Facility has also undertaken significant steps in retraining staff and engaging in competency checks. This was evident when the Monitoring Team interviewed Direct Care Professionals (DCPs).
- The process the Facility used to review investigation reports (the Abuse/Neglect/Exploitation Committee) and the documentation that results from this review are thorough and ensure regular executive management level review of such incidents.
- The scope of the tracking and trending of incidents has been expanded. The Facility has initiated a process for under-reporting of injury audits.

- Improvements Needed
  - There continues to be a problem with investigations of abuse and neglect being initiated within the required 24 hours (or sooner, if necessary) of discovery/reporting.
  - The process, and related documentation, of Facility investigations of serious discovered injuries needs improvement.

Quality Assurance

The Facility has been making efforts toward improving its quality assurance program. This has been hampered by the turnover in the position of director of Quality Assurance. Nevertheless, planning was ongoing. The Monitoring Team was provided with a list of 50 monitoring tools that are in various stages of implementation and data collection. A process is in place to disseminate corrective action plans and follow-up on the implementation of those plans when specific problems are discovered through monitoring.

The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes:

- Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department.
- Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders.

BSSLC was engaged in considerable work activity related to development of specific actions necessary to correct specific or individual problems discovered through monitoring and auditing. For some monitoring tools the results of the monitoring was

producing summary data that could be useful for the broader QA analysis presented as strategy two. There was very little evidence that the QA activity at the BSSLC had begun to address the second strategy.

- Positive Practices and Improvements Made
  - BSSLC was engaged in considerable work activity related to development of specific actions necessary to correct specific or individual problems discovered through monitoring and auditing.
- Improvements Needed
  - Although BSSLC tracks most data required in the SA, the integrity of those data was not always clear. For example, in reviewing separate logs of injuries for the same time period and same individuals the dates and times of injuries that should have matched did not.
  - As with the injury data, data in the trend report had apparent discrepancies. The Monitoring Team, in reviewing two pages of the trend report, would have expected certain data to match on each page. It did not.
  - In some areas the reporting of trend data could be expanded to be useful for process improvement decision-making. For example, it may be useful for injury tracking and trending to provide some level of summary analysis where now the report merely presents numbers.

<u>Integrated Protections, Services, Treatments and Supports</u>
The "Supporting Visions" process had continued; some improvement in team member participation was noted. Quality Assurance processes had been put in place. However, the PSP format and process was hampered by failure to conduct and post comprehensive assessments that could identify the individual's strengths, preferences, and needs.

- Positive Practices and Improvements Made
  - The Facility continued to implement the "Supporting Visions" PSP process, which was intended to reinforce the concept that planning is intended to support the individual's vision for the future for him/herself. Some improvement in the area of team member participation in the PSP had been noted, and this was particularly evident with the participation of Direct Care Professionals.
  - The Monitoring Team was also pleased to see additional training, coaching and mentoring being provided to the QMRPs and PSTs. These initiatives, which included the Q-Construction facilitation skills training and follow-up as well as a dedicated external consultation on the development of quality PSPs, were recent developments, but demonstrated some promise for enhancing the PSPs at BSSLC.
  - The Facility had implemented additional quality assurance processes that intended to identify and remediate the most apparent problems observed during a PSP meeting. The Monitoring Team commends the Facility staff for this quality assurance activity and encourages ensuring careful documentation of follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold.

- Improvements Needed
    - The new PSP format, and process was being implemented at BSSLC with limited success specific to the requirements of this section of the SA. No meaningful preparation was provided to ensure the PFA and/or PSP processes were conducted in a manner that facilitated real participation by the individuals. PST members often came to planning meetings without a basic knowledge or awareness of an individual's current status or needs. In addition, PSTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
    - PSPs did not consistently specify 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 and meet identified needs.
    - Identification of barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.

Integrated Clinical Services

The Facility has taken many steps toward providing clinical services in an integrated manner. Several initiatives were in place. However, most of the participation remained multidisciplinary with limited evidence of joint planning and case formulation.

- Positive Practices and Improvements Made
    - Participation by disciplines jointly in review of restraint, development of PBSPs and integration within those of pharmacological treatment, and provision of timely information on status of individuals in hospital.
    - Although (according to the POI), work remains to have all clinicians trained in the process of review and documentation regarding recommendations by non-Facility clinicians, reviews by the Monitoring Team found that the new documentation process ensured that there was evidence of such review.

- Improvements Needed
    - Collaboration currently was mostly provision of information across disciplines. Clinicians need to understand and implement joint planning and case formulation.

Minimum Common Elements of Clinical Care

Although progress had been made in completing assessments, completion of assessments was still in progress. The use of clinical indicators was not formalized, nor were clinical indicators used to identify areas for systemic improvement.

- Positive Practices and Improvements Made
    - Progress had been made in completing assessments and evaluations. The current process shows promise of completing the initial psychological and psychiatric assessments.

- Diagnoses were consistent with the current DSM and ICD.

- Improvements Needed
  - There is still considerable variability in completion of assessments across disciplines; the Facility will need to ensure that other clinical assessments are done and posted timely and permit the PST to make reasonable decisions about treatment and interventions.
  - The Facility must develop processes to ensure individuals are assessed when they show changes in health or behavioral status, or when no progress occurs following an extended period of planned treatment.
  - Because there was a gap in completion of assessments and evaluations, the Monitoring Team could not determine that all diagnoses clinically fit the assessments and evaluations.
  - Although physicians reported they use standard clinical indicators in providing care, there were no clinical pathways or guidelines in place. Furthermore, the Facility did not have in place a process to use clinical indicators to review systemic health issues.

<u>At-Risk Individuals</u>

The new risk assessment process had been implemented, but much work remained to ensure risks are identified accurately and lead to appropriate assessment, monitoring, supports, and services.

- Positive Practices and Improvements Made
  - The new statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated.
- Improvements Needed
  - The BSSLC processes to demonstrate compliance with this section of the SA were insufficiently organized to achieve the desired results.
  - In 76% of records sampled, risk assessments were not conducted within five working days of risk identification or a change in circumstances.
  - Professional staff implementation of the Risk Assessment policy was inconsistent indicating a need for additional training and professional oversight.
  - Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not apparent to the Monitoring Team. For example, in most records sampled, the Monitoring Team determined that assessments were not sufficiently comprehensive to enable interdisciplinary discussion. The lack of work flow organization, and professional oversight of the risk assessment process, prevents the BSSLC from identifying risk timely and appropriately, which in turn prevents the development of timely and appropriate risk mitigation plans.

<u>Psychiatric Care and Services</u>

Psychiatrists were board-certified. Improvements had been made in evaluations and screening for side effects. Nevertheless, there was still a need to complete psychiatric evaluations and to integrate care through combined assessment and case formulation.

- Positive Practices and Improvements Made
  - Psychiatrists were all board certified, and they actively and appropriately participated in the interdisciplinary process.
  - 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, the Monitoring Team's observations of meetings showed that there was active member participation. Improvements were noted in the psychiatrists' identification of the reason that each medication was used, and how it was linked to behavioral characteristics of the identified psychiatric disorder.
  - The quality of recent psychiatric evaluations was high, and all met the requirements of the provision.
  - A good process was in place to provide Reiss screens to individuals who required them.
  - 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. Oversight of psychotropic medications practices was significantly enhanced by the development of a software program that tracks Facility use of all classes of psychotropic medications.
  - New formats for informed consent demonstrated that medical decision makers (LARs) were provided with needed information about medications, and the process of consent typically included a conversation between the decision maker and the treating psychiatrist.

- Improvements Needed
  - Only about 55% of individuals who received psychotropic medication had received psychiatric evaluations. A total of only 31 evaluations had been completed, and there were 168 individuals who needed them.
  - The response to each medication treatment must be tracked with a least one measure that is linked meaningfully to the psychopathology targeted by the medication.
  - The Facility has made significant improvements in the medical/nursing monitoring for safety during medical and dental pre-treatment sedation, but for oral and intramuscular pretreatment sedation the way this was done varied considerably from case to case. Many individuals did not have treatment plans to minimize or eliminate the need for the pre-treatment sedation, there was no process in place to evaluate the effectiveness of the plans, and no data on pre-treatment sedation rates was reviewed at the Restraint Reduction Committee.
  - A process was not in place to provide integrated behavioral care through combined assessment and case formulation.

- Primary Care Physician (PCP) and Nurse participation in decisions about new medications was not properly documented.
- In many cases, physicians did not document their review of nurse ratings for side effects.

Psychological services

Although the Facility had made a commitment to increasing the skills of psychologists in preparation of interventions, this had not yet been reflected in improved quality of programs. The Facility was addressing that through peer review and was engaged in planning to address this issue.

- Positive Practices and Improvements Made
  - The Facility had achieved progress with the peer review process. Steps taken by the Facility included enhancing the documentation and review of internal peer review, the addition of the "First Reviewer" process to internal peer review, and the contract with Texas State University to provide external peer review. In addition to peer review improvements, the Facility had ensured that all PBSPs were reviewed by a BCBA on a monthly basis.

- Improvements Needed
  - BSSLC entered into a contractual agreement for the provision of intellectual and adaptive testing. The review indicated that testing was progressing at an adequate pace, and that the testing reports included information that could be beneficial to the development of skill acquisition programs. However, there was still a significant list of people needing evaluation.
  - The Facility failed to use available data to revise behavior interventions promptly and effectively.
  - The Psychology and Psychiatry disciplines were working more closely than in the past.. There continued to be several limitations, however, in this integration. Record reviews reflected that symptoms of mental illness were seldom incorporated into the behavior assessment process.

Medical Care

The Monitoring Team had identified significant improvement in many areas of medical services. Still, a number of issues requiring improvement remained. The vacancy in the position of Medical Director may limit the pace at which improvement will occur.

- Positive Practices and Improvements Made
  - All diagnostics, including laboratory studies were commented upon. Documentation by the Clinician had significantly improved. Follow-up to acute medical conditions had improved.
  - The Monitoring Team compliments the State Office and Facility for developing and implementing a Medical Provider Quality Assurance Audit process. The process enables the State Office and Facility to identify many

compliance issues associated with Clinicians at the Facility and will enable quality enhancements system wide. The State Office and Facility continue to develop a mechanism that will enable the assessment of standard of care practices of Clinician Staff by incorporating standard of care benchmarks to the assessment process.

- Improvements Needed
  - On-going follow-up and documentation of chronic care issues remains an area that requires continued enhancement.
  - System issues, especially the ability to track medical conditions and treatments, and enable effective scheduling of consults, diagnostics and follow-up on medical issues, continue to be major barriers to the provision of medical services at the Facility.
  - The ability of direct care staff to identify signs and symptoms of medical exacerbations and report to nursing staff and nursing staff ability to perform meaningful assessments and appropriately report medical conditions to physicians also remains a barrier to the delivery of health appropriate care by the Clinician.
  - The Facility had not developed a mechanism to assess medical quality outcome measures at the Facility.

Nursing Care

Many improvements had been made in Nursing Services. The most notable was the development of an exemplary Medication Error Database and subsequent reduction in medication errors. Nevertheless, there are significant improvements needed.

- Positive Practices and Improvements Made
  - The Facility had maintained a stable nursing staff. The staffing ratio of nurses to individuals was consistently met during the past six months. There was evidence that the Facility continued to evaluate staffing needs and to realign nursing assignments when needed to strengthen nursing services.
  - All 12 nursing monitoring tools were being completed by the various nursing administration and management nursing staff. Plans of correction were being implemented as deficiencies were identified on the monthly audits, on a unit by unit basis by the Nursing Managers.
  - The availability and organization of the clinical records had continued to improve.
  - There was evidence that all core State and Facility nursing policies, procedures, and processes had been finalized. The Facility had trained 100% of the nursing staff on all policies, procedure, and processes; and they had all been implemented.
  - There was evidence that a concerted effort had been put forth to ensure that the direct care professionals were trained on health maintenance and acute care plans.
  - The Facility had developed and implemented an exemplary Medication Error Database to track, analyze and trend medication errors using a root cause analysis approach. It was readily apparent the Nursing Department had put

forth considerable effort to reduce the incidence of medication errors. A review of medication error data indicated there had been a progressive reduction of medication errors over the past six months.

- Improvements Needed
  - The quality assurance data from the monitoring tools were not aggregated, analyzed and trended campus-wide in order to identify systemic nursing deficiencies and develop systemic plans of correction.
  - There was a delay in filing medical records received in the health clinic from outside providers.
  - The infection control sub-section of this provision also needs continued improvement in reporting, tracking, aggregating, analyzing, and trending infection control related data in order developing systemic plans of correction for identified trends. The infection control nurses need technical assistance to assist with developing a standardized and effective infection control program.
  - The quality of the mock emergency drills need improvement.
  - Although great strides had been made to improve the quality of the nursing assessments, the nursing summaries need continued improvement to critically analyze clinical data derived from the assessments, for each identified nursing problem/diagnosis, to accurately reflect whether individuals' health status was improving, maintaining, or regressing. As the RNs complete the Physical Assessment Class, their enhanced knowledge and skills should improve nurses' ability to critically analyze clinical data and summarize it to accurately reflect individuals' health status.
  - Health maintenance and acute care plans continued to need to be individualized to meet individuals' unique health care needs.

<u>Pharmacy Services and Safe Medication Practices</u>
Pharmacy has taken steps to improve the QDRR process, including physician follow-up. The Pharmacy needs to develop policies and procedures. The Facility needs to implement procedures to address Adverse Drug Reactions (ADRs).

- Positive Practices and Improvements Made
  - The Monitoring Team determined that pharmacists are ensuring that physicians address their recommendations from the QDRRs.
  - The Monitoring Team noted significant improvement with the quality of the QDRR process. QDRRs are more comprehensive and take into account important clinical issues through the review of the nursing assessments, annual medical review, problems list, laboratory results, psychiatric assessments and OT/PT evaluations.
- Improvements Needed
  - The Facility did not have a policy and/or procedure in place that comprehensively addressed the Facility's review process of medication orders. The Facility did not have a formal mechanism that ensured that pharmacy

recommendations were followed up by the Clinician. Review of Single Patient Intervention Reports indicated the need for enhanced follow-up on physician recommendations.
  - Because of staffing issues, the Facility is between four and six weeks delayed in completing QDRRs.
  - At the time of this review, there was no organized process in place to provide on-going tracking and analysis of the use of all benzodiazapines, anticholinergics, polypharmacy and STAT medication use. The Facility continues to rely on selective professional staff to "select" samples for review.
  - The Monitoring Team identified several issues of concern with monitoring of tardive dyskinesia (TD). There is no evidence to support that more frequent monitoring of TD is routinely provided to Individuals, when appropriate. More frequent monitoring should be conducting whenever there is a dosage increase or decrease of an antipsychotic medication and when there are observed changes in behavior and functional abilities of the individual. Also, the Monitoring Team noted that nursing staff were completing the prescriber's component of the drug monitoring assessment tools.
  - The Facility had not implemented a comprehensive, local policy to address ADRs. The Facility did not collect, archive, nor conduct trend analysis on ADR, which is necessary to accurately report on ADRs.
  - The Monitoring Team compliments nursing services on its stellar performance in enhancing the medication variance process at the Facility. Unfortunately, the process remains fragmented among nursing, physician and pharmacy services; there is no unified method to initiate remediation of professionals; pharmacy does not have a meaningful mechanism to conduct longitudinal analysis of medication errors; and there is no unified local policy that clearly and comprehensively outlines the Facility's medication variance process

<u>Physical and Nutritional Management</u>

Although improvements in the Physical and Nutritional Management Committee (PNMC) had occurred, and PNMPs were accessible to staff who needed them and were clear and included pictures, this had not translated into improved implementation of plans.

- Positive Practices and Improvements Made
  - The Physical and Nutritional Management Committee (PNMC) had consistent membership and participation of all relevant disciplines, and a localized policy outlining the roles and responsibilities of the PNMT.
  - PNMPs were readily available to staff. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs.
  - Another positive was that the PNMPs included detailed information regarding adaptive equipment, bathing/showering positioning, transfer information, mealtime strategies as well as communication strategies.:

- Improvements Needed
    - There was no evidence that data were collected and the PST or PNM team were reviewing this data to better identify system issues or respond to recurrent issues on a regular basis.
    - Individuals were not provided with a comprehensive assessment by the PNM team or PST that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day and during nutritional intake. The OT components regarding oral care and medication administration were missing or lacking in detail.
    - PNMPs were not comprehensive due to the plans lacking detailed information regarding oral care and medication administration as well as staff positioning for these activities.
    - Although information was available and accessible, staff were observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned and with safe dining strategies not implemented. Per interview, 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.
    - Although BSSLC had ample frequency of monitoring of PNM, 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.
    - Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem. The clinicians did not conduct routine, proactive review of the plans with frequency based on health risk level.
    - All Individuals receiving enteral feeding 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.

<u>Physical and Occupational Therapy</u>
Statement of Status
BSSLC has 1.5 open positions for PT and 2 positions for OT; filling these should assist in lowering the caseload but these positions had not been filled as of this review.

- Positive Practices and Improvements Made
    - OT/PT assessments continue to be comprehensive.
- Improvements Needed
    - Assessments were completed in accordance to the schedule set forth by BSSLC; however, assessments were not being consistently completed in response to a change in status and are not consistently comprehensive

- 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.
- OT/PT plans were not implemented as written and staff was not knowledgeable of the OT/PT plans.
- A system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions.
- OT/PT assessments need information regarding oral hygiene and medication administration intake as well as positioning strategies for this activities and the lack of clinical justification for recommendation.

Dental Services

Staffing issues were a concern. The lack of appropriate number of Dentists, and Hygienists and limited dental assistance, is preventing progression towards compliance with the Settlement Agreement. At present there is only one dental assistant who is also responsible for all clerical activities; one dental hygienist, who is also responsible for the suction tooth brush program;, and one dentist. The Facility is recruiting one full time dentist and hygienist

- Positive Practices and Improvements Made

- Improvements Needed
  - Dental policies and procedures were inadequate.
  - Oral health and dental services were not adequately provided to Individuals served.
  - Desensitization programs were not implemented.

Communication

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. Significant progress had occurred with the communication assessment; many assessments were among the best seen at the state centers. However, staff were not knowledgable of the programs.

- Positive Practices and Improvements Made
  - It should be noted that significant progress had occurred with the communication assessment and that many of the assessments reviewed were some of the best that this Monitoring Team had seen from any of the state centers.
  - Individuals identified as having decreased communication had not consistently been provided with the needed assessments; however, the assessments being provided by BSSLC since November 2010 were noted to be comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning. Additionally, BSSLC presented a plan that would ensure all individuals would receive the new comprehensive assessments by the end of 2013.

- Improvements Needed

- SLPs were not able to adequately track or write goals or provide the level of monitoring and modeling needed to implement communication strategies and policies at the home level.
- Direct care staff interviewed were not knowledgeable of the communication programs and communication plans and how the individual communicates was not consistently included in the PSP.
- The Facility had 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

Improvement had occurred in the development of skill acquisition programs; however, there was no evidence the programs were being implemented.

- Positive Practices and Improvements Made
- One area of progress involved the development of skill acquisition programs. During the documentation review, it was noted that 100% of sampled skill acquisition programs included the majority of necessary components, such as operational definitions, schedules for implementation, and specific consequences for successful trials.

- Improvements Needed
- Despite improvements in the skill acquisition programs, the implementation of those programs was inadequate. Staff were seldom observed providing formal or informal training, and individuals were often observed in situations that lacked functional activity.

Most Integrated Setting

BSSLC was not in compliance with most of the provisions of this Section, but did achieve substantial compliance in two areas, those being the issuance of a Community Placemen Report under Provision T1 and involving the individual and LAR in the decision-making process of the CLDP.

- Positive Practices and Improvements Made
    - Twelve individuals had transitioned to a community placement in the past six months, which was a relatively high pace.
    - It was noted during PFA and PSP meetings held during the monitoring visit that staff appeared to be more open to the concept of community living and more interested in learning about the available options. This was a positive development.

- DADS had developed and provided QMRP Facilitation training, and were providing follow-up evaluation and coaching. The Monitoring Team applauds this investment and was able to see not only some new skill sets, but also a new energy and attitude among the QMRPs observed and interviewed.
- PMM Checklists were being completed in a timely manner.
- The Facility reported such alternative discharge to another SSLC during this monitoring period, and this appeared to have been implemented consistent with CMS-required discharge planning procedures, but the Facility reported pending revisions to its current policy and procedure to address alternative discharges. This should be sufficient to achieve substantial compliance once complete.

- Improvements Needed
  - 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 and development of individualized strategies for education about community living options to promote informed choice. There were a number of times staff seemed unfamiliar with key aspects of an individual's current status, needs and/or preferences.
  - The Facility reported it believed it was in compliance with some key indicators related to the CLDP and the Monitoring Team found there were improvements in the CLDP processes, but these continued to be hampered by the deficiencies in assessment practices at the Facility. Overall, the Facility was only in substantial compliance with involving the individual and LAR and seeking their input in the decision-making, but not with other components in the CLDP process.
  - A single PMM visit observed during the compliance visit continued to demonstrate improvement in thoroughness and attention to detail, but there were still some supports that were not methodically observed and documented. This finding was affirmed by a review of additional completed PMM Checklists in which supports were not always observed, documented and/or had deficiencies carefully followed-up. The Monitoring Team did find that the most recent PMM activities were significantly improved over those from the beginning of this six month period.

<u>Consent</u>
The Facility was taking steps toward meeting the requirements of this provision but was awaiting the DADS policy, which was still in draft.

- Positive Practices and Improvements Made

  - The Facility did maintain a list of individuals without an LAR, and had recently updated the list using the criteria in the draft statewide policy. The HRO had undertaken some preliminary activity to identify specific rights restrictions

for each individual on the list that might indicate a need for assistance in decision-making. This was a commendable step toward individualizing the process of determining each person's need for assistance.
    - The Monitoring Team commended the HRO's appreciation of the need to carefully consider the level of guardianship needed on an individual basis, even as she undertook preliminary steps to identify potential resources.

- Improvements Needed
    - The required policies and procedures have not yet been promulgated. .Draft statewide policies did address the philosophical basis for informed consent and the responsibility of the PST in supporting the ability of individuals to make informed decisions, they did not address the standardized tools or methodology PSTs would use to assess and prioritize the need for an LAR.

<u>Recordkeeping and General Plan Implementation</u>
Recordkeeping showed a great deal of improvement. Records were more complete and legible. They still did not meet all requirements of Appendix D or of Facility policy. The audit process has potential to lead to continued improvement. Policy development was ongoing.

- Positive Practices and Improvements Made
- The Facility maintained a Unified Record for each individual. The Unified Record at BSSLC consisted of an Active Record, Master Record, and an individual notebook called the "All About Me" book. In addition, the Share Drive, although not part of the Active Record, provided the potential for information to be made available to all PST members.
- BSSLC had implemented several new policies since the last compliance visit. Each policy contains a statement of the training to be provided. For some policies, the training is clearly defined. The Nursing Department includes tests when providing training on departmental policies, an excellent practice.
    - There is, for some policies, a competency check done by program auditors who interview a sample of staff each month on topics that rotate and include some essential policies, such as reporting of abuse.
    - The Facility had one audit process for review of five records per month and a second review process for additional records. The two Unified Records Coordinators (URCs) conducted the audit of ten records per month. Program auditors also conducted focused reviews of several records each month.
    - Audits by the Monitoring Team of records that had been audited recently by the Facility found acceptable inter-observer agreement, indicating that the audits are likely to be accurate and valid.
    - The Facility had implemented a process to monitor how staff use the records in making care, medical treatment and training decisions.

- Improvements Needed

- Recordkeeping was improved from the last compliance visit. The Active Records were more generally complete and legible. Nevertheless, continued improvement is needed. Although records were generally in order and, for the most part, complete and legible, none of the Active and Individual records met all the requirements of Appendix D or of Facility policy.
- There were instances in which data were missing for programs.
- Policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. Both DADS and the Facility continued to develop and revise policies
- The selection of records for URC audits was not random; random selection is a requirement of the provision.

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. DADS Policy 001 Use of Restraint (8/31/09) 2. BSSLC Restraint for Behavioral Crisis Policy (6/8/11) 3. BSSLC Medical and Dental Restraint Policy (6/18/11) 4. BSSLC Level of Supervision Policy (3/30/11) 5. BSSLC Plan of Improvement (POI) dated 7/12/11 6. Section C Presentation Book (undated) 7. List of all physical restraint use from 1/12/11 to 7/12/11 8. List of all protective restraint use from 1/12/11 to 7/12/11 9. List of all chemical restraint use from 1/12/11 to 7/12/11 10. List of all medical restraint use from 1/13/11 to 7/13/11 11. Sample of physical restraint records (Sample C.1): Individual #3 (3/1/11, 6/20/11, and 7/8/11), Individual #4 (5/16/11), Individual #9 (6/4/11 and 6/13/11), Individual #11 (6/20/11), Individual #173 (5/18/11), Individual #181 (4/29/11 4:40am, 5/13/11, 5/27/11 8:12am and 9:12am), Individual #381 (3/17/11), Individual #399 (6/29/11 1:15pm), Individual #417 (3/22/11), Individual #488 (4/21/11 9:22am and 9:36am), Individual #490 (6/27/11 4x), and Individual #513 (6/27/11) 12. Sample of medical restraint records (Sample C.2): Individual #75 (4/1/11), Individual #102 (6/3/11), Individual #269 (6/10/11), Individual #332 (5/20/11), Individual #462 (3/9/11), Individual #490 (2/1/11), Individual #538 (2/18/11), and Individual #574 (6/2/11) 13. Sample of chemical restraint records (Sample C.3): Individual #9 (6/29/11), Individual #399 (6/29/11), and Individual #490 (7/1/11) 14. Sample of protective restraints (Sample C.4): Individuals #126 and #478 15. Data sheets to document implementation of PST approved programs were put in place to minimize need for pre-treatment sedation for dental procedures 16. Sample of 25 direct care professionals' training records (Sample C.5) 17. Staff training records for those staff designated as restraint monitors 18. Staff training material developed by BSSLC for restraint monitoring (Class RMT2011) 19. Minutes of Restraint Reduction Committee 2/17/11, 3/17/11, and 5/15/11 20. Minutes of Human Rights Committee 5/26/11, 6/2/11, 6/9/11, and 6/16/11 21. Log of restraint related injuries to individuals since the last review. 22. Personal Support Plans (PSPs) and related documents for Individuals #3, #9, #181, #399, #488, and #490 23. BSSLC Restraint Trend Report 6/30/11 **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs (ADOP) 2. Susie Johnson, Settlement Agreement Coordinator (SAC)

	3. Jill Quimby, RN, Acting QA Director 4. Terry Hancock, PhD, BCBA, Chief Psychologist 5. Victoria Morgan, M.D., Lead Psychiatrist 6. Janet Crane, Psychology Assistant 7. Caitlin Connor, Program Compliance Auditor 8. Shawn Cureton, M.S., Psychology Manager 9. Debbie Williams, Chief Nurse Executive (CNE) 10. Kerry Weyand, Data Analyst 11. Ten direct care professionals (DCPs) **Meeting Attended/Observations:** 1. Facility Incident Management Team meeting 7/25/11 2. Cottages Unit Incident Management Team meeting 7/28/11 3. QA/QI committee meeting 7/28/11 Restraint Reduction Committee meeting 7/27/11
	Facility Self-Assessment: The BSSLC Plan of Improvement reported substantial compliance with three (Provisions C.1, C.2, and C.8) of the eight provisions of Section C of the Settlement Agreement (SA). The Monitoring Team determined substantial compliance with provisions C.3, C.6 and C.8 but not Provisions C.1 and C.2. This is indicative of the progress being made In Section C of the SA at BSSLC. Regarding Provision C.1, actions described by the Facility had occurred, but the Facility did not use its own data to identify that restraint use was trending upward. Additional staff training and quality assurance activity, by both the Psychology Department and the Quality Assurance (QA) Department, contributed to the quality and accuracy of the documentation associated with episodes of physical and chemical restraint This documentation was significantly improved than that observed at the monitoring review. The Facility is to be commended for these process improvements.
	Summary of Monitor's Assessment: Since the last review BSSLC revised both policies that govern restraint use: Restraint for Behavioral Crisis Policy (6/8/11) and Medical and Dental Restraint Policy (6/18/11) consistent with recommendations made by the Monitoring Team. Both policies are comprehensive and are directed to the practices necessary to achieve compliance with the Settlement Agreement. Restraint use at BSSLC is trending up. Crisis intervention restraint (physical and chemical) was used an average of 4.3 times/month the first quarter of FY11, 13 times/month the second quarter, 24 times/month the third quarter, and 31 times in June, 2011, the first month of the fourth quarter. Despite this there were individuals for whom the frequency of restraint was significantly less during this review period than the last review period. The quality and accuracy of the documentation associated with episodes of physical and chemical restraint improved significantly since the last review. Staff were more knowledgeable of restraint policies and procedures.

	The Facility had taken the initiative to create an electronic version of the State-required Restraint Checklist and Face-to-Face Assessment/Debriefing documents (FFAD). This facilitated improved internal review of restraint documentation by the Facility, and external review by the Monitoring Team. The Facility is to be commended for this initiative. The Facility restraint review process was more extensive and comprehensive than observed at the last review, including a process of post restraint review by a psychologist that is more extensive than that recorded on the FFAD by the restraint monitor. This review by a psychologist is more clinically oriented and occurs soon after the restraint episode ends. It provides important data that is not recorded on the FFAD. The Facility is to be commended for this initiative. Additionally, the Facility is piloting an additional review process that would occur several days after a restraint episode. This review process would have a psychologist review the restraint episode with those staff involved in the restraint in a more reflective, collaborative, and integrated manner than what typically can happen in the immediate aftermath of a restraint episode. The Facility is to be commended for this initiative. The Facility was especially proactive in successfully implementing a fading plan for an individual who experienced the use of protective mechanical restraint for years. Restraint was discontinued in June following a six month period of fading. The Facility is to be commended for its proactive approach in eliminating this individual's dependence on protective restraint. Little improvement in the management processes associated with medical restraint was observed by the Monitoring Team. Little data was being tracked and trended. The Facility was unable to produce an accurate list of individuals who had medical restraint. Treatments or strategies to minimize or eliminate the need for medical restraint were not implemented consistently or not at all. Significant improvement is needed in this area.

#	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	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this provision of the Settlement Agreement (SA). Although the Facility had made significant progress in managing use of restraint, there is an upward trend in restraint use. Therefore, the Monitoring Team does not concur. BSSLC Restraint for Behavioral Crisis Policy (6/8/11) and BSSLC Medical and Dental Restraint Policy (6/18/11) 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. The Facility had taken the initiative to create an electronic version of the State-required	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Restraint Checklist and Face-to-Face Assessment/Debriefing documents (FFAD). This facilitates improved internal review of restraint documentation by the Facility, and external review by the Monitoring Team. The electronic version of the checklist is easier to read, easier to identify missing or contradictory data, and can be sent electronically to staff that are expected to participate in review processes, such as the Incident Management Review Team (IMRT). The Facility is to be commended for this initiative. The Facility continues to conduct a process of post restraint review by a psychologist that is more extensive than that recorded on the FFAD by the restraint monitor. This process was described in the last Monitoring Team report. This review by a psychologist is more clinically oriented and occurs soon after the restraint episode ends. It provides substantive data that is not recorded on the FFAD. The Facility is to be commended for this initiative. Additionally, the Facility is piloting an additional review process that would occur several days after a restraint episode. This review process, as presented to the Restraint Reduction Committee, would have a psychologist review the restraint episode with those staff involved in the restraint in a more reflective, collaborative, and integrated manner than what typically can happen in the immediate aftermath of a restraint episode. The Facility is to be commended for this initiative. Restraint use at BSSLC is trending up. Crisis intervention restraint (physical and chemical) was used an average of 4.3 times/month the first quarter of FY11, 13 times/month the second quarter, 24 times/month the third quarter, and 31 times in June, 2011, the first month of the fourth quarter. Despite this there were several individuals for whom the frequency of restraint is significantly less during this review period than the last review period, specifically Individuals #11 and #173. Two individuals accounted for approximately half the increased frequency of restraint; one of these individuals had been admitted just prior to the last compliance visit. <u>Prone Restraint</u> Policies clearly prohibit use of prone restraint. 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 did not discover any use of prone restraint and, in fact, found evidence that if an individual was in horizontal restraint and staff found it difficult to apply the restraint technique without risking inadvertent, accidental, and/or momentary placement of the individual in a prone position, the Individual was immediately released from the procedure. Additionally, the Monitoring Team interviewed ten Direct Care Professionals (DCPs), all of whom had been involved in restraint application. All ten were very clear in their understanding that prone restraint	

#	Provision	Assessment of Status	Compliance
		was prohibited and if in the course of using restraint an Individual's aggression was such that the Individual may roll into a position that could result in prone restraint the restraint application was to cease and staff attempts to implement restraint were to be interrupted. <u>Restraint Samples</u> Four samples of restraint episodes from lists of restraint episodes provided by the BSSLC were developed. These lists were to include restraints that had occurred since the last monitoring visit and included: Sample C.1: Physical Restraint – the list provided by the BSSLC contained 112 restraint episodes and a 20% sample was developed. The Monitoring Team, in selecting the restraints to sample, ensured that the sample included restraints with Individuals who are frequently restrained and ensured the type of restraint used in the sampled episodes included physical holds, horizontal side-lying restraint, and application of the bear-hug restraint. The sample included records for Individual #3 (3/1/11, 6/20/11, and 7/8/11), Individual #4 (5/16/11), Individual #9 (6/4/11 and 6/13/11), Individual #11 (6/20/11), Individual #173 (5/18/11), Individual #181 (4/29/11 4:40am, 5/13/11, 5/27/11 8:12am and 9:12am), Individual #381(3/17/11), Individual #399 (6/29/11 1:15pm), Individual #417 (3/22/11), Individual #488 (4/21/11 9:22am and 9:36am), Individual #490 (6/27/11 4x), and Individual #513 (6/27/11). Files prepared by the Facility for these 22 restraints were to contain the restraint checklist, face to face assessment/debriefing document (FFAD), medical orders, documentation of review activity of the restraint episode, and any other information the Facility felt might be helpful in understanding the circumstances associated with the restraint use and to establish Settlement Agreement (SA) compliance. Sample C.2: Medical Restraint - the list provided by the BSSLC contained 39 restraint episodes, and a 20% sample was developed. The Monitoring Team, in selecting the restraints to sample, ensured that the sample included equal numbers of medical pretreatment sedation and Total Intravenous Anesthesia (TIVA) for dental procedures. The list from which this sample was taken was to include oral pretreatment sedation for dental procedures but did not; the Facility was unable to provide a list of such restraints. The sample included records for Individual #75 (4/1/11), Individual #102 (6/3/11), Individual #269 (6/10/11), Individual #332 (5/20/11), Individual #462 (3/9/11), Individual #490 (2/1/11), Individual #538 (2/18/11), and Individual #574 (6/2/11). Files prepared by the Facility for the eight restraints in this sample were to include the restraint checklist, face to face assessment/debriefing document, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring medical restraint (if applicable), PSP information regarding the development and implementation of plans to minimize the use of medical restraint for the individual	

#	Provision	Assessment of Status	Compliance
		(including completed data sheets if a program was developed and implemented), documentation of review activity of the restraint episode, and any other information the Facility felt would be helpful in understanding the circumstances associated with the restraint use to establish SA compliance. Sample C.3: Chemical Restraint - the list provided by the BSSLC contained 17 restraint episodes. Three (20%) were selected for review. The Monitoring Team, in selecting the three restraints to include in the sample, included the Individual most frequently restrained by chemical means, and two Individuals who were also frequently the subject of physical restraint. The sample included records for Individual #9 (6/29/11), Individual #399 (6/29/11), and Individual #490 (7/1/11). Files prepared by the Facility for these three restraints were to include the restraint checklist, face to face assessment/debriefing document, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring chemical restraint (if applicable), documentation of review activity of the restraint episode, and any other information the Facility felt would be helpful in understanding the circumstances associated with the restraint use and necessary to establish SA compliance. Sample C.4: Protective Mechanical Restraint - the list provided by the BSSLC contained nine Individuals who were, or had been since the last review, in protective restraint. Two (20%) were selected for review. The Monitoring Team, in selecting the two restraints to review ensured that two different types of protective restraints were included. <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 and the face-to-face assessment/debriefing document. The following are the results of this review: ▪ In 22 of the 22 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. ▪ For 22 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 22 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment.	

#	Provision	Assessment of Status	Compliance
		▪ In 18 of 22 of the records (82%), 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. The four instances of unclear documentation all involve Individual #490. This Individual had a Safety Plan that included pre-restraint strategies to be used by staff. In the section of the Restraint Checklist entitled "Interventions Attempted to Avoid Restraint" the interventions described in the Safety Plan are individually checked. Unchecked is the box for "Interventions in Safety Plan." This would indicate to the Monitoring Team that Safety Plan interventions were used but the staff completing the Restraint Checklist did not know to also check the box noting they were used. In each case the Restraint Monitor indicated on the FFAD that restraint was used in a clinically justifiable manner. These are relatively minor inconsistencies in restraint documentation that did not materially affect the correct implementation of restraint with this Individual. All 22 restraint checklists indicated use of many pre-restraint interventions. including prompted replacement behavior, prompted coping skills, interventions in PBSP, interventions in Safety Plan, verbal prompt, redirection, PMAB protection skills, moved others away, traded out staff, and moved furniture. For Individuals with a Safety Plan the specific pre-restraint interventions were clearly presented in the Safety Plan. ▪ The Settlement Agreement (SA) also requires that restraint be used in a clinically justifiable manner. As described in Section K the Facility needs to improve in DCP knowledge of Positive Behavior Support Plans (PBSPs) and when to implement them. This lack of knowledge about implementation by DCPs can compromise the efficacy of treatment in a manner where it is possible that restraint is not always used in a clinically justifiable manner. The lack of PBSP knowledge, or of PBSP implementation methods, can lead to unnecessary restraint. Similarly, as reported in Section S, much more effort is required in the delivery of training to Individuals. The Monitoring Team noted that staff were not implementing training programs, or implementing them consistently, and individuals had too much time without formal or informal training. This can lead to unwanted behavior by an individual which can lead to restraint. As reported in section K the BSSLC has made significant improvements in its overall approach to behavioral programming that move the Facility into closer compliance with the SA. Until these improvements are observable to the Monitoring Team, it is not possible to conclude that restraint use always occurs in a clinically justifiable manner. On the other hand, for the restraints that were reviewed by the Monitoring Team there were no indications that any had occurred that were not clinically justifiable. Therefore, for purposes of assessing compliance with this provision, the Monitoring Team has judged that restraint is used in a clinically justified manner.	

#	Provision	Assessment of Status	Compliance
		▪ Facility policies identify a list of approved restraints. Based on the review of 22 restraints, involving 12 individuals, 22 (100%) were approved restraints. The quality and accuracy of the documentation associated with episodes of physical restraint improved significantly since the last review. Additional staff training and quality assurance activity, by both the Psychology Department and the Quality Assurance (QA) Department have made this possible. The Facility is to be commended for these process improvements. Although the Facility had made significant progress in ensuring restraint was used only in compliance with the requirements of this policy, the upward trend in use leads to question about effectiveness of interventions and will need to be addressed.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team does not concur. The 22 restraint records involving the 12 individuals in Sample C.1 (physical restraint) were reviewed. In 18 (82%) records the Restraint Checklist indicated the release code P "released immediately because no longer an immediate and serious risk of harm to self/others." In the other four records, involving one individual (#490) the Restraint Checklist, in each instance, indicated the release code N "released due to not able to maintain restraint correctly." The restraint method in each case included horizontal side-lying. The BSSLC Restraint Debriefing Form, completed by a psychologist after interviewing staff directly involved in these four restraints, reports that each time the Individual was released she appeared "calm" but was still considered to be at risk of immediate and serious harm to self/others. After a very brief period of remaining calm the precipitating behavior resumed necessitating additional restraint. The sequence of restraint events began at 2:31pm and ended at 3:14pm. The psychology department had been tracking issues with restraint release and presented a report in its presentation book labeled "Problematic Releases on Restraints." Forty-two instances of problematic release were noted from 2/10/11 through 7/26/11, all attributed to "released due to not able to maintain correctly." From the documentation presented, the Monitoring Team was able to determine that physical restraints were terminated as soon as the individual is no longer a danger to him/herself or others. Sample C.2 (medical restraint) is not applicable to this provision of the SA.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Sample C.3 (chemical restraint) is not applicable to this provision of the SA. Sample C.4 (protective mechanical restraint) reports on two Individuals. Individual #478's protective restraint called for the wearing of coveralls at night for the prevention of severe self-injurious behavior. The Monitoring Team reviewed Restraint Checklists, which are completed daily, for the two week period 6/1/11 through 6/14/11. None (0%) of the 14 Restraint Checklists contained entries for the date and time of release. Eleven (79%) of the 14 Restraint Checklists included the release code M ("released from jumpsuit to be dressed in daily attire") in the Action/Release Codes section of the Restraint Checklist. It should be noted that Individual #478's Personal Support Team (PST) had been working on a fading plan since December, 2010 to decrease dependence on protective restraint. It was reported protective restraint had been in place for years. Protective restraint was discontinued on 6/20/11. The Facility is to be commended for its proactive approach in eliminating Individual #478's dependence on protective restraint. Individual #126's protective restraint called for the use of mittens during the day to prevent self-injury. The Monitoring Team reviewed Restraint Checklists, which are completed daily, for the two week period 5/14/11 through 5/27/11. None (0%) of the 14 Restraint Checklists contained entries for the date and time of release. None (0%) of the 14 Restraint Checklists included a release code in the Action/Release Codes section of the Restraint Checklist. It should be noted that protective restraint had been in place for Individual #126 for several years. Protective restraint was discontinued on 6/13/11. The physician order for the discontinuation of the protective restraint reports it is because of family request. The Human Rights Committee review indicates the "mittens have been discontinued and there has been no scratching. It appears that this was a medical issue that has been resolved." It is unfortunate the PST for Individual #126 was not more assertive in attempting to decrease dependence on protective restraint, similar to what occurred with Individual #478. The Facility's overall management of use of protective restraints, and related documentation, needs to improve to achieve substantial compliance with this, and other, provisions of the SA.	
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	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team does not concur and believes the BSSLC has achieved SA with this provision of the SA. The Facility's policies related to restraint are discussed, in part, in Section C.1. The Restraint for Behavioral Crisis Policy (approved 6/8/11) addresses the requirements of	Substantial Compliance

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	the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	the SA associated with behavioral crisis restraint use. The Facility policy Medical and Dental Restraint (approved 6/18/11) also addresses the requirements of the SA. With regard to use of physical restraint (Sample C.1) 22 of 22 records (100%), contained documentation that restraints used were approved restraints as delineated in both BSSLC and DADS policy. Restraints used with all 12 individuals, except Individual #490, contained documentation that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner (refer to section C.1). All 22 restraint checklists indicated use of a large number of pre-restraint interventions. including prompted replacement behavior, prompted coping skills, interventions in PBSP, interventions in Safety Plan, verbal prompt, redirection, PMAB protection skills, moved others away, traded out staff, and moved furniture. For Individuals with a Safety Plan the specific pre-restraint interventions were clearly presented in the Safety Plan. 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. The BSSLC Restraint for Behavioral Crisis policy identified specific classes required for all staff, for staff designated as restraint monitors, and for physicians and nurses as follows: • All DCP staff: PMA320 (PMAB Intermediate Protection), PMA400 (PMAB Restraint), PMA700 (PMAB Prevent), and RES0105 (Restraint: Prevention and Rules for Use at MR Facilities). • Designated Restraint Monitors: PMA320 (PMAB Intermediate Protection), PMA400 (PMAB Restraint), PMA700 (PMAB Prevent), RES0105 (Restraint: Prevention and Rules for Use at MR Facilities), CPR0100 (CPR Basic), RIG0100 (Rights of Consumers), ABU0100 (Abuse, Neglect, and Exploitation), and RMT2011 (Restraint Monitoring Training). • Physicians/Nurses: RES0300 (Ordering, Assessing, and Evaluating Restraints). Note: The policy does not require that any staff take class MEC1000 Application of Mechanical Restraints. The Facility did not use mechanical restraint for crisis intervention but did use mechanical restraint for protective purposes. DADS restraint policy requires that staff be trained in proper restraint techniques. The DADS policy does not specify specific classes that are required. If BSSLC policy continues to permit use of mechanical protective restraint, the Facility should define in its policy what type of	

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		training is required of staff to ensure proper application and monitoring of mechanical devices used for protective restraint. The Monitoring Team reviewed training transcripts of 25 randomly selected direct care (selected by picking the first DCP name on each page of the list of BSSLC employees until 25 names were selected) to validate completion of the required courses. All (100%) of the transcripts confirmed that the required training was completed. Additionally, 10 DCPs were interviewed by the Monitoring Team and asked the following questions: 1. From the training you've received describe some strategies you would use with an individual whose behavior may lead to restraint. 2. If you are involved in restraint what might be a typical sequence of activity you'd be engaged in? 3. If you are involved in restraint what other staff would typically be with or near you to assist? 4. Have you ever been involved in a restraint technique that called for the individual to lay on their back or stomach? Describe? All 10 (100%) provided responses that indicated they were appropriately knowledgeable of restraint policies and procedures. The Monitoring Team reviewed training transcripts of three nurses and three physicians. These were selected by going through the alphabetical list of BSSLC employees and selecting the first three nurses and the first three physicians appearing on the list. All six (100%) had completed the required course RES0300 (Ordering, Assessing, and Evaluating Restraint).	
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	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. Based on a review of 22 physical restraint records (Sample C.1), 22 (100%) contained documentation that each use of restraint was due to crisis intervention. This documentation consisted of entries on the Restraint Checklist, FFAD, and the BSSLC Restraint Debriefing form. Based on a review of three chemical restraint records (Sample C.3), three (100%) contained documentation that each use of restraint was due to crisis intervention. This documentation consisted of entries on the Restraint Checklist, FFAD, Administration of Chemical Restraint Consult form, and the BSSLC Restraint Debriefing form.	Noncompliance

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	eliminate the need for restraint.	Based on a review of two protective mechanical restraint records (Sample #C.1), two (100%) contained documentation that each use of restraint was planned to respond to imminent risk of harm expected if the restraint was not used. This documentation consisted of descriptive information in the Individual's Safety Plan and monthly reviews done by the Individuals PST. The review of use of protective restraints needs to be more thorough to ensure protective restraint is necessary due to imminent risk of harm. The BSSLC Restraint for Behavioral Crisis policy states that restraint "is limited to acute emergencies that place the individual or others at serious threat of violence or injury" and that the purpose of a Safety Plan "is to provide instructions for staff regarding how to prevent harm and injury during an acute behavioral crisis, It is not to be considered to be a therapeutic intervention." Section VII of the policy Safety Plans for Crisis Intervention (Non-Contingent Restraint) establishes a series of measures that guide implementation of mechanical restraints (they are not referred to as protective restraint in the policy) but does not provide any language directed at mechanical restraint being used to address a chronic and continuing behavior that is addressed in a safety plan. The language in this policy suggests to the Monitoring Team that mechanical restraint can only be used to intervene in acute situations of crisis intervention, but it is unclear that protective restraint is used for crisis intervention. Based on a review of 22 physical restraint records (Sample C.1), 15 (68%) contained documentation that no restraint was used that is prohibited by the individual's medical orders or ISP. Documentation to substantiate compliance with this requirement of the SA consisted of identification and review of a form entitled "Considerations for Implementing Restraint Medical/Physical." Every Individual should have this completed form in their record. This form includes a physician identification of any medical conditions that may preclude use of restraint. The physician either checks "no" (meaning no restrictions to restraint use) or lists the medical conditions and factors that must be considered in the context of restraint use. The form also includes an entry indicating PST review of the physician entry. This form was not available for Individuals #381, #488, and #490 (who had four restraints in the sample). Based on a review of three chemical restraint records (Sample C.3), two (67%) contained documentation that no restraint was used that is prohibited by the individual's medical orders or ISP. The required form was not available for Individual #490. Based on a review of two protective mechanical restraint records (Sample C.4), two (100%) contained documentation that no restraint was used that is prohibited by the individual's medical orders or ISP.	

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		In summarizing the three samples the form documenting compliance for 27 restraints was present for 19 (70%) of the restraints. In a document request asking for a list of all individuals with medical restraint, which would include pretreatment oral sedation for dental and medical procedures as well as TIVA for dental procedures, the Monitoring Team was provided a list of 39 individuals. None of the individuals on this list had received pretreatment oral sedation for dental procedures. This seemed unusual. Upon interview, the section lead for Section C reported a great deal of work needed to be done to ensure medical restraint data from the dental department was organized and accurately and regularly reported. The section lead, and her assistant, was unable to tell the Monitoring Team whether the medical restraint information already provided should be considered accurate. No additional information relative to this subject was provided before the review ended. A great deal of work will be needed to develop standardized protocols and documentation requirements associated with medical restraint. This subject is addressed in some detail in Section J.4 of this report. It is commendable that the need for substantial improvement in this area was acknowledged by the section lead and the Monitoring Team looks forward to reviewing a well-organized system for reporting, tracking, and analyzing use of medical restraint in future reviews. As described above, the Monitoring Team did not have enough information provided by the Facility to conduct an adequate compliance review of use of medical restraint. Nevertheless, the Monitoring Team conducted a very limited review of what was reported to be individuals with medical/dental support plans. The Facility reported in a document request that medical and dental support plans were in place for 107 individuals. The Monitoring Team selected a small sample of five individuals to determine if data supported plan implementation. • For two of the five (40%) individuals (#249 and #440) data sheets validated plan implementation. • For Individual #106 no data were available to validate plan implementation. • For Individual #486, the plan was supposed to be implemented on 5/13/11 with the program implemented 3x/week. There were no data to validate program implementation in May. Data validated program implementation one time (as opposed to the 3x/week called for in the plan) in June. • For Individual #488 in lieu of a data sheet the Individual's QMRP provided a written description of why the program wasn't being implemented, although the program he/she was describing was not the dental support plan (the subject of the Monitoring Team's inquiry).	

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		Based on the limited data presented above, the absence of a credible list of medical restraints, and inconsistent implementation of support plans to minimize the need for medical restraint, the Monitoring Team is unable to conduct a more comprehensive review of this element of the SA and 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. 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.	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. The training curriculum developed by the BSSLC psychology department for persons who conduct face to face assessments (restraint monitors) was reviewed by the Monitoring Team and determined to be competency based. The Monitoring Team was provided with a list of all staff designated to perform the duties of a restraint monitor. These names were crosschecked against the names noted on the Restraint Checklist for Sample C.1 (physical restraint) and Sample C.3 (chemical restraint). This consisted of 25 Restraint Checklists. The staff person noted as the restraint monitor on the Restraint Checklist matched the list of restraint monitors provided by the Facility in each instance (100%). The Monitoring Team reviewed the training transcripts for the restraint monitors that monitored restraints in these two samples in order to validate completion of the following classes: PMA320 (PMAB Intermediate Protection) PMA400 (PMAB Restraint) PMA700 (PMAB Prevent) RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) CPR0100 (CPR Basic) RIG0100 (Rights of Consumers) ABU0100 (Abuse, Neglect, and Exploitation) RMT2011 (Restraint Monitoring Training). For four restraints (16%), the Restraint Monitor had not completed all required training. The four restraints where this was the case were Individual #399 (physical restraint 6/29/11), Individual #181 (physical restraint 4/29/11), Individual #9 (chemical restraint 6/29/11), and Individual #399 (chemical restraint 6/29/11). Three of these four relate to one employee who had not taken the RMT2011 course. Based on a review of 22 physical restraint records (Sample C.1), a face-to-face assessment/debriefing (FFAD) was conducted in 20 (91%) of 22 episodes of restraint by an adequately trained restraint monitor. The two that were not involved Individual #399 (physical restraint 6/29/11) and Individual #181 (physical restraint 4/29/11).	Noncompliance

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		Based on a review of three chemical restraint records (Sample C.3), a FFAD was conducted in one (33%) of three episodes of restraint by an adequately trained restraint monitor. The two that were not involved Individual #9 (chemical restraint 6/29/11), and Individual #399 (chemical restraint 6/29/11). Based on a review of two protective mechanical restraint records (Sample C.4), a FFAD was not conducted for either protective restraint. These two individuals were in restraint daily for an extended period of time. A daily FFAD would be required to meet the terms of the SA. The FFA document includes an entry for "time monitor arrived." The Monitoring Team views this time as the time the assessment began. For 25 of 25 instances (100%) for Samples C.1 and C.2, the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. For many restraint episodes the restraint monitor was onsite when restraint began because he or she had been called earlier to assist in de-escalation efforts. In 25 instances (100%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. In 25 instances (100%), the documentation on the FFA showed that an assessment was completed of the circumstances of the restraint. The Monitoring Team commends the BSSLC for these 100% compliance rates which are indicative of improved staff training and improved internal controls (QA) within the psychology department. None of the 25 non-medical restraint records in the sample indicated an alternative physician ordered monitoring schedule. Based on a review of Sample C.1 (physical restraint) 22 records for 12 individuals were reviewed. These included Individuals #3l #4, #9, #11, #173, #181, #381, #399, #417, #488, #490, and #513. There was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 11 (50%) of the instance of restraint. Records that did not contain timely documentation of this included: Individual #4, 5/16/11; Individual #9, 6/4/11; Individual #181, 5/13/11 and 5/27/11 at 9:12 a.m.; Individual #488, 4/21/11 at 9:22 a.m. and 9:36 a.m.; Individual #490, 6/27/11 at 2:31 p.m., 2:42 p.m., 2:54 p.m., and 3:09 p.m.; and 7/1/11.	

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		▪ Monitored and documented vital signs in 15 (68%). Records that did not contain documentation of this included: Individual#9, 6/4/11; Individual #181, 5/27/11 at 9:12 a.m.; Individual #490, 6/27/11 at 2:31 p.m., 2:42 p.m., 2:54 p.m., 3:09 p.m., and 7/1/11. ▪ Monitored and documented mental status in 11 (50%). Records that did not contain documentation of this included the following cases in which the individual was not monitored every 30 minutes: Individual#3, 6/20/11; Individual#9, 6/4/11 at 10:10 a.m. and 6/13/11 at 10:35; Individual #181, 5/27/11 at 9:12 a.m.; Individual #488, 4/21/11 at 9:22 a.m. and 9:30 a.m; Individual #490, 6/27/11 at 2:13 p.m., 2:42 p.m., 2:52 p.m., 3:09 p.m., and 7/1/11. Sample C.2 was selected from the list of individuals the Facility provided that was to include all instances of medical restraint since the last review. As noted in Provision C.1 of this report, this list was later reported to be incomplete, as it did not appear to include oral pretreatment sedation for dental procedures. Sample C.2 included files for eight medical restraints. Files prepared by the Facility for review of these eight restraints were to include the restraint checklist, face to face assessment/debriefing document, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring medical restraint (if applicable), PSP information regarding the development and implementation of plans to minimize the use of medical restraint for the individual (including completed data sheets if a program was developed and implemented), documentation of review activity of the restraint episode, and any other information the Facility felt would be helpful in understanding the circumstances associated with the restraint use to establish SA compliance. None of the eight (0%) files contained documentation of physician specified type of monitoring or schedule for monitoring. The files contained considerable documentation of post restraint monitoring such as Pre and Post Sedation Checklists, detailed entries in the Interdisciplinary Progress Record, and Post Anesthesia Care Vital Signs Flow Sheets. The files did not include any indication that this monitoring was ordered by a physician, or being done in accordance with a standard written facility protocol. BSSLC may be satisfied that its practices associated with these medical restraints are adequate but they do 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." Finally, it is likely a significant number of oral pretreatment sedation restraints occurred related to dental procedures. Until the facility management systems are able to track and record these data the Monitoring Team will be unable to conduct a representative compliance review for this provision of the SA.	

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C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team determined this provision is in substantial compliance with the SA. Sample C.1 of 22 physical restraints and Sample C.3 of three chemical restraints were reviewed using the Restraint Checklist as the primary source of documentation. The following compliance rates were identified for each of the elements required to comply with Appendix A: 1. In 25(100%), continuous one-to-one supervision was documented; 2. In 25 (100%), the date and time restraint was begun was documented; 3. In 25 (100%), the location of the restraint was documented; 4. In 25 (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented, although in some cases the information presented on the checklist could be more targeted to describing "the events leading to behavior that resulted in restraint." In some cases the behavior is described (e.g. "aggressing against staff") without any description of precipitating events. Examples include Individuals #9 (6/4/11), #399 (6/29/11), and #488 (4/21/11). More detailed information is typically presented in a debriefing document the psychology department uses to document post-restraint interviews with staff. The Monitoring Team considers this a good practice but the Restraint Checklist is viewed as a primary source of restraint documentation and should be as complete as possible; 5. In 25 (100%), the interventions taken by staff prior to the use of restraint were documented and are adequate for post restraint review. All indicated multiple types of interventions being attempted prior to restraint such as a change in environment, moving furniture, implementing the PBSP and Safety Plan, trading out staff, and moving other individuals away. 6. In 25(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 FFAD, and the BSSLC debriefing the specific reasons for the use of restraint was evident in each case. 7. In 25(100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. 8. The Restraint Checklist documented observations of the individual and actions taken by staff while the individual was in restraint, including: o In 25(100%), the observations documented at least every 15 minutes and at release. Most restraints in the sample were of short duration. Five exceeded 15 minutes;	Substantial Compliance

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		o In 25(100%), the specific behaviors of the individual that required continuing restraint were noted; and o Most restraints were of short duration. For those that were not there was documentation that staff provided, 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. 9. In 25(100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. 10. In 25 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. In 23 of 25 (92%), 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. This was not the case for Individual #181 (5/13/11 and 5/27/11). In 25 of 25 (100%) the FFAD restraint debriefing forms were present. The BSSLC has an additional restraint debriefing process where a psychologist interviews staff involved in the restraint episode. This process, viewed by the Monitoring Team as a positive practice, often produces useful information the PST can use to develop strategies to decrease the likelihood of need for restraint in the future. This restraint debriefing process probes the following: 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? The files produced pursuant to Sample C.1 and C.3 included this facility specific restraint review process sporadically. The Monitoring Team was under the impression this process was standard operating procedure and will seek clarification at the next review.	

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		The quality and accuracy of the documentation associated with episodes of physical and chemical restraint improved significantly since the last review. Additional staff training and quality assurance activity, by both the Psychology Department and the Quality Assurance (QA) Department have made this possible. The Facility is to be commended for these process improvements.	
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:	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs.	Noncompliance
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	Records were reviewed for each individual who experienced restraint more than three times in a rolling thirty-day period since the last compliance visit. For none of the individuals/instances reviewed (0%), the individuals' team reviewed the individual's adaptive skills. The following are examples of where teams failed to do this adequately: 1. Adaptive assessments were available for only Individual #390 during the time in question. There were no indications in the record that this information was discussed in relation to the use of restraint or restrictive practices. For none of the individuals/instances reviewed (0%), individuals' teams reviewed the biological, medical and psychosocial factors in relation to use of restraints. The following are examples of where teams failed to do this adequately: 2. For Individual #3, documentation reflected only a narrative discussion of behavior displays. 3. For Individual #181, documentation reflected only a narrative discussion of behavior displays. 4. For Individual #490, documentation reflected only a narrative discussion of behavior displays.	Noncompliance
	(b) review possibly contributing environmental conditions;	For none of the individuals/instances reviewed (0%), individuals' teams reviewed the possibly contributing environmental conditions. As demonstrated for the three examples reported in Provision C7(a), documentation reflected only a narrative discussion of behavior displays.	Noncompliance
	(c) review or perform structural	For none of the individuals/instances reviewed (0%), individuals' teams reviewed	Noncompliance

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	assessments of the behavior provoking restraints;	and/or performed structural assessments of the behavior that led to restraints.	
	(d) review or perform functional assessments of the behavior provoking restraints;	The Behavior Services department at BSSLC combines the functional assessment and structural assessment into a single process. Please refer to Provision C.7(c).	Noncompliance
	(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;	All seven of the individuals reviewed (100%), had a PBSP. Of the seven individuals in the sample who had PBSPs, the following was found: 5. Seven (100%) were based on the individual's strengths; 6. Seven (100%) specified the objectively defined behavior to be treated that led to the use of the restraint; 7. Seven (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint (although the information did not always lead to choice of appropriate replacement behavior and development of programs that reflected consideration of function); and 8. Seven (100%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. Although all seven individuals in the sample were provided with a PBSP that was based upon an SFA, the Facility indicated that PBSPs continued to reflect practices that did not include the basic principles of applied behavior analysis, including the lack of review of structural and functional assessments, and the lack of consideration of medical and other environmental conditions when use of restraints continued. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: 9. In seven of seven Safety Plans reviewed, (100%), the type of restraint authorized was delineated; 10. In 7 (100%), the maximum duration of restraint authorized was specified; 11. In 7 (100%), the designated approved restraint situation was specified; and 12. In 7 (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a	At the time of the current site visit, BSSLC had completed initial inter-observer agreement (IOA) and treatment integrity measures for a sample of the individuals living at the Facility. Individuals were selected for the sample based upon recent increases in undesired behavior or having been identified as being behaviorally at high risk. The Facility planned to begin conducting IOA and treatment integrity measures for all individuals with a PBSP in August of 2011. A system was not yet in place to track the results of the IOA and treatment integrity measures.	Noncompliance

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	targeted behavior; and		
	(g) as necessary, assess and revise the PBSP.	In six of the records reviewed (86%), there was documentation that the individual's PBSP had been revised as appropriate. The following is an example of an individual for whom this was done appropriately: 1. The interventions for Individual #490 were revised in a systematic fashion based upon the available data. Both aggression and destruction dropped substantially in early July 2011. The following is an example of where teams failed to do this adequately: 1. For Individual #399, it was reported in progress notes that the individual was making progress. The data, however, reflected that the individual had demonstrated no increase in replacement behavior since the PBSP was initiated in September 2010.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. The BSSLC process for reviewing each episode of restraint, as reported by staff, begins with a FFAD done by the restraint monitor immediately after the restraint episode. This was ordinarily followed 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, FFAD, 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 ordinarily includes a referral to the PST for PSP revisions. The actual operation of this process was evident to the Monitoring Team as it reviewed documents, attended unit and facility wide IMRT meetings, and interviewed staff. The Monitoring Team was impressed that these restraint reviews did not appear perfunctory, were interdisciplinary in nature, and resulted in immediate steps that can be taken to try and minimize the need for restraint of the individual in the future. Because the Restraint Checklist has been converted to an electronic format at least some of the information staff need to review restraint episodes is more accessible. Documentation of these reviews are recorded in IMRT meeting minutes. There is also space on the FFAD to document that both a unit and IMRT review took place and the date and entries were noted on 24 of the 25 (96%) of the records reviewed in Samples C.1 and C.3. If a restraint related issue is referred to the PST the results were documented in a Personal Support Plan Addendum (PSPA).	Substantial Compliance

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		The Restraint Reduction Committee included on its agenda a case study each month. This is typically the most difficult behavioral/restraint case at the time of the meeting. The discussion at the Restraint Reduction Committee observed by the Monitoring Team was interdisciplinary and collaborative, including efforts by the Facility Director to generate discussion and develop hypotheses about why restraint application is most common in the child and adolescent residences. Much of that discussion was anecdotal with no evidence-based plans to investigate the hypotheses generated. It is anticipated that as this process matures discussions in these case studies will include more behavioral data. 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.	

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

1. Many Individuals are released from restraint because staff was unable to maintain the restraint. This needs to be addressed, either through assessment of restraint techniques or staff training, in the context of the specific individuals for whom this is a prevalent issue. (Provision C.2).
2. The Facility's overall management of use of protective restraints needs to improve and adhere to State and Facility policy, and the requirements of the SA. (Provisions C.2 and C.5).
3. The BSSLC should define in its policy what type of training is required of staff to ensure proper application and monitoring of mechanical devices used for protective restraint and train staff accordingly. (Provision C.3).
4. Develop standardized work processes, including protocols and documentation requirements, which comply with State and Facility policy, and the requirements of the SA, with respect to medical restraint. (Provision C.4)

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated 4/14/11) 2. BSSLC Plan of Improvement (POI) dated 7/12/11 3. DADS Policy 021 – Protection From Harm – Abuse, Neglect, and Exploitation dated 6/18/10 4. DADS Policy 023 Incident Management dated 1/31/11 5. Form 1020 for 25 employees 6. Your Rights and Zero Tolerance posters 7. Training materials used by BSSLC in recent Abuse/Neglect classes 4/18/11 and 5/12/11 8. Abuse/Neglect/Exploitation Competency Exam dated 4/18/11 9. Log of Department of Family and Protective Services (DFPS) case dispositions 1/20/11 to 6/7/11 10. Log of serious injuries 6/9/10 to 6/6/11 11. Log of serious injuries 1/13/11 to 7/13/11 12. Log of Incidents reported by Individuals, Family members, or Legally Authorized Representatives (LAR) 12/21/10 to 5/31/11 13. DFPS investigation reports and related materials selected for Sample D.1: 38719290, 39332927, 38561614, 39538067, 38679814, 38601325, 39413247, 38831638, 39517970, 39562747, 39617847, 38628368, 38573828, 38679080, and 38658998 14. Other DFPS case reports: 38888955, 39155647, 38988007, and 38999811 15. BSSLC investigations selected for Sample D.2: UIRs 100, 153, 164, 171, and 187 16. Other BSSLC investigations: UIRs 123,161,162, and 197 17. List of employees placed in No Direct Contact (NDC) status 11/16/10 to 2/28/11 18. Log of law enforcement referrals 1/12/11 19. Incidents with local law enforcement involvement: UIRs 124, 175, and 216 20. OIG Case reports: 06723-11(UIR 122), 07134-11(UIR 184) and 06759-11(UIR 135) 21. List of abuse/neglect investigations from 1/1/10 to 1/11/11 22. Incident Management Team meeting minutes 11/29/10, 12/6/10, 12/13/10, 12/20/10, 1/10/11, and 1/11/11 23. List of the ten most injured individuals since the last review (6/7/11) 24. List of the peers who caused the most injuries since the last review (6/7/11) 25. BSSLC Unusual Incident Reports Trend Report 6/30/11 26. BSSLC Abuse, Neglect, Exploitation Trend Report 6/30/11 27. BSSLC Injury Trend Report 6/30/11 28. Training transcripts for Facility Investigators 29. Training transcripts for DFPS Investigators 30. Minutes of Self-Advocacy group 2/28/11, 3/28/11, 4/25/11, and 5/23/11 31. List of BSSLC employees 7/13/11

	32. Materials used to educate guardians dated 10/1/07 33. Minutes of Human Rights Committee 5/26/11, 6/2/11, 6/9/11, and 6/16/11 34. List of incidents resulting in increased supervision of the Individual 11/22/10 to 5/23/11 35. Document entitled "Filing Systems for an Unusual Incident Investigation" 36. Incident Management Review Team (IMRT) minutes 5/16/11, 5/23/11, 5/31/11, 6/5/11 and 7/25/11 37. Positive Behavior Support Plans for Individuals #1, #3, and #49 38. List of approved/implemented policies of BSSLC 39. Program Auditor form Abuse, Neglect and Exploitation Competency Exam revised 1/14/11 **People Interviewed:** • Robert Ham, Facility Director • Kim Littleton, Assistant Director of Programs • Michael Johnson, Facility Lead Investigator • Susie Johnson, Settlement Agreement Coordinator • Caitlin Connor, Program Compliance Auditor • Ten Direct Care Professionals (DCPs) • Joe Bleecker, DFPS Investigator • Kerry Weyand, Data Analyst **Meetings Attended/Observations**: 1. Facility Incident Management Team meeting 7/25/11 2. Cottages Unit Incident Management Team meeting 7/28/11 3. QA/QI committee meeting 7/28/11 4. Restraint Reduction Committee meeting 7/27/11 5. Self-Advocacy Group Meeting 7/25/11 6. PSP meeting for Individual #56 and #390
	Facility Self-Assessment: The BSSLC Plan of Improvement reported substantial compliance with two (D.1 and D.5) of the five provisions of Section D of the Settlement Agreement (SA). The Monitoring Team determined substantial compliance with three provisions (D.1, D.4, and D.5) The BSSLC Plan of Improvement reported substantial compliance with 15 components of SA provisions. The Monitoring Team found BSSLC to be in substantial compliance with 14 of those 15 components of SA provisions. This is indicative of the progress towards substantial compliance demonstrated by the BSSLC.
	Summary of Monitor's Assessment: Since the last review the BSSLC has revised its Abuse/Neglect/Incident Management policy to reflect recommendations from the Monitoring Team. The Facility has also undertaken significant steps in retraining staff and engaging in competency checks. This was evident when the Monitoring Team interviewed Direct Care Professionals (DCPs). The process the Facility used to review investigation reports (the Abuse/Neglect/Exploitation Committee) and the documentation that results from this review are thorough and ensure regular executive

	management level review of such incidents. The scope of the tracking and trending of incidents has been expanded. The Facility has initiated a process for under-reporting of injury audits. According to the 6/30/11 Trend Report, abuse/neglect allegations were trending up. For FY2011 there was an average of 18 allegations/month in quarter one, 23/month in quarter two, 28/month in quarter three, and 28 in the first month of quarter four. According to the 6/30/11 Trend Report, UIRs (other than A/N) were trending down. For FY2011 there was an average of 12 UIRs/month in quarter one, 10/month in quarter two, 7/month in quarter three, and four in the first month of quarter four. According to the 6/30/11 Trend Report, injuries were trending down. For FY2011 there was an average of 291 injuries/month in quarter one, 256/month in quarter two, 262/month in quarter three, and 243 in the first month of quarter four. There continues to be a problem with investigations of abuse and neglect being initiated within the required 24 hours (or sooner, if necessary) of discovery/reporting. The process, and related documentation, of Facility investigations of serious discovered injuries needs improvement.

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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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated 4/14/11 governs this provision of the Settlement Agreement (SA). BSSLC'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. This policy is further supported by the ongoing training provided to all staff and competency checks conducted by program auditors in the Quality Assurance (QA) Department. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management (4/14/11), requires that staff 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. In the prior review the Monitoring Team expressed concern that at least some staff	Substantial Compliance

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		stated they would report suspected abuse to a supervisor, facility investigator, or administrative staff on call and, if so instructed by that person, would call the allegation in to DFPS. To the extent this may have happened it represented inappropriate filtering by administrators. It should be noted that the Monitoring Team did not find any instance where this process did not result in the incident being reported to DFPS. As a result of the Monitoring Team's concern, the Facility undertook an extensive retraining effort to emphasis that staff who observe, suspect, or hear about abuse are to call DFPS before they do anything else. The success of this retraining was evident to the Monitoring Team. When interviewing Direct Care Professionals (DCPs) during this review they clearly understood they were to call DFPS before doing anything else. This raised a different concern. When calling DFPS it is not uncommon for the caller to be placed on hold, sometimes for an extended period of time. If a DCP takes no further onsite action this can potentially place Individuals at risk of further harm. Facility policy correctly identifies what the Monitoring Team believes should be the proper sequencing of reporting and client protection events in Section III of the policy: 1. Take the necessary action to stop the ANE and the action necessary to remove the perpetrator from contact with residents, if applicable. 2. Seek medical treatment (or assessment) for the victim as needed; comfort and reassure the victim. 3. Report the incident to DFPS immediately and then record the details of the situation in writing including documenting on a Client I injury Report (CIR) form (completed by nursing staff). 4. Alert the Center Director, or designee, of the details of the incident so that protective measures can be taken as soon as possible. Ten of 10 staff interviewed (100%) understood the proper sequencing of reporting. It is suggested that through the Facility's regular competency checks, new employee training, and annual refresher training, emphasis be placed on the sequencing described in policy and that #3 (calling DFPS) be emphasized as something DCPs must do, irrespective of what another staff person, supervisor, or administrator may advise them to do. As described above, program auditors, when doing periodic interviews of staff, ask questions about actions surrounding suspected abuse, including calling DFPS. The program audit and competency check procedure used by the Facility should ensure that all staff have this knowledge. Therefore, the Monitoring Team finds this provision in substantial compliance.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as	BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated 4/14/11 governs this provision of the Settlement Agreement (SA).	

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	appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. According to the BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (4/14/11), 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. With regard to serious incidents, the BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 does not provide specific instructions relative to the reporting of serious incidents (other than abuse, neglect, and exploitation) and the Monitoring Team was not provided any other policy which included such instructions. The Monitoring Team reviewed the list of "Approved/Implemented Policies of BSSLC" and did not find any policy that, at least by its title, addressed serious incidents in general, or injury reporting. From a response to a document request asking for the six month period from 1/1/11 through 6/30/11 - total number of abuse allegations and disposition/status the following data were provided by the Facility: Total Number of Abuse Allegations 127 Substantiated 4 Unsubstantiated 107 Inconclusive 2 Administrative Referral 4 Disposition Pending 10 Total Number of Neglect Allegations 47 Substantiated 15 Unsubstantiated 20 Inconclusive 1 Administrative Referral 10 Disposition Pending 1	Noncompliance

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		Total Number of Exploitation Allegations 0 Based on an interview of 10 staff responsible for the provision of supports to individuals, all ten (100%) accurately described the reporting procedures for abuse, neglect, and/or exploitation. Because of recent training they had received they all answered, "call DFPS first." In response to follow-up questions by the Monitoring Team it was evident that most knew that they were to ensure individual safety, notify the nurse, and remove the alleged perpetration, and then call DFPS, and then notify the appropriate administrator. This was the case with eight (80%) of the ten DCPs interviewed. BSSLC provided a log of serious injuries during the period from 1/31/11 to 5/28/11, essentially a four month period. From this report the Monitoring Team was able to determine the BSSLC had 25 serious injuries during this time period. This is an average of 6.25 serious injuries per month. In the last review the Monitoring Team reported BSSLC Individuals had 29 serious injuries between 7/1/10 and 12/2/10, an average of 5.8 per month. Two samples of investigations were selected for review by the Monitoring Team. These included: Sample D.1: DFPS Investigations. A sample of 15 (20%) investigations was selected from the list of DFPS cases provided by the Facility. This list included cases from the last review to 6/6/11. This sample included the following DFPS cases: 38719290, 39332927, 38561614, 39538067, 38679814, 38601325, 39413247, 38831638, 39517970, 39562747, 39617847, 38628368, 38573828, 38679080, and 38658998. These 15 cases included eight cases of unconfirmed physical abuse, two cases of confirmed physical abuse, one case of physical abuse determined to be unfounded, one case of physical abuse determined to be inconclusive, one case of unconfirmed verbal abuse, one case of unconfirmed neglect, and one case of confirmed neglect. Sample D.2: Facility Investigations. A sample of five investigations (20%) was selected from the facility log of serious injuries. Two had been reported to DFPS. Three were discovered injuries. The sample consisted of the following UIRs: 100, 153, 164, 171, and 187. Based on a review of the 20 investigation reports included in both Sample D.1 and Sample D.2, nine (45%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. The 11 that did not include such evidence were the following: 1. DFPS case 39332927 was reported to DFPS on 5/10/11 at 9:43am. The	

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		accompanying UIR notes an injury description of bruises and/or scratches on the back chest, collarbone, forearm, hand, head/scalp, hip, leg, ribs, thigh, upper arm, and wrist. The LVN nurse assessment occurred at 6:30 am and the RN assessment occurred at 8:00am. 2. DFPS case 39413247 was reported to DFPS on 5/16/11 at 11:02 am. The accompanying UIR notes an injury description of a bruise to the right thigh and a bruise to the left hip. The LVN nurse assessment occurred at 6:20 am and the RN assessment occurred at 11:00 am. 3. DFPS case 39562747 was reported to DFPS on 5/26/11 at 9:18am. The alleged abuse occurred on 5/25/11. 4. DFPS case 39617847 was reported to DFPS on 5/31/11 at 5:58 pm. The alleged abuse occurred on 5/31/11 at 4:40pm. 5. DFPS case 38628368 was reported to DFPS on 2/10/11. The alleged abuse occurred on 11/2/10. 6. DFPS case 38573828 was reported to DFPS on 1/25/11. The alleged neglect occurred on 1/19/11. 7. BSSLC UIR 164: serious injury was noted by medical examination on 4/16/11. Notification to Facility Director/designee was on 4/17/11. 8. BSSLC UIR 171: serious injury was noted by medical examination on 4/27/11 at 9am. Notification to Facility Director/designee was at 11:00am. 9. BSSLC UIR 187: serious injury was noted by medical examination on 5/23/11 at 9:30 am. Notification to Facility Director/designee was at 10:44am. 10. BSSLC UIR 100: serious injury was noted by medical examination on 1/31/11 at 8:00 am. Notification to Facility Director/designee was at 9:31am. 11. BSSLC UIR 153: serious injury was noted by medical examination on 4/8/11 at 1:35pm. Notification to Facility Director/designee was at 4:00pm. The Facility had a standardized reporting format, the Unusual Incident Report (UIR). Staff completing and reviewing the UIR did not always follow the instructions that accompany the form. This makes it very difficult for staff (and the Monitoring Team) to determine accurately whether reporting timeframes required in the SA are met. For example, the UIR instructions for Section 2 ask that the date and time that the incident occurred (witnessed), or was discovered, be entered. The form also provides a third option, "reported". For each of the serious injuries in Sample D.2 the injury is marked as being "reported" rather than "discovered." In each case the time reported is well after the time the injury likely occurred based on nursing/physician and other entries in the UIR. These injuries were obviously witnessed or discovered much earlier. Additional instructions require that if an injury is non-serious and becomes serious "then mark as reported and use the date/time the injury was determined by the physician to be serious." In each of these six UIRs the time of the physician exam (presumably the time it	

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		was determined the injury was serious) did not match, even approximately, the time noted as "reported" in Section 2 of the UIR. Based on a review of 20 investigation reports included in Sample D.1 and Sample D.2, 20 (100%) contained a copy of the report utilizing the required standardized format.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. According to BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (4/14/11), 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 the 15 investigation reports in Sample D.1 alleged perpetrators (AP) were identified in 12 investigations. Documentation shows that the alleged perpetrators were placed in non-direct care (NDC) status in each case; however, in three (25%) of these 12 investigations there were inconsistent timeframes noted in the documentation. These are 38679814, 38719290, and 39538067. In each case, the time the AP was noted in the UIR to be placed on NDC status was earlier than the time the alleged incident occurred that is recorded on the cover sheet of the DFPS investigation. UIRs and DFPS reports undergo a significant amount of review at BSSLC. The Monitoring Team would expect these review processes to detect, and correct, data inconsistencies that directly affect SA compliance. In reviewing the 15 investigations in Sample D.1 there were not any instances were a staff person who had been removed from direct contact was subsequently returned to normal duties until the investigation had been completed and the investigation review process determined it was appropriate for the staff person to return to his/her normal assignment .	Substantial Compliance

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		Based on a review of the 15 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, retraining, and environmental conditions that could have created a safety hazard for other individuals were corrected.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 requires that all staff complete class ABU0100 Abuse and Neglect, and UNU0100 Unusual Incidents at least yearly. These two classes are 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 actions constitute 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.5), showed that 25 (100%) of these staff had completed competency-based training on abuse and neglect and unusual incidents within the last 12 months. Based on interviews with 10 staff: ▪ Ten (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation with sufficient depth to demonstrate competency of understanding; and ▪ Ten (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident	Substantial Compliance

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	Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	Management dated 4/14/11 does not include specific requirements associated with this component of the SA and the Monitoring Team was not provided any other policy that included such information. Nevertheless, practices were in place to ensure the requirements of this component were met. 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, 26 of 26 (100%) 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. A sample of 25 staff (Sample C.5) was randomly selected to determine if annual acknowledgements had been signed. Twenty-five of 25(100%) had signed annual acknowledgments form 1020. The Facility identified eight instances of late reporting of abuse, neglect, exploitation for the Monitoring Team. In one instance, the late reporting was a result of the alleged perpetrator not reporting until a record review identified an instance of verbal abuse which should have been reported several months earlier. Appropriate personnel action was taken in each of the eight instances.	
	(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 reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. 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 who attended PSP meetings during the review reported no discussion of abuse, neglect, or other reportable incidents. The minutes of the Self-Advocacy group, and the meeting attended by the Monitoring Team, did not reveal any discussion of these topics. Despite the apparent lack of effort directed at this component of the SA there were 37 instances of reported allegations coming from individuals and/or their families/LARs. Nearly a third of these were reported by one Individual. Nineteen different Individuals (or their family/LAR) reported incidents.	Noncompliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs.	Substantial Compliance

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	individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management (4/14/11) 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. Nevertheless, practices were in place to ensure the requirements of this component were met. 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 areas 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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 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 15 investigations completed by DFPS (Sample #D.1) DFPS had made law enforcement referrals in all allegations of physical abuse. It is important that allegations of physical abuse be reported to law enforcement because, if substantiated, they would represent potentially chargeable criminal offenses. Based on a review of six investigations completed by the Facility (Sample #D.2), law enforcement referral was not necessary or appropriate, except for those investigations that were subsequently reported to DFPS, 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	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 includes specific requirements associated with this element of the SA.	Substantial Compliance

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	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.	These are found in section V of the policy. Based on interviews with the Facility Director and the Incident Management Coordinator it was clear that retaliation would not be tolerated, and this was reinforced in training and during the course of individual investigations. Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential retaliation. Ten DCPs were interviewed and asked the following questions: 1. If you reported abuse would you have to worry about being retaliated against by a coworker or supervisor? Staff consistently responded they would not be worried about retaliation. 2. If retaliation did happen, or was suspected, how do you think facility administration would respond? Staff consistently expressed confidence that the administration would respond appropriately. 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 reported it did not have such a list because there were no reported allegations of retaliation since the last review.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. Since the last review the Facility had initiated a process to lead to compliance with this component of the SA. It was in a test phase and no formal policy or procedure had been written to support this effort. The Facility had developed an "Under Reporting Monitoring Tool," and instructions for it, that enable program auditors to review, on a sample basis and for a defined look back period, Integrated Progress Notes, Observation Notes, and Behavior Log Notes to determine if any entries report or suggest an injury. These data are crosschecked with the injury database to determine if a record of the injury is in the database. In reviewing initial reports conducted by one program auditor the Monitoring Team determined that there were apparent reporting problems with nine (32%) of the 28 individuals reviewed. This was a very new process and the Monitoring Team looks forward to assessing its	Noncompliance

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		progress in the next review.	
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:	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated4/14/11 governs this provision of the Settlement Agreement (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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. State and Facility policy articulate training requirements for investigators and these are sufficient to meet the requirements of this component of the SA. Facility investigators are not in the direct line of supervision of alleged perpetrators unless the alleged perpetrator was the Incident Management Coordinator or QA Director. If this were the case there is a staff person outside this chain of supervision authorized and trained to conduct investigations. 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 were generally thorough and comprehensive and case reports were generally well written the Monitoring Team believes the training DFPS investigators receive was achieving the desired results. BSSLC policy reported that Facility Investigator training is to consist of the following classes: 1. ABU0100 Abuse and Neglect 2. UNU0100 Unusual Incidents 3. MEN0300 People with Mental Retardation 4. CIT0100 Comprehensive Investigator Training, or LRA training Conducting Serious Investigations 5. Root Cause Analysis The Monitoring Team believes this training, if completed as described, was adequate for	Substantial Compliance

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		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 had 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 had two staff designated as principal investigators. The training records for these investigators were reviewed. Both have completed the required training. BSSLC had an additional four staff identified as investigators, primarily campus coordinators and program auditors. The Monitoring Team reviewed their training records. All had completed the required training. LRA training did not appear on the training transcript of four of the six investigators. The Monitoring Team accepted a copy of the LRA issued certificate as documentation. The Facility should ensure the LRA training is properly recorded in the CTD record-keeping system so that it appears on future transcripts.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 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 action.	Substantial Compliance

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		As described earlier in this report, 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 15 of 15 investigations (100%), Facility staff cooperated with DFPS investigators. Additionally, the Monitoring Team interviewed a DFPS investigator who regularly works cases at the BSSLC and he reported a high degree of cooperation.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. 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." Review of the investigation files in Sample D.1 showed no indication of interference by one agency or the other in 15 of 15 investigations (100%). Of the five serious injury investigation records from the Facility (Sample D.2), two had been referred to DFPS for further investigation, one of which resulted in a law enforcement referral. There was no evidence in any of these investigation records that would suggest any lack of cooperation or coordination between the Facility, DFPS, and law enforcement.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. While on site, the Monitoring Team observed the area the Facility uses for safeguarding evidence as well as 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	Substantial Compliance

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		(Sample D.1) and the Facility (Sample D.2) no issues related to the storage or integrity of evidence was noted. Additionally, The DFPS investigator reported, when interviewed by the Monitoring Team, that he had never encountered a situation at the BSSLC where necessary evidence was unavailable or evidence handling compromised the integrity of an investigation.	
	(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.	BSSLC reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. 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: Ten of 15 (67%) 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 an adequate investigatory process did not occur within the first 24 hours or sooner: • Investigation 38658998: this was an allegation of physical abuse (unconfirmed) reported to DFPS on 2/20/11 at 12:50pm. The initial face-to-face interview was on 2/23/11 at 1:29pm. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided. • Investigation 38679080: this was an allegation of physical abuse (confirmed) reported to DFPS on 2/25/11 at 8:58pm. The initial face-to-face interview of the nonverbal alleged victim was on 2/28/11 at 12:30pm. Staff interviews did not begin until 3/2/11. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided. • Investigation 38601325: this was an allegation of physical abuse (unconfirmed) reported to DFPS on 2/1/11 at 6:14pm. The initial face-to-face interview with the alleged victim was on 2/3/11 at 5:00pm. Staff interviews did not begin until 2/7/11. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided.	Noncompliance

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		• Investigation 38561614: this was an allegation of physical abuse (confirmed) reported to DFPS on 1/20/11 at 9:46pm. The initial face-to-face interview of the nonverbal alleged victim was on 1/22/11 at 4:45pm. Staff interviews did not begin until 1/26/11. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided. • Investigation 38679814: this was an allegation of physical abuse (unconfirmed) reported to DFPS on 2/26/11 at 8:45pm. The initial face-to-face interview of the alleged victim was on 2/28/11 at 4:45pm. Staff interviews did not begin until 3/8/11. No additional documentation of other investigatory activities occurring within 24 hours of the report was provided. Twelve of the 15 (80%) were completed within 10 calendar days of the incident. Those that were not included: • Investigation 38561614: The allegation was reported on 1/20/11. The report was completed on 1/31/11. The document used by DFPS for an investigator to request a time extension, and the circumstances associated with the request, was not included in the investigatory file prepared for the Monitoring Team. • Investigation 39538067: The allegation was reported on 5/24/11. The report was completed on 6/13/11. The document used by DFPS for an investigator to request a time extension, and the circumstances associated with the request, was not included in the investigatory file prepared for the Monitoring Team. Following the compliance visit, the Monitoring Team was notified that the documentation was available, but the source document was not provided, so the Monitoring Team cannot verify that the required actions occurred. Note: both of the above investigation reports contained a note indicating the date that an extension request was faxed to Michael Johnson, BSSLC Investigator. Extension requests for DFPS investigation should be sent to the DFPS supervisor, not to the BSSLC. • Investigation 38719290: The allegation was reported on 3/11/11. The file prepared by the BSSLC for the Monitoring Team contained two DFPS reports that appear to be identical in content. The completion date for one is noted as 3/22/11 by the DFPS investigator with a handwritten note by the supervisor that it was approved 3/21/11. The other report had a completion date of 3/28/11 noted by the DFPS investigator. This report also contains a note indicating the report was delivered to the BSSLC on 3/21/11 (even though the investigator indicated through her signature a completion date of 3/28/11). Because of this confusing information the Monitoring Team is unable to determine if this investigation was completed within 10 days, as required by the	

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		SA. Fifteen (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 seven of the investigations reviewed, the DFPS report included concerns and recommendations for corrective action that were appropriate to the circumstances of the investigation. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: In reviewing Sample D.2 (five serious injuries) the information in the UIR was insufficient to determine that the investigation began within 24 hours of the incident in all five (100%) investigations. The UIR's contain considerable information with respect to different chronological events associated with the Individual. The process to begin gathering the information (i.e. commencing the investigation) contained in sections 7, 8, and 9 of the UIR could have been gathered by the Investigator within 24 hours of the incident being reported, or it could have begun later. There is not an explicit date/time to indicate when the Investigator actually began the investigation. This is likely a technical oversight in report preparation or UIR instructions as the observations and interviews conducted by the Monitoring Team (including the Unit and Facility IMRT process) demonstrate that investigations begin immediately (ordinarily within minutes) of being reported. It is reasonable for the Monitoring Team to look at the entirety of the incident management process and presume investigations commence within 24 hours but it would be helpful if an explicit recording of the date/time the Investigator first commenced investigatory activity was included in the UIR. Two of five (40%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Those that were not include UIRs 100, 164, and 187. Five of five (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 five (100%) of the investigations reviewed, recommendations for corrective action were included. In all five of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation.	

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	(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 investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team does not concur. This component had been rated as in substantial compliance. During this review important elements of SA requirements for investigation reports were discovered, including State policy instructions which were, in one very important area, contrary to a SA requirement. The contents of the investigation reports reviewed are required to be sufficient to provide a clear basis for its conclusion and the reports utilized a standardized format that sets forth explicitly and separately: ▪ Each serious incident or allegations of wrongdoing; ▪ The name(s) of all witnesses; ▪ The name(s) of all alleged victims and perpetrators; ▪ The names of all persons interviewed during the investigation; ▪ For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ▪ All documents reviewed during the investigation; ▪ All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ▪ The investigator's findings; and ▪ The investigator's reasons for his/her conclusions. 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 findings related to DFPS investigations and Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: • In 14 of 15 investigations reviewed (93%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The exception was case 39051947 (UIR 164) which was a serious discovered injury reported to DFPS but referred back to the Facility as an administrative matter. The narrative presented in the DFPS referral form reported the incident would not be investigated because of the statement of the Individual's doctor who believed this injury was not the result of abuse but rather by accidental means and could possibly have been the result of an incident of peer-to-peer aggression, which	Noncompliance

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		occurred eight days earlier. In the opinion of the Monitoring Team the nature of this injury would have caused the individual a considerable amount of pain and could not have gone unnoticed for eight days. Because of this, it is not likely this serious injury occurred eight days prior to discovery. Other than the doctor's statement, the DFPS referral form does not indicate any staff statements were taken or staff interviews conducted. This report did not contain sufficient information to provide a clear basis for its conclusion. There should have been a more thorough investigation by DFPS; however, the Texas Administrative Code states that DFPS has jurisdiction to investigate if "appropriate medical personnel, after examining the person served, suspect the injury is the result of abuse or neglect." Although DFPS did not have jurisdiction because medical personnel did not report suspicion of abuse or neglect, the Monitoring Team finds that the circumstances surrounding this injury should have led to at least suspicion of abuse that would have resulted in an investigation. ▪ The DFPS case report utilized a standardized format that set forth explicitly and separately o In 15 (100%), each serious incident or allegations of wrongdoing; o In 15 (100%), the name(s) of all witnesses; o In 15 (100%), the name(s) of all alleged victims and perpetrators; o In 15 (100%), the names of all persons interviewed during the investigation; o In 15 (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 15 (100%), all documents reviewed during the investigation; o In 15 (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 15 (100%), the investigator's findings; and o In 15 (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 four of five investigations reviewed (80%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The exception was UIR 164 which was a serious discovered injury reported to DFPS but referred back to the Facility as an administrative matter. The narrative presented in the DFPS referral form reported the incident would not be investigated because of the statement of the Individual's doctor who believed this injury was not the result of abuse but rather by accidental means and could	

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		possibly have been the result of an incident of peer-to-peer aggression, which occurred eight days earlier. In the opinion of the Monitoring Team the nature of this injury would have caused the Individual a considerable amount of pain and could not have gone unnoticed for eight days. Because of this it is not likely this serious injury occurred eight days prior to discovery. Other than the doctor the UIR does not indicate any staff statements were taken or staff interviews conducted. This report did not contain sufficient information to provide a clear basis for its conclusion. There should have been a more thorough investigation by the Facility. The facility investigatory process needs to improve to ensure staff statements and staff interviews are regularly completed and documented ▪ The report utilized a standardized format that set forth explicitly and separately o In five (100%), each serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; o In five (100%), the name(s) of all alleged victims and perpetrators; o In none (0%), the names of all persons interviewed during the investigation; o In none (0%), 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 five (100%), all documents reviewed during the investigation; o In five (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 five (100%), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. The presentation of information in the UIR is not organized in manner that ensures all the details of this component of the SA are met. This makes it difficult for internal reviewers (e.g. BSSLC program auditors, unit and facility IMRTs) to determine if each and every required topic has been addressed. Additionally, the Monitoring Team discovered that the State policy instructions that accompany the UIR, in some cases and if followed, would make compliance with this component of the SA very difficult. For example, the instructions for Section 5 of the UIR read, in part, "enter the name, title and shift of all staff who have relevant knowledge of the incident and/or who were or may have been present during the time the incident occurred. Do not routinely list all staff on the shift/home if they do not have relevant knowledge or investigative value." The Monitoring Team believes it would be difficult to determine if a particular staff person has relevant knowledge without at least requiring a staff statement and/or conducting an interview. The instructions for Section 7 in attachments to the DADS Incident Management policy	

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		read, in part, "Information from initial written statements of witness and/or interviews with staff members that reveal relevant information about the incident should be included here," and, "It is not necessary nor recommended that you summarize information received from each individual interviewed." This last statement is directly contrary to one of the requirements of this component of the SA.	
	(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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 requires that staff supervising investigations review 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 findings related to the DFPS investigations and Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Fifteen of 15 (100%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. ▪ Fifteen of 15 (100%) case files, contained evidence that the BSSLC Abuse/Neglect/Exploitation Committee 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 (100%) investigation files there was evidence that the supervisor had conducted a review of the investigation report. ▪ In all six (100%) there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. The Facility should consider including Facility investigations of discovered serious injuries within the scope of administrative review conducted by the Abuse/Neglect/Exploitation Committee.	Substantial Compliance

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	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC uses 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 participates as needed.	Substantial Compliance
	(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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident Management dated 4/14/11 requires disciplinary or programmatic action necessary to correct a situation and/or prevent recurrence be taken promptly and thoroughly. The Facility had an 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 meeting minute's record and track intended actions until their completion and the expected outcome occurs. The Facility provided the Monitoring Team with sufficient direct evidence of employee disciplinary action and programmatic actions to demonstrate compliance with this component of the SA.	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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this component of this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC maintained a database from which it can quickly access prior history of alleged perpetrators and alleged victims. DFPS also has a data management system that allows a search of prior case history of alleged perpetrators and alleged victims. The Monitoring Team did not review that system as the BSSLC database met the requirements of the provision. However, the Monitoring Team appreciates that a backup system was in place.	Substantial Compliance

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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 reported in its Plan of Improvement (POI) that it was not yet in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team does not concur and believes the BSSLC has achieved substantial compliance with this provision of the SA (although as described further in this section of the report the Monitoring Team believes there are many opportunities to improve the tracking and trending beyond that required in the SA). BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated 4/14/11 governs this provision of the Settlement Agreement (SA). 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 the start of the prior fiscal year. This includes the number of cases referred to DFPS. Total allegations were trended for a rolling 12 months. The rolling 12 month data were also delineated by unit, by living area within each unit, and by individuals involved in allegations. Current month data also identified alleged perpetrators. The BSSLC produced a similar report tracking and trending injuries to individuals and Unusual Incident Reports. Some of the data on these reports are difficult to interpret. This can be improved with explanatory footnotes or topical headings that are clearly describing what each data item is intended to represent. The Monitoring Team reviewed this, and provided technical assistance, with the Assistant Director of Programs, Acting QA Director, and Data Analyst. From these trend reports it is relatively easy to spot trends. For example: • Abuse/neglect allegations were trending up. For FY2011 there was an average of 18 allegations/month in quarter one, 23/month in quarter two, 28/month in quarter three, and 28 in the first month of quarter four. • UIRs (other than A/N) were trending down. For FY2011 there was an average of 12 UIRs/month in quarter one, 10/month in quarter two, 7/month in quarter three, and four in the first month of quarter four. • Injuries were trending down. For FY2011 there was an average of 291 injuries/month in quarter one, 256/month in quarter two, 262/month in quarter three, and 243 in the first month of quarter four. In some areas the reporting of trend data could be expanded to be useful for process improvement decision-making. For example, it may be useful for injury tracking and trending to provide some level of analysis where now the report merely presents	Substantial Compliance

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		numbers. The Monitoring Team reviewed the trend report for "type of injury" and manually calculated the three most prevalent types over the previous three months and was able to see that over that three month period 27% of injuries were scratches, 20% were bruises, and 18% were abrasions. Or, 65% of reported injuries were attributable to these three types. Similar summary analysis over a rolling period of time may be useful in looking at discovered versus witnessed injuries, as well as other issues that could lead to action. The trend report for UIRs could be improved in the tracking of serious injuries. The report tracks "undetermined cause" and "determined cause." The determined cause category includes discovered injuries for which a probable cause (as opposed to an injury that was witnessed) was established as part of the investigation process. It may be useful for analysis purposes to have two subcategories under determined cause: delineating those that were "witnessed" and those that were "discovered but for whom the facility investigation established a probable cause." There may be many other things topics that an inquisitive Quality Assurance/Quality Improvement Council would want to build into trend reports and routine analysis of these data. The trend report information provided to the Monitoring Team did not include outcomes of investigations. If the Facility does not already gather and review that information, it would be useful to add it to the Trend Report. 3953806739538067	
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	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated 4/14/11 governs this provision of the Settlement Agreement (SA). 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	Substantial Compliance

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

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

1. The UIR document should have a defined entry to display the date/ time of an alleged incident occurring or being discovered that would enable the Facility (and monitors) to more clearly determine that SA reporting timeframes are properly measured. Terminology, where subject to misinterpretation, should be clarified and staff trained accordingly (D.2.a).
2. All incidents must be reported timely, in accordance with State and Facility policy (D.2.a).
3. The Facility should develop more robust strategies to educate and support Individuals, family members, and LARs on identifying and reporting incidents, including abuse and neglect (D.2.e).
4. The process for regular audits to determine under-reporting of injuries needs to be formalized (D.2.i).
5. The State needs to ensure that DFPS investigations are regularly initiated within the 24 hour timeframe required by the SA and that initial investigatory actions are documented (D.3.e).
6. UIR documentation needs to more clearly indicate the date/time a facility investigator first begins substantive investigatory activity (D.3.e).
7. The facility investigatory process needs to improve to ensure staff statements and staff interviews are regularly completed and documented as required by the SA (D.3.f).
8. The organization of information related to facility investigations (the UIR document) needs to improve to be in alignment with data required by the SA (D.3.f). This will facilitate improved internal review to ensure SA compliance. State office should consider a revamp of the UIR and its instructions to achieve this alignment.
9. The facility investigations of serious injuries, particularly discovered injuries, needs to be more thorough, probing in depth rather than accepting the first presentation of probably/likely cause (D.3.f).

The following additional recommendations are offered to the Facility:

1. If any administrative activity necessary to achieve SA compliance is not specifically covered in BSSLC policy, include it the next time the policy is undergoing revision.
2. Work on qualitative enhancements to the trend reports that make sense to facility leadership in understanding where issues requiring focused attention are within the organization.

3. When investigating/reviewing discovered injuries, especially serious discovered injuries, be more suspicious of abuse and neglect being a causal factor until a thorough investigation can convince the IMC and/or ANE Committee otherwise. Interviews of staff should be an expected component of each investigation and if interviews are not part of the investigative process a rationale should be provided in the UIR, such as "video surveillance validated the Individual accidentally fell from the wheelchair while reaching for the TV." . It is also prudent to conduct this thorough of an investigation for non- serious discovered injuries to certain areas of the body (e.g. head, genital area, etc.), or of a certain type (e.g. burn), if they were not witnessed and there was not any video surveillance to establish the cause of the injury.
4. The Facility A/N/E Committee should consider including serious discovered injuries, and other non- serious discovered injuries to certain areas of the body (e.g. head, genital area, etc.), or of a certain type (e.g. burn) within its scope of review responsibilities.

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 (11/22/10) 2. BSSLC Policy Quality Assurance/Quality Improvement Council (9/30/10) 3. BSSLC Plan of Improvement (POI) (7/12/11) 4. BSSLC Nursing Peer Review Policy (12/10/10) 5. BSSLC Quality Enhancement Plan (untitled and undated) 6. BSSLC Program Improvement Council meeting minutes from 7/26/10 and 8/30/10 7. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes 2/28/11, 3/31/11, 4/27/11, 5/4/11, 5/11/11, and 6/2/11 8. QA/QI meeting agenda and meeting handouts 7/27/11 9. Log of serious injuries 6/9/10 to 6/6/11 10. Log of serious injuries 1/13/11 to 7/13/11 11. Log of Injuries Updated in Avatar 6/8/11 12. Facility Trend Reports 6/30/11 13. Fifty monitoring tools currently in use by the QA department **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs 2. Jill Quimby, Acting QA Director 3. Susie Johnson, Settlement Agreement Coordinator 4. Caitlin Connor, Program Auditor 5. Jackie Gertman, Program Auditor 6. Juanita Taylor, Program Auditor 7. Kerry Weyand, Data Analyst **Meetings Attended/Observations**: 1. Facility Incident Management Team 7/25/11 2. Quality Assurance/Quality Improvement Council 7/28/11 3. Restraint Reduction Committee 7/27/11
	Facility Self-Assessment: The self-assessment provided by the BSSLC in its POI reported it was not in compliance with any provision of this section of the SA. The Monitoring Team concurs. The BSSLC policies Quality Assurance Process (11/22/10) and Quality Assurance/Quality Improvement Council (9/30/10) govern Section E of the SA. The BSSLC also has an informal Quality Enhancement Plan (characterized in staff interviews as a work in progress) which delineates the monitoring/audit tools used at the Facility, the frequency of review, sample sizes, and other relevant information necessary for carrying out QA activity.
	Summary of Monitor's Assessment: BSSLC tracks most data required in the SA although the integrity of those data was not always clear. For example, in reviewing separate logs of injuries for the same time period and same individuals the dates and

	times of injuries that should have matched did not. BSSLC produces the following a monthly trend reports: 1. Abuse/Neglect/Exploitation Trend Report 2. Facility Restraint Trend Report 3. Facility Injury Trend Report 4. Facility UIR Monthly Trend Report As with the injury data, data in the trend report had apparent discrepancies. The Monitoring Team, in reviewing two pages of the trend report, would have expected certain data to match on each page. It did not. In some areas the reporting of trend data could be expanded to be useful for process improvement decision-making. For example, it may be useful for injury tracking and trending to provide some level of summary analysis where now the report merely presents numbers. The Monitoring Team believes a Quality Assurance and Corrective Action Planning process should include two different sets of activities and strategies for outcomes: • Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. • Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. The BSSLC was engaged in considerable work activity related to the first strategy. The Monitoring Team was provided with a list of 50 monitoring tools that are in various stages of implementation and data collection. A process is in place to disseminate corrective action plans and follow-up on the implementation of those plans when specific problems are discovered through monitoring. For some monitoring tools the results of the monitoring was producing summary data that could be useful for the broader QA analysis presented as strategy two. There was very little evidence that the QA activity at the BSSLC had begun to address the second strategy. Finally, it should be noted that at the time of review the position of QA Director was vacant. This position was filled since the last review and was again vacant at the time of this review. 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 BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The BSSLC policy's Quality Assurance Process (11/22/10) and Quality Assurance/Quality Improvement Council (9/30/10) are intended to govern Section E of the SA. The BSSLC also has an informal Quality Enhancement Plan which delineates the monitoring/audit tools used at the Facility, the frequency of review, sample sizes, and other relevant information necessary for carrying out QA activity. BSSLC tracks most data required in the SA although the integrity of those data was not always clear. For example, in reviewing separate logs of injuries for the same time period and same individuals the dates and times of injuries that should have matched did not. This was the case with the following two documents provided to the Monitoring Team: Log of serious injuries 6/9/10 to 6/6/11 and Log of serious injuries 1/13/11 to 7/13/11. This inconsistent data was apparently attributable to some reports reflecting date and time of the actual injury, some the date and time of nurse assessments, and some the date and time of entry in the UIR database. These discrepancies could not be immediately explained by the QA department and, in some instances, required considerable research to determine what identical data items on different reports represented. The lack of understanding what data on a report represents undermines the Facility's ability to undertake effective QA analysis. This was an example of the need to more clearly define on each report what each data item represents, or, more importantly the Facility should decide which data items (e.g., time of injury vs. time of nurse assessment, vs. time of UIR database entry) are important to the QA process. Perhaps, in this example, all three are important to track and trend and one report should display all three. BSSLC produces a number of trend reports that result from QA activity. The reports that have been in place the longest, and are subject to regular review by the QA/QI Council were selected for review. These include the following a monthly trend reports: 1. Abuse/Neglect/Exploitation Trend Report 2. Facility Restraint Trend Report 3. Facility Injury Trend Report 4. Facility UIR Monthly Trend Report As the facility's QA process expands it will be important that it regularly produce summary reports targeting other subject matters important to facility improvements and SA compliance. The Abuse/Neglect Exploitation report displays the number and type of abuse, neglect,	Noncompliance

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		and exploitation allegations for each month going back to the start of the prior fiscal year. This includes the number of cases referred to DFPS. As with the injury data described above, data in the trend report had apparent discrepancies. The Monitoring Team, in reviewing the trend report entitled "Facility ANE Monthly Report – Total Allegations by Month/Quarter" and "Facility ANE Monthly Report – Total DFPS Cases by Month/Quarter" would have expected certain data items to match on each page. They did not. The data analyst (not the QA staff) was able to explain that data in one report were reporting the number of Individuals involved in allegations. Data in the other report reported the number of DFPS cases represented in the allegations involving those individuals. Because one DFPS case may include multiple individuals as alleged victims the numbers on the two reports would not match. This was a logical explanation but because of the titles of the reports, and absence of explanatory notes, these reports first appeared to be conflicting and caused data integrity to be questioned. It was also of concern that administrative staff using these data, presumably for performance analysis, could not immediately explain the apparent conflicting data. This raised concern regarding the degree to which tracking and trending data are substantively reviewed by the Facility. Total allegations were trended for a rolling 12 months. The rolling 12 month data was also delineated by unit, by living area within each unit, and by individuals involved in allegations. Current month data also identifies alleged perpetrators. Similar levels of detail were included in tracking and trending restraints, injuries to individuals, and Unusual Incident Reports. As described above, some of the data on these reports are difficult to properly interpret. This can be improved with explanatory footnotes or topical headings that clearly describe what each data item is intended to represent. The Monitoring Team provided technical assistance in this regard to the Assistant Director of Programs, Acting QA Director, and Data Analyst. From these trend reports it is relatively easy to spot at least big picture trends. For example: 1. Abuse/neglect allegations were trending up. For FY2011 there was an average of 18 allegations/month in quarter one, 23/month in quarter two, 28/month in quarter three, and 28 in the first month of quarter 4. 2. UIRs (other than A/N) were trending down. For FY2011 there was an average of 12 UIRs/month in quarter one, 10/month in quarter two, 7/month in quarter three, and four in the first month of quarter 4. 3. Injuries were trending down. For FY2011 there was an average of 291 injuries/month in quarter one, 256/month in quarter two, 262/month in	

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		quarter three, and 243 in the first month of quarter four. In some areas the reporting of trend data could be expanded to be useful for process improvement decision-making. For example, it may be useful for injury tracking and trending to provide some level of summary analysis where now the report merely presents numbers. The Monitoring Team reviewed the trend report for "type of injury" and manually calculated the three most prevalent types over the previous three months and was able to see that over that three month period 27% of injuries were scratches, 20% were bruises, and 18% were abrasions. Or, 65% of reported injuries were attributable to these three types. Similar summary analysis over a rolling period of time may be useful in looking at discovered versus witnessed injuries, etc. It is important that the QA process move from just presentation of numbers to analysis that leads to organizational understanding and performance improvement. Another example is the trend report for UIRs. This could provide additional useful information in the tracking of serious injuries. The report tracks "undetermined cause" and "determined cause." The determined cause category includes discovered injuries for which a probable cause (as opposed to an injury that was witnessed) was established as part of the investigation process. It may be useful for analysis purposes to have two subcategories under determined cause: delineating those that were "witnessed", and those that were "discovered but for whom the facility investigation established a probable cause". There may likely be many other topics that an inquisitive Quality Assurance/Quality Improvement Council may want to build into trend reports and routine analysis of these data in order to have information useful in identifying areas to improve and tracking effectiveness of corrective actions and improvement initiatives relevant to meeting all requirements of the SA.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in	The BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Quality Assurance process, and Corrective Action planning consists of two different strategies: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by Program Auditors in the QA Department. 2. Development of broader strategic action plans to correct systemic problems identified through the analysis of data collected over time from a variety of sources, such as: the results of monitoring/auditing referenced above; tracking and trending data described in E1; regulatory reports (CMS 2567's); reports	Noncompliance

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	which each action step must occur.	(anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. BSSLC was engaged in considerable work activity related to the first strategy. The Monitoring Team was provided with a list of 50 monitoring tools that were in various stages of implementation and data collection. Many were directed at SA requirements and others at clinically oriented performance, such as restraint use and nursing. The Monitoring Team reviewed documents and through interview established that a process is in place to disseminate corrective action plans and follow-up on the implementation of those plans when specific problems are discovered through monitoring. This occurs primarily through the IMRT review process. For some monitoring tools the results of the monitoring was producing summary data that could be useful for the broader QA analysis presented above. Implementation of many of these CAPs was tracked through the IMRT. Others were tracked by individual departments, such as nursing. There did not appear, as yet, to be an organized method for bringing data associated with all these CAPs, together in one place to determine the degree to which they were implemented, implemented timely, and were effective in correcting whatever problem they were designed to correct. The Monitoring Team did not detect any evidence, through document review and interview that any substantive activity was yet occurring relative to the broader systemic facility wide corrective action planning required under this provision of the SA. 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. This is unlikely to occur in a meaningful way until the QA process matures and begins to identify systemic issues needing a broader and strategic corrective action plan and process.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	The BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Per interview, the Monitoring Teams determined that the BSSLC did not as yet have a fully organized and uniform system for the development, assignment and dissemination, implementation, and tracking of corrective action plans. There were elements in place, for example, the follow-up tracking that is a part of the Incident Management Review Team process. Corrective action plans were developed differently in different departments and tracking mechanisms were different in different departments. From	Noncompliance

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		this review the Monitoring Team is unable to validate that corrective action plans are disseminated to all entities responsible for their implementation. A challenge facing the QA Department will be to bring all this work effort together into a uniform system with common reports, common tracking, and common follow-up mechanisms.	
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 BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. As noted in Provision E2 there was insufficient information presented to the Monitoring Team to conclude compliance with this provision of the SA. With respect to action plans directed at specific problems detected through monitoring, the IMRT tracked implementation to ensure plans are implemented. There did not appear to be any substantive work activity directed at ensuring the plans met the desired outcome of remedying or reducing the problems originally identified. Action planning directed at broader systemic issues was not yet in place.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Per interview, the Monitoring Teams determined that the BSSLC did not as yet have a fully organized and uniform system for the development, assignment and dissemination, implementation, modification, and tracking of corrective action plans. There were elements in place, for example, the follow-up tracking that is a part of the Incident Management Review Team process. Corrective action plans were developed differently in different departments and tracking mechanisms were different in different departments. From this review the Monitoring Team is unable to validate that corrective action plans are modified when necessary to ensure effectiveness. A challenge facing the QA Department will be to bring all this work effort together into a uniform system with common reports, common tracking, and common follow-up mechanisms. While the Facility had begun to demonstrate a capacity to generate corrective action plans responding to sentinel events it had not as yet developed the capacity to develop, implement, and modify corrective action plans that address problems identified through the quality assurance process. To meet this requirement of the SA the Facility must be able to demonstrate its QA process is collecting sufficient data from which comprehensive analysis can produce the identification of underlying systemic causes of problems that can be addressed through facility-wide, or department-wide, improvement initiatives.	Noncompliance

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

1. Review the organization of trend and other reports to ensure data are correctly labeled, and footnoted if needed, to ensure anyone reviewing and analyzing the data correctly interprets the data (Provision E1).
2. Determine how to further organize and display data that can be used for process and performance improvement (Provision E1).
3. Develop a formal Quality Assurance Plan, approved through the Facility approval process, that is comprehensive, logically organized, and consistent in presentation of information, plan of activities for improvement, and expected outcomes (Provisions E1, E2, E3, E4, and E5).
4. Use the QA/QI Council for discussion of trends and selection and assignment of systemic corrective actions and improvement initiatives relevant to meeting requirements of the SA (Provision E2).

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 (12/10/10) 2. BSSLC Plan of Improvement (POI), 7/12/11 3. Settlement Agreement Compliance Report 1/1/11-7/28/11 4. PSPs and related documents for Individuals #1, #3, #12, #14, #43, #49, #68, #149, #165, #247, #260, #312, #407, #471, #485, and #576 5. Personal Focus Assessments (PFA) for individuals #12, #14, #43, #68, #149, #165, 242, #247, #260 ##312, #407, #471, #485, and #576 6. Personal Support Plan Meeting/Documentation Checklist (9/1/10) for Individuals #4, #237, #358, #379, and #566 7. Report titled "Individuals and PSP Dates" 6/17/11 8. HMPs and Acute Care Plans (ACP) for Individuals #191, #24, #83, #66, #576, #303, #163, #38, #392, #270, #165, #421, #422, #68, #96, #557, #59, #291, and #554 9. Physical and Nutritional Management (PNM) documentation for Individuals #33, #60, #79, #163, #291, #342, #413, #496, and #591 **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs 2. Pam Boehnemann, Acting QMRP Coordinator 3. Susie Johnson, Settlement Agreement Coordinator 4. Shawn Cureton, M.S. Psychology Manager 5. 10 Direct Care Professionals (DCPs) 6. Ric Savage, Consultant 7. Sally Schultz, Consultant 8. Bill Davis, DADS Operations Coordinator 9. Four QMRPs **Meetings Attended/Observations**: 1. Quality Assurance/Quality Improvement Council 1/12/11 2. PSP Meeting for Individuals #56 and #390 3. Personal Focus Assessment meeting for Individuals #115, #242, and #408 PST risk assessment meetings for Individuals #26 and #181
	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. For the most part, the current POI simply reported on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. The POI did not provide details as

	to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. In the case of Provision F1b, the Facility did indicate it had created a database to track the attendance/participation of the personal support team members and planned to review and monitor the information from the database to identify appropriate corrective actions. In the future, this process should be used to provide focus for the POI. The Facility also reported plans to develop a tracking system to monitor and ensure that initial PSPs and Annual PSP are held and implemented within the proper timeline, which was in progress, and to develop a system to monitor staff's comprehension of the PSP and Action Plan programs, along with a database to track and trend the result of this monitoring system. The latter initiatives were not yet underway. The Monitoring Team commends the Facility for these plans to obtain objective data in these areas and recommends it also consider developing methodologies to ensure the data are used to self-assess status of compliance and further focus their efforts to achieve compliance with the SA.
	Summary of Monitor's Assessment: BSSLC indicated it was not in compliance with any of the components for this provision and the Monitoring Team concurred. The findings are as follows: **Provision F1:** The Facility continued to implement the "Supporting Visions" PSP process, which was intended to reinforce the concept that planning is intended to support the individual's vision for the future for him/herself. Some improvement in the area of team member participation in the PSP had been noted, and this was particularly evident with the participation of Direct Care Professionals. The Monitoring Team was also pleased to see additional training, coaching and mentoring being provided to the QMRPs and PSTs. These initiatives, which included the Q-Construction facilitation skills training and follow-up as well as a dedicated external consultation on the development of quality PSPs, were recent developments, but demonstrated some promise for enhancing the PSPs at BSSLC. Overall, however, the new PSP format, and process was being implemented at BSSLC with limited success specific to the requirements of this section of the SA. No meaningful preparation was provided to ensure the PFA and/or PSP processes were conducted in a manner that facilitated real participation by the individuals. PST members often came to planning meetings without a basic knowledge or awareness of an individual's current status or needs. In addition, PSTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. The Monitoring Team found this to be a pervasive issue at the Facility that will need immediate and sustained attention to remediate. The PFA process was not being implemented in a manner that was either timely nor meaningful to the individuals for whom the plan was being developed. **Provision F2:** PSPs did not consistently specify 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 and meet identified needs, nor did identification of barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. The continued lack of revision to inadequate data collection and presentation practices will be a substantial impediment

	for BSSLC in making progress toward compliance with this portion of the Settlement Agreement. The Facility had implemented additional quality assurance processes that intended to identify and remediate the most apparent problems observed during a PSP meeting. The Monitoring Team commends the Facility staff for this quality assurance activity and encourages ensuring careful documentation of follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The self-assessment provided by the BSSLC in its POI reported it was not in compliance overall with this provision of the SA. As described below, the Monitoring Team concurs.	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 supports.	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. BSSLC had undertaken some actions to assist QMRPs to more effectively implement person-directed planning through the PFA and PSP. All of the QMRPs at BSSLC had completed Q-Facilitation training and were receiving ongoing coaching and follow-up training from three DADS-certified trainers. This curriculum focused on key facilitator skills needed to enhance participation by all PST members. The training process also included a three (3) day training that consisted of four mock PSP meetings. This training was intended to allow the QMRPs to practice their facilitation skills and allowed for the teams to learn how to have integrated team meetings in a variety of situations. BSSLC had also begun to receive external consultation centered on the PSP and PFA processes. A three-consultant team had been providing classroom training, coaching and mentoring to the QMRPs and PSTs in the development of the PFA and the PSP. This process was in the early stages of implementation but appeared to have had some immediate impact and held promise for continued improvement. The Monitoring Team commends DADS and the Facility for beginning to address the needs of the QMRPs and PSTs. Nevertheless, 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, as described below.	Noncompliance

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		For this provision to be in compliance, not only does this process need to be facilitated by one person, but team members also must participate in assessing each individual and in developing, monitoring, and revising treatments, services, and supports as necessary throughout the year. The Monitoring Team did note that team member participation was improved over previous visits. This improvement was particularly evident in the participation of direct care professionals, who were observed to be much more active participants than in previous monitoring visits. The Facility was implementing the new Personal Focus Assessment (PFA) which was intended to ensure the PSP would be centered on the needs, preferences and personal goals of the individual. The PFA was therefore an essential part of the PSP process. This requires that the participants in the PFA include the individual as well as those people who have close relationships with the individual and those who have knowledge of important preferences, goals and events in the individual's life. The PFA process had not yet improved the level of participation of individuals in their own planning. The PFA, particularly as it is currently implemented should not be seen as a singular vehicle for preparing an individual to participate in his or her own planning in a meaningful way and to envisioning his or her future. Although individuals typically attended the PFA and PSP meetings, their actual participation was often very limited. For zero of three (0%) PFAs attended during this monitoring visit, individuals could have been said to have active and meaningful participation in the proceedings. For example, for at least two of the meetings, the individuals were noted by the PST to be uncomfortable with the process because it conflicted with their usual work routine. At the very least, the Facility should ensure that PFA and PSP meetings are held at times that work best or the individual. In addition, individuals with intellectual disabilities benefit from repeated and ongoing experiential activities in this area, as with many others, 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 recommends that the Facility implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html. Such a planning process might include, for instance, many opportunities across the year for staff to assist each individual to create pictorial representations of the things that matter to them. Using photographs, drawings, pictures from magazines and books, for example, each individual could develop a poster portfolio of such things as "Important People in My Life," Things I Want to Do," Places I Want to Go," What My Ideal Home Looks Like," "Things I am Good At," etc. These posters could then be placed on the walls	

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		to begin the PFA meeting, making it much more meaningful to the individual, simply by having the visual cues. It would also provide a more meaningful way for the PST to explore the PFA areas with the individual. The portfolio could then be revised for the PSP meeting based on the PFA results. This would make the PSP a much more comprehensible and positive experience. As an example of how the current person-directed planning process is being implemented overall, the Monitoring Team attended a PSP for Individual #390 on 7/26/2011 and noted the following limitations: • Minimal effort was demonstrated by the QMRP to include the individual's sister, who was on speaker phone, in the PST discussion. o Shortly after the PSP meeting begins, the sister stated twice that she couldn't hear the conversation. The QMRP does not ask PST members to speak louder or move the phone to better capture the discussion. o Three times during the PSP meeting, while the sister was conversing with the individual, the QMRP continued the PST discussion. This prevented both the sister and the individual from participating in the discussion. o At 3:00pm, 40 minutes had passed without the QMRP directing comments or questions to the sister. • Multiple instances reflected poor awareness of the individual's preferences or attempts to meet the individual's preferences. o The SLP indicated that the individual preferred to use speech to communicate, but is often difficult to understand. It was reported that the individual has "rejected" programming and communication devices, but the PST did not discuss ways to explore this "rejection" or to devises alternate strategies. o Although the individual indicated that he prefers to work, he had attended the Harmony retirement program for several months. o It was indicated that the individual enjoys television and radio. Both his television and radio had been broken for several months. o During the discussion of attending church services, the individual indicated he would like a tie to wear. His comment was ignored. • The PST discussion did not offer full and complete discussion of programmatic needs. o Despite fine motor limitations, no discussion was offered concerning the need for adaptive dining equipment. The SLP indicated a PNMP was needed, but there was no discussion of why the plan was needed or what it would involve. o When undesired behavior was discussed, the psychologist indicated that indicated that behavior that had been labeled as pica, "was behavior and not	

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		true pica." No further discussion of pica or undesired behaviors was offered.	
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. • In reviewing PSP sign-in sheets for seven of nine of recent PSPs (for two of seven, the completed sign-in sheets were not made available), QMRPs and RNs were always present at the annual meetings. It was not always clear by the signatures and designations on the sign-in sheets, but it appeared DCPs were present at five of seven meetings (71%); QMRPs reported that efforts to have DSP staff available at PST meetings were at best inconsistent. No data were available regarding the frequency or duration of attendance by DSPs. On the other hand, physicians were present at only two of seven (29%) meetings. For six of seven PSP signature sheets (86%), both the individual and family/LAR attended, either in person or by phone. As described in F1a, however, facilitating the real participation of individuals in planning for their own futures is essential to the process. This was not occurring. For two of two PFAs attended by one member of the Monitoring Team during the monitoring visit, staff acknowledged that the individual was uncomfortable with the timing of the meeting because it conflicted with their usual routines. No consideration had been given to scheduling the meeting at another time in such a way as to encourage the individuals' participation. No meaningful preparation was provided to ensure the PFA and/or PSP processes were conducted in a manner that facilitated real participation by the individuals.	Noncompliance
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. Assessments were not routinely being completed on a timely basis. For example: • For the CLDP for Individual #102 held during the monitoring visit, a number of assessments were not available 24 hours prior to the meeting. These included the Behavioral Services Review Summary, Annual Medical Assessment, Pharmacy Update and QMRP Report. • A review of the assessments available for review for PSPs due in the two weeks following the monitoring visit revealed that more than 25% were unavailable. DADS and Facility policy call for assessments to be due in the shared drive 10 days before the PSP to ensure that PST members were prepared to use the results to develop a PSP that outlines the protections, services, and supports to be provided to the individual.	Noncompliance

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		In addition to issues of timeliness, BSSLC PSTs did not routinely conduct comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. Staff often came to planning meetings without a basic knowledge or awareness of an individual's current status or needs. In some instances, members of the Monitoring Team had knowledge from previous visits and/or from reviewing the individual's record for which the individual's PST had no awareness. This appeared to be a pervasive issue that occurred across all types of planning and assessment activities. For example: • For Individual #102, a CLDP was held during the monitoring visit. As described in Provision T1c1, the individual had not had a physical examination in at least two years, despite having lost, unplanned, almost 20 pounds in the last year and a half and exhibited an increasing propensity for falls. • For Individual #26, a Risk Assessment Meeting was held during the monitoring visit. There was discussion regarding the rating for gastrointestinal risk. Neither the physician nor the nurse were aware the individual had had a hospitalization with a bowel impaction within a few months prior. • For Individual #390, a PSP meeting was held during the monitoring visit. PST members were unfamiliar with key preferences, such as an interest in cooking, even though these were identified during his PSP the year before. It was not even clear staff were aware the individual preferred to be called by a certain name, even though this had been identified in the PSP the previous year. • For Individual #390, the individual's sister indicated the individual enjoyed water activities. The team members present did not express any awareness of this and called for the individual to have a water safety assessment, even though this issue was raised by the sister at the previous year's PSP. The team also appeared to be unaware there was a water safety assessment in the record dated July 2010. This assessment was not completed with sufficient accuracy, as it indicated there was no knowledge of the individual's participation or enjoyment of water activities despite the sister having shared that information at the PSP just prior to the completion of the assessment. In a number of instances, needed assessments were not completed in response to significant changes in an individual's life, as illustrated in a number of instances in which there were Physical and Nutritional Management needs. Only two out of nine (22%) individuals who were diagnosed with a PNM issue (Individuals #33, #60, #79, #163, #291, #342, #413, #496, and #591) were assessed by the PNMT or PST. For example: • Individual #413 was diagnosed with aspiration pneumonia on 4/14/11 and 5/12/11 with no evidence of discussion or assessment by the PNMT. The PST conducted a risk screening on 4/16/11 but there was no evidence of discussion regarding etiology of the event.	

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		• Individual #291 had aspiration pneumonia on 5/30/11 with no evidence of discussion or assessment by the PNMT or PST. • Individual #342 had aspiration pneumonia on 3/10/11 with no evidence of discussion or assessment by the PNMT or PST. Of particular concern was Individual #60. Based upon review of the aspiration trigger data sheet, the individual experienced 77 episodes of coughing with struggle during the month of April 2011, 94 episodes of coughing with struggle during May 2011, and 181 episodes of coughing with struggle as well as 28 episodes of Wet vocal quality during the month of June 2011. Documentation and communication surrounding this event were vague and at times nonexistent. For example: • DCPs were noting on the trigger sheet all the aspiration triggers but were not consistently documenting in the observation notes • Nursing was signing off demonstrating that review of the trigger sheet was completed but did not follow up consistently with a note in the IPN or an assessment. Although the triggers were occurring throughout April, May and June 2011, the first note acknowledging this issue was not until July 3, 2011. A total of three nursing notes were noted in the IPNs related to this issue. There was no evidence that the information was shared with the physician. • Nursing note on 7/15/11 stated that although there was coughing, lung sounds were good and that coughing was not an appropriate trigger. This determination was made without PST input or assessment by Speech Therapy. • Physicians' note on 6/17/11 stated that DCP reported to him that Individual #60 had been coughing on ensure for awhile but he did not know how long this had been occurring although it had been identified on the trigger data sheet for months. Physician requested modified barium swallow study (MBSS) as soon as possible. • 6/28/11 Physician's order written for MBSS if SLP thought individual could tolerate. No SLP evaluation was provided until 7/17/11, therefore no MBSS was completed. • 7/17/11: SLP/OT evaluate individual and state that individual is in distress and "drowning" on liquids and needs to be admitted to hospital. Individual was admitted and returned to BSSLC with a g tube. The above demonstrated a severe lack of communication between team members and an alarming lack of awareness regarding aspiration indicators. This was evident not only by what is stated above but by the lack of PST intervention throughout the last three months. Additionally, during the PNMT meeting, the physician stated that there was an order for abdominal girth measurements to be conducted daily; however, this order could not be located in the chart and members of the team were not aware of this order.	

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		Refer to Provision O.6 for more issues regarding lack of aspiration trigger notification. Findings were submitted to the Director of the Facility who contacted protective services of the concern. Similar deficiencies in assessment practices were noted in nursing services as well. For example, nineteen clinical records were reviewed for compliance with the Nursing Department's Management of Acute Illness and Injury Procedures, Nursing Documentation Guidelines, and evidence of integrated services. Since the last review, little progress had been made in this sub-section of the provision. Consistent with previous findings, there continued to be significant problems regarding the nurses' competency in assessment and documentation in a number of areas, including the following (Please refer to Provision M1 for further detail): • Due to the lack of documentation, it was often not possible to determine when changes in heath status were initially occurring. • A lack of complete and appropriate nursing assessments in response to presenting signs and symptoms of changes in status; and/or changes in vital sign and oxygen saturation measurements. • A lack of follow-up from issues noted in previous nurses' progress notes.	
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 did not match the findings of the assessment. Examples in the areas of communication and health care are described below. • The PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to communicate were also very limited or non-existent. Some examples included: o Only three of the 16 records reviewed (18%) clearly identified how the individual communicates with others and interacts with his surroundings. o Individual #403's communication assessment stated that he never responds to pictures but the SSO has him working with pictures. This demonstrates lack of review prior to the development of goals • A sample of HMPs and Acute Care Plans (ACP) for individuals' whose Annual and Quarterly Comprehensive Nursing Assessments were reviewed in Provision M.2.	Noncompliance

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		Consistent with past reviews, the HMPs reviewed continue to lack any individual specific interventions based on the individuals' need, and did not provide adequate direction for caring for the individuals who where identified as being at risk related to health/mental issues. In addition, the nursing interventions contained in the HMPS failed to include proactive interventions directed at preventing or minimizing the specific health risk. For each risk factor that was designated at high risk for the Individuals listed above, such as, seizures, osteoporosis, weight issues, aspiration, falls, fractures, cardiac issues, and GI problems, HMPs were essentially the identical protocol, with only difference being the individuals' baseline data. For Individual #390, The PST failed to fully assess risk and the provision of adequate protections, including: o A medical assessment had revealed silent aspiration of thin liquids and chopped meats. The nurse indicated that she, "had no idea where the diagnosis of dysphagia came from." No further discussion of the condition was offered. o In discussion of the circulatory risks, the nurse indicated that many things were close, "but technically in the safe range." No further discussion was offered.	
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 two PSP annual planning meetings and reviewed nine recently completed PSPs as measures. For only one of two (50%) PSP meetings observed during the monitoring visit, and for zero of nine (0%) PSPs reviewed, did the PST 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 #390 expressed during the PSP meeting a desire to move to the community, but the sister/LAR was opposed. The QMRP did assist the individual to express this desire, and the PST did not identify any obstacles to community living. Despite this, the PST determined the most integrated setting was BSSLC. When questioned after the meeting, there was a general consensus that the community was the most integrated setting. The PST was not aware of its	Noncompliance

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		responsibility to make a professional determination of the most integrated setting appropriate to the individual's needs. • For Individual #312, the PST agreed there were no obstacles for the individual to live in the community, but also noted the individual's mother preferred BSSLC. In the PFA, the team documented the individual would like to live closer to family and that his dream for the future was to live in he community. The team indicated that education regarding living options was available upon request of the individual and/or the mother, but left the most integrated setting segment of the PSP blank. No Action Plans were developed to increase awareness of community living options to facilitate the individual's desire to live closer to family or dream to live in the community. It was noted this individual was not listed on the Community Placement Report as not referred due to LAR Choice. • For Individual #14, the PFA indicated the individual wanted to live at home with the individual's parent. The PST identified the only obstacle to community living was the LAR choice for the individual to continue to live at BSSLC. The team then determined the most integrated setting was BSSLC. No action plans were developed to increase awareness of options for either the individual or the LAR. No Action Plans for community integration were developed. It was noted this individual was not listed on the Community Placement Report as not referred due to LAR Choice. 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 procedures that provide for the development of integrated ISPs for each individual as set forth below:	The self-assessment provided by the BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs.	
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 overall with this component of the SA, as described in detail below. The Monitoring Team concurs, as described below.	Noncompliance
	1. Addresses, in a manner building on the individual's preferences and strengths,	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

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	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 PFA process did not consistently use the individual's preferences and strengths to identify appropriate prioritized needs that would lead to increased independence. For example, for nine of nine recent PFAs (100%), the PST failed to identify any specific needs in the area of employment that would have led to increased independence. Examples included: • For Individual #14, the PFA indicated the individual "did not meet the criteria" to consider what kind of job the individual might like. • For seven individuals, the response to what job the individual would like if he/she could have any job in the world was to indicate it was unknown, or no response was given. Neither was community participation sufficiently encouraged by the PSTs. Examples included: • For Individual #471, one of the preferences identified in the PSP was participating in a variety of community outings. Although the PFA completed in preparation for the PSP did not indicate what the individual specifically liked to do in the community, no community-related assessments were recommended to be completed. The only Action Plan developed in the PSP to address this preference was to be provided with at least monthly outings into the community. • For Individual #485, community outings were identified as one of the individual's top prioritized preferences. The only Action Plan related to this key preference developed stated the individual "will be provided the opportunity to participate in social activities at least once weekly either on or off campus." There were no specific strategies that built on the preferences or strengths that would encourage actual community participation. Even though community activities were the identified preference, this Action Plan does not differentiate between activities on or off-campus, nor require community activity.	
	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. PSPs did not consistently specify 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 and meet identified needs. PSPs reviewed contained Action Plans but most did not contain complete or specific information. Several of these are described below. • 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 PSPs offered very limited descriptions of how	Noncompliance

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		an individual communicated with others. In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to communicate were also very limited or non-existent. • Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. For example, for Individual #14, the PFA indicated the individual wanted to live at home with the individual's parent. The PST identified the only obstacle to community living was the LAR choice for the individual to continue to live at BSSLC. The team determined the most integrated setting was BSSLC. No action plans were developed to increase awareness of options for either the individual or the LAR. No Action Plans for community integration were developed. A number of additional examples may be found in Provision T1b.	
	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. Although the structure of an interdisciplinary team process is in place, most involvement was multidisciplinary. From document review and meeting observation it was evident that different disciplines carried out separate assessments and made decisions outside the interdisciplinary process, reporting information and decisions, but not routinely integrating information to make joint or shared decisions. The Facility PSPs often failed to integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. Examples included: • The Facility did not routinely integrate the special education services that children living at BSSLC receive with the Facility PSP. For 3 of 3 PSPs (100%) reviewed during the site visit for individuals under the age of 22, there was no coordination with the PSP regarding the goals, objectives and services found in the IEP. 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. • Rationales and descriptions of interventions regarding use and benefit from AAC were not clearly integrated into the PSP. Only three of the 16 records reviewed (18%) had a clear rationale and description of communication interventions integrated into the PSP. • Communication information was not integrated into the daily schedule. Zero of	Noncompliance

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		the 16 records reviewed (0%) had communication interventions and methods to improve communication integrated into the daily schedule.	
	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. The Monitoring Team found that much progress had been made in this area as documented in Provision S1. There remained limitations that needed to be addressed. One was the lack of a specific consequence when an individual failed to perform the required task. The response to a failed trial is a critical component of the learning process. If reinforcement is available following a failed trial, the individual is reinforced for displaying a different behavior. Even when such circumstances occur rarely, it is possible that the power of reinforcement for success is weakened. Adequate data collection should include such elements as the occurrence of reinforcement, incorrect responses, refusal, and displays of undesired behavior. Most importantly, data collection should capture the extent to which the individual is developing the target skill. Data collection should focus upon the behavior displayed by the learner in relation to the goals of the training program.	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. The Facility did not consistently provide interventions, strategies, and supports that effectively addressed the individual's needs for services and supports and that were practical and functional at the Facility and in community settings. Examples included: • For Individual #407, one of the preferences identified in the PSP was participating in a variety of community outings. Although the PFA completed in preparation for the PSP did not indicate what the individual specifically liked to do in the community, no community-related assessments were recommended to be completed. The only Action Plan developed in the PSP to address this preference was to be provided with at least twice-monthly outings into the community. There was no methodology for how these outings might be used to assist in identifying the individual's preferences for things to do or to promote the ability to make choices about how to spend his leisure time. The individual also has a money management program to identify a dollar bill, but this was not integrated with the community outings Action Plan.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be	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 PSPs did not always consistently identify the data to be collected and/or documentation to be	Noncompliance

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	maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review. Some progress had been noted in this regard, particularly as it related to skill acquisition programs as described in Provision S1. For example, for 15 sampled skill acquisition programs, 100% included a documentation methodology and a plan for maintenance and generalization that included an assessment and measurement methodology. On the other hand, the Monitoring Team found that this remained a weak area for PBSPs. For example, zero of five PBSPs (0%) included a specific description of data collection procedures. Plans did not always identify appropriate staff responsible for data review. For example, in zero of 16 records reviewed (0%), individuals with needs for language acquisition had goals/objectives/outcomes written in which an SLP was assigned responsibility for data review on either a monthly basis if service was direct and/or quarterly if indirect.	
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. As documented in examples found in several sections of this Report, there was a lack of coordination in the PSPs among the goals, objectives, anticipated outcomes, services, supports, and treatments There were few examples observed in which more than one goal was developed to provide an integrated approach to meeting a desired outcome. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas. Evidence of an interdisciplinary approach, which the Monitoring Team did not observe, could include, among other possibilities: • Interventions include actions taken or directed by more than one discipline, such as PBSPs for which a communicative behavior serves as the functional replacement for the target behavior, and for which the SLP has some responsibility for planning the intervention and monitoring effectiveness. • Goals for which more than one intervention aimed at accomplishing the goal is planned. For example, there could be documentation that weight gain is addressed by diet, teaching choice of low-calorie items for snacks, exercise, and review of psychotropic medication.	Noncompliance

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		• Documentation that more than one discipline reviewed the same data and collaborated to decide whether revision of services and supports should be made, and, if so, what should be revised. While the Monitoring Team found a lack of coordinated supports and services throughout the facility, it was evident that the facility was attempting to ensure better coordination among disciplines. Team members from various disciplines met together to develop the PSP and discuss specific issues particularly around behavioral and health care needs. PSTs were also noted to be engaged in somewhat more integrated discussions during team meetings. These represented improvement over previous site visits.	
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. The Monitoring Team found that some progress had occurred. Ten of ten (100%) 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. All were able to provide an example of how they used the PSP. It was also positive to find, since the past reviews, that the HMPs and ACPs consistently contained the signatures of the Home Leaders on the plans validating that the direct care professionals had been trained on the plans, as were Training Rosters signed by the direct care professionals. Occasionally the Training Rosters did not include the name of the specific plan. Direct care professionals were interviewed regarding Individuals' #270, #191, and #163 health care plans. All three direct care professionals were able to verbalize their responsibilities for these individuals' care. Two of the three direct care professionals showed the Monitoring Team the Pink Care Plan Book. One direct care staff could not locate the book but was able to verbalize the required care. When asked how she would know what care was needed, she explained that the nurse had provided her with training on the plans. The RN Case Manager located the missing Pink Care Plan Book, which had been moved from its usual location. In addition, the RN Case Managers had begun developing and implementing a training sheet specific to the individuals' plans for the direct care professionals. Nevertheless, there continued to be indications that plans were not comprehensible to staff as evidenced by failures to implement the programs and strategies contained in the documents. For example: • For Individual #20, there were no data available for May 2011 for any of the individual's training programs or SSOs. Individual #20 had a number of	Noncompliance

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		objectives and SSOs for which data were inconsistently collected. • Individual #408 had an SSO for once-weekly community outings for the PSP dated 11/18/10. The Monitoring Team requested documentation of community outings offered since the PSP date. Documentation of only two outings was provided. • Individual #390's money management program, the quarterly review for February through April 2011 indicated that data was needed for both February and March. • Staff on one residence were unable to describe the methods of a PBSP to be used with an individual demonstrating aggression. Staff were also unable to find the PBSP in the chart or identify in what section the PBSP should be located. In addition, there was significant evidence that plans were not accessible to staff within required timeframes. As detailed below in Provision F2f, 84 of 305 (28%) individuals did not have a PSP in place within 30 days of its preparation.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	The 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, but 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 #20, there was no data available for May 2011 for any of the individual's training programs or SSOs. Individual #20 had a number of objectives and SSOs for which data was inconsistently collected and no action taken. The QMRP, who was temporarily assigned, acknowledged the PSP and its implementation were inappropriate to the individual's needs and a new meeting would be held. • For Individual #102, there was an objective to choose preferred items from the campus store for three of four sessions for two consecutive months. The quarterly review documented that four sessions were not offered during any of these months, and that the individual refused almost all sessions offered. No plan to revise was documented. • For Individual #390, in response to a question by the PST regarding the efficacy of the PBSP, it was reported at the PSP meeting that treatment integrity checks were being conducted at least once per week for the PBSP. No such checks had been completed. In order to assess the monitoring of PBSP progress, the records of 25 individuals with	Noncompliance

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		PBSPs developed or revised during the previous six months were selected for review. During the review, the following positive elements were noted. • 25 of 25 records (100%) were reviewed on a monthly basis. • 25 of 25 monthly reviews (100%) were completed by a BCBA. The review of records during the current site visit also revealed a variety of weakness in the PBSP monitoring process. For example, as reported in detail under Provision K4: • Eight of 25 records (32%) revealed prolonged elevations in target behaviors without changes in treatment having been assessed or attempted. • Eleven of 25 records (44%) revealed a prolonged lack of replacement behavior development. As the increase of functionally related replacement behaviors is essential to the decrease of undesired behavior, the lack of progress in teaching replacement behavior would inhibit the efficacy of the noted PBSPs. • Four of 25 records (16%) included discrepancies between behavior data reported in Psychology progress notes and data on the same targets provided in Psychiatry progress notes. 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 the current site visit, data and progress reports at BSSLC did not focus upon specific behavior or functional classes, 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. Based upon the factors presented above, it was not clear at the time of the current site visit that BSSLC had implemented a comprehensive, evidence-based approach to monitoring and revising behavior interventions. Although not always the case, several examples were encountered in which individuals were allowed to continue potentially dangerous behaviors for several months. This presented an unwarranted level of risk to the people living at the Facility.	
F2e	No later than 18 months from the	The self-assessment provided by the BSSLC in its POI reported it was not in compliance	Noncompliance

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	Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	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, are competency based, that every employee responsible for development or implementation of individuals' PSPs has completed required training, and that staff can demonstrate competency on the job with reasonable consistency. The Facility had provided initial training on the new PSP process for staff responsible for the development of individuals' PSPs. The Facility had also begun a process of QMRP facilitation skills performance tracking. Skilled assessors observed a PSP meeting and rated the QMRP's meeting facilitation skills, particularly the QMRP's ability to draw different disciplines into an interdisciplinary discussion of an Individual's program plan such that plans could be developed that integrate elements from relevant disciplines. As of 5/24/11 nine QMRPs had their facilitation skills assessed through this process. One was deemed competent by the assessor. Two of three QMRPs interviewed regarding the PFA indicated they had not had any real training in the PFA process. The QMRPs continued to feel the PFA was too long and cumbersome. It was apparent in the PFA meetings that the QMRPs did not understand how to use the PFA as a tool to assist an individual to envision a future. 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 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	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 (dated 6/17/11) in a document request, the Monitoring Team identified 84 of 305 (28%) 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 84 were only a few days in excess of 30	Noncompliance

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	preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	days there were also many instances in which the PSP was not put in place until six weeks or longer after the PSP meeting. In five instances the tracking report provided by the Facility reported the PSP was not put in place as of the date of report preparation (6/17/11) even though these PSPs went back as far as 1/4/11 This was the case for Individuals #141, #254, #304, #442, and #543.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	The 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 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. In addition, the Facility had begun to monitor the QMRPs for their competency in implementing the facilitation skills trained in the Q Construction curriculum. This was a very recent development. The Monitoring Team commends the Facility staff for this quality assurance activity and encourages ensuring careful documentation of follow-up quality improvement activities and then tracking them to ensure the improvements have taken hold.	Noncompliance

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. Implement a formal curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html.
4. 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.
5. 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.
6. 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.

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 (POI) 7/12/11 2. BSSLC July 2011 Presentations notes 3. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 4. Active Record for Individuals #5, #26, and #437 5. Individual Record for Individuals #26 and #437 6. PSPs, CLDPs, and other documents reviewed by the Monitoring Team 7. Consultation reports for Individuals #1, #33, #163, #169, #181, #337, #411, #453, #567, #590, and #591 **People Interviewed:** 1. Group interview: Robert Ham, Facility Director; Mary Anne Brett, M.D.; Adolfo Carvajal, M.D.; Malcolm Lochiel, M.D. **Meeting Attended/Observations:** 1. Entrance Presentation by Facility Staff 1/10/11 2. PSP Annual Planning meeting for Individual #56 3. Risk Meetings-Individuals #181 and #26 PFA Meeting for Individual #115
	Facility Self-Assessment: The Facility reported it was not in compliance with either provision of this Section. The Monitoring Team concurs with the self-assessment for Provision G1 but found Provision G2 in substantial compliance. For Provision G2, the procedures were in place, and the sample reviewed found the requirements to be met. It will be important for the Facility to establish a process to ensure the requirements continue to be met. The Facility reported that staff had attended PSP training, that committees continued to meet to integrate services (but provided no information on status of actions planned or implemented as a result of those meetings), and that guidelines had been developed for consultation review. Other than the implementation of guidelines for consultation review, the report did not identify any products our outcomes to indicate improvement in integrated planning. The Facility also provided a list of action steps to be done. Some of these steps build on each other and were presented in an appropriate order. Others were simply additional tasks to be done. It would be helpful if the Facility were to plan actions to accomplish specific goals and requirements, and present them in a way that shows an organized approach that can be tracked. As noted above, one missing action is the development of processes to monitor and ensure requirements continue to be met over time. These, along with measures of outcome, could provide the framework for reports of status.
	Summary of Monitor's Assessment:

	The Facility has taken many steps toward providing clinical services in an integrated manner. Several initiatives were in place, including participation by disciplines jointly in review of restraint, development of PBSPs and integration within those of pharmacological treatment, and provision of timely information on status of individuals in hospital. However, most of the participation remained multidisciplinary with limited evidence of joint planning and case formulation. Therefore, Provision G1 remains out of compliance. Provision G2 is in substantial compliance. Although (according to the POI), work remains to have all clinicians trained in the process of review and documentation regarding recommendations by non-Facility clinicians, reviews by the Monitoring Team found that the new documentation process ensured that there was evidence of such review.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	The Facility has taken many steps toward providing clinical services in an integrated manner. Clinicians have attended the Supporting Visions PSP training. Physicians attend PSPs for people with complex medical conditions, although they may not participate in the entire meeting. Additional initiatives continue to occur. For example, as described in Provision J1, Psychiatry participated in a pilot for an additional review process that would occur several days after a restraint episode (please refer to Provision C1). The Lead Psychiatrist participated in this process via participation in the Restraint Reduction Committee. The committee reviewed the restraint, and the discussion was led by a psychologist who analyzed the details of the restraint with staff involved in the episode. The BSSLC process for reviewing each episode of restraint, included review by the IMRT. The actual operation of this process was evident to the Monitoring Team as it reviewed documents, attended unit and facility wide IMRT meetings, and interviewed staff. The Monitoring Team was impressed that these restraint reviews were interdisciplinary in nature, and resulted in immediate steps that can be taken to try and minimize the need for restraint of the individual in the future. The Restraint Reduction Committee included on its agenda a case study each month. This is typically the most difficult behavioral/restraint case at the time of the meeting. The discussion at the Restraint Reduction Committee observed by the Monitoring Team was interdisciplinary and collaborative, including efforts by the Facility Director to generate discussion and develop hypotheses about why restraint application is most common in the child and adolescent residences. The Hospital Liaison Nurse had begun to place IPNs describing status of individuals in	Noncompliance

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		the hospital on the Share Drive so information was accessible to team members on a timely basis, and to attend the daily morning medical meetings to provide updates. An excellent example of a process that can lead to integrated clinical services was the involvement of Speech and Language clinicians (SLPs) in planning services for individuals receiving behavioral interventions. Per interview and review of PBSC minutes, an SLP regularly attended the meeting and served as a liaison to the other therapists. Additionally, the behavior support plans are distributed prior to the committee meeting thus allowing all members of the communication staff to review and determine potential correlations between the behaviors being addressed and the impact communication or lack of communication. Although review of assessments and PBSPs (including reviews of PBSPs for individuals experiencing more than three restraints in 30 days) did not yet show documentation that assessment of communication and inclusion of communication strategies was occurring, this approach provides opportunities for different disciplines to contribute their knowledge and skills to address the same concerns and goals. Beginning the week of July 18, 2011, the PNMT's focus changed to include review of all individuals who were hospitalized with a PNM issue. Although this provides a good opportunity to integrate clinical planning, per interview, this change was implemented due to the lack of PST follow up upon discharge. For integration of clinical decision-making, it is essential that the PST serve as the central point for joint planning. The Facility's system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation had not yet reached a level of integrated planning. As reported in Provision J8, the process was multidisciplinary and involved sharing of information but little evidence that this resulted in a common understanding of the individual. Still, clinicians sometimes demonstrated a comprehensive understanding of individuals that integrated information from their own discipline with information usually presented by other disciplines. Similarly, information about individuals was regularly communicated through meetings and workgroups, but there was not evidence that treatments were integrated. Record reviews reflected that symptoms of mental illness were seldom incorporated into the behavior assessment process. DADS had drafted a policy. It might be helpful if that policy added clarification on what would demonstrate integrated clinical services and provided examples. To summarize, Provision G1 is not in compliance, but many steps have been taken toward compliance. To reach compliance with this provision, the Facility will need to demonstrate that the processes implemented to provide information and review cases	

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		across disciplines actually result in join planning and case formulation.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	The Facility reported through interview and presentation of status that a new procedure had been implemented to ensure Facility clinicians review reports from non-Facility clinicians. This process, which had just begun, requires the clinician to write agreement or disagreement and place a progress note in the IPN. This will be discussed at the next morning meeting in order to provide information to other members of the PST. The QDDP will determine the need for a PST meeting. The Monitoring Team sampled one consultant report for each of 13 individuals. Twelve of the 13 (92%) showed documentation of review by a Facility clinician. Of the 12, agreement was documented for 10 (83%), rejection for one (8%) and nothing was documented for one (8%). For the one consultation for which rejection was documented, no rationale or alternative plan was provided. In addition to documenting reviews of consultations, there was now an expectation that physicians attend neurology clinic; psychiatrists were expected to do so if an individual is prescribed psychotropic medication. Tracking of physician attendance had begun.	Substantial Compliance

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

1. Add to the draft DADS policy by specifying certain required activities to foster integrated clinical services, and providing examples of additional actions the facility could take to indicate that integrated clinical services were occurring. (Provision G1)
2. Provide training, review and mentoring, or another process to assist clinicians to develop integrated case formulations and treatment recommendations and to develop documentation that clearly demonstrates this integration in PSPs and the active record. (Provision G1)
3. To ensure maintenance of review and documentation by clinicians of recommendations by non-Facility clinicians, implement a quality assurance process that includes checks of IPNs and addresses both actions taken when a recommendation is rejected and referral to the PST for decisions. (Provision G2)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI) 7/12/11 2. BSSLC July 2011 Presentations notes 3. DADS Draft Policy Minimum and Integrated Clinical Services 1/12/10 4. BSSLC Policy III.4.b Personal Support Plan Process 12/10/10 5. Physician Procedure and Best Practice Guidelines **People Interviewed:** 1. Group interview: Robert Ham, Facility Director; Mary Anne Brett, M.D.; Adolfo Carvajal, M.D.; Malcolm Lochiel, M.D. **Meeting Attended/Observations:** 1. Entrance Presentation by Facility Staff 1/10/11 2. PSP Annual Planning meeting for Individual #56 3. Risk Meetings-Individuals #181 and #26 4. PFA Meeting for Individual #115
	Facility Self-Assessment: The Facility reported it was not in compliance with any provision of this Section. The Monitoring Team concurs. For each provision, the Facility listed actions that had occurred. The Facility gave no indication of evidence to ensure the actions had actually occurred. For example, for Provision H stated that a nurse informs the physician when an individual's status changes. There are examples in several sections of the report, and noted in Provision H1, that indicate this did not always occur. The Facility needs to identify evidence it will gather to assess whether the steps reported as complete actually were completed and, if appropriate, are being maintained. The POI also included a set of Action Steps planned for Provision H1. Some are actions that are occur in order to move toward compliance, and others are activities that are part of the daily work of the staff. Although the Monitoring Team would encourage planning of actions to be taken to reach compliance, these should be organized in a way that moves stepwise to reach a specific goal or outcome.
	Summary of Monitor's Assessment: The Monitoring Team that the Facility that remains noncompliant with all provisions of this Section. Progress had been made in completing assessments and evaluations. The current process shows promise of completing the initial psychological and psychiatric assessments. As there is still considerable variability in completion of assessments across disciplines, the Facility will need to ensure that other clinical assessments are also done and posted timely and permit the PST to make reasonable decisions about treatment and interventions.

	The Facility must develop processes to ensure individuals are assessed when they show changes in health or behavioral status, or when no progress occurs following an extended period of planned treatment. Diagnoses were consistent with the current DSM and ICD. Because there was a gap in completion of assessments and evaluations, the Monitoring Team could not determine that all diagnoses clinically fit the assessments and evaluations. Although physicians reported they use standard clinical indicators in providing care, there were no clinical pathways or guidelines in place. Furthermore, the Facility did not have in place a process to use clinical indicators to review systemic health issues.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	Provision of assessments on both a regular basis and in response to change in health or behavioral status was not consistent across all disciplines. The Facility continued to progress in completing required regular assessments. An overall facility plan was not in place to address provision H of the Settlement Agreement and, therefore, a plan was also not in place to address this provision item. That is, the Facility did not have any procedures in place to ensure assessments and evaluations were completed on a regular basis and in response to developments or changes in an individual's status across all areas of clinical service. As reported in Provision V3, even when there was a process to monitor that assessments have been completed, not all assessments were posted timely. Two out of nine Individuals who were diagnosed with a PNM issue (Individuals #33, #60, #79, #163, #291, #342, #413, #496, and #591) were not assessed by the PNMT or PST. Of particular concern was individual #60 (Please refer to Provision O2 for detail). The individual experienced numerous documented aspiration trigger episodes. Although Nursing was signing off demonstrating that review of the trigger sheet was completed there was no follow-up assessment, nor was there evidence that the information was shared with the physician until a Direct Care Professional reported to the physician. The Nursing note on 7/15/11 determined that coughing was not an appropriate trigger. This determination was made without PST input or assessment by Speech Therapy. Physicians' note on 6/17/11 stated that DCP reported to him that Individual #60 had been coughing on ensure for awhile but he did not know how long this had been occurring although it had been identified on the trigger data sheet for months. Physician requested modified barium swallow study (MBSS) as soon as	Noncompliance

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		possible if the SLP thought the individual could tolerate. No SLP evaluation was provided until 7/17/11; therefore no MBSS was completed. The evaluation completed by the SLP stated that individual is in distress and "drowning" on liquids and needs to be admitted to hospital. Individual was admitted and returned to BSSLC with a g tube. Assessment by the appropriate clinician based on change of health status was not requested timely and was not done when ordered. Data for behavioral interventions also did not always lead to appropriate and timely assessment and program revision. For example, 32% of reviewed PBSP progress notes reflected that undesired behaviors, including self-injury and aggression, were allowed to continue for several months without the PBSP being revised. Similarly, 44% of the reviewed records revealed that individuals had made no progress in developing replacement behaviors with no further assessment of function or of whether the replacement behaviors were appropriately selected. Despite the noted increase in staff pursuing credentialing as a behavior analyst, the Facility indicated that Behavior Services staff continued to produce behavior assessments and interventions that were inadequate. Nevertheless, progress had been made in completing psychological evaluations, although this process had not been completed. Through a contract to complete intellectual and adaptive assessments, the Facility had completed 60 intellectual and adaptive assessment reports. The efforts by BSSLC to ensure assessment of intellectual and adaptive abilities of individuals living at the Facility reflected substantial progress in this area. Despite this substantial progress, psychological assessments were not based upon complete clinical and behavioral data. Regarding psychiatric assessments, overall the Monitoring Team found that the Appendix B evaluations were strong and reflected the professionalism and high standards of care provided by the psychiatrists. Nonetheless, less than 20% of the individuals who require evaluations have had them and this was not a sufficient number to demonstrate that a credible and sufficient process was underway to complete the required evaluations. The Monitoring Team reviewed clinical processes in which the psychiatrist was involved. There was evidence of timely provision of a psychiatric evaluation or preliminary consultation. As was discussed in detail under Provision J7, psychiatrists provided timely evaluations (final or preliminary) for newly admitted individuals, Regarding medical assessments, although annual medical assessments were found in the annual record, they did not always reflect actual physical examinations. For example, for Individual #102, the Monitoring Team conducted a review of the active	

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		clinical record and the most recent community living discharge plan as of July 27, 2011 for Individual #102. Following its review, the Monitoring Team noted that the past two annual physical assessments were not complete and appeared identical, despite being completed by two different physicians. Given that a complete physical examination was not documented two years in a row, the Monitoring Team had concerns that underlying medical conditions were not accurately reflected in the record, nor known to the PST as it considered community transition. Medical issues observed by the Monitoring Team for this individuals were not all reflected in the assessments or in the CLDP. Medical assessments must better address neuromuscular and musculoskeletal conditions, such as scoliosis, cerebral palsy, spasticity, contractures, arthritis and other congenital and acquired anomalies.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	Diagnoses in assessments and records were consistent with current versions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification. However, there were issues concerning whether they clinically fit the assessments and evaluations. These revolved primarily around a need for greater follow up to ensure adequate information for accurate diagnoses, as indicated by the following: • Although the overall quality of the evaluations was good, six of the twenty evaluations (30%) had NOS diagnoses; psychiatrists should revisit these evaluations and attempt to resolve the NOS diagnoses. • Follow up to identify etiologies and progression of chronic conditions was less than optimal. Examples included: • Individual #84 had a barium swallow test that identified; the etiology of the GERD was not assessed clinically. • Individual #557 periodically hits herself for no apparent reason. Despite observing this behavior and staff's understanding of the behavior, review of Active Record did find evidence to support that this behavior was assessed for a possible underlying medical conditions, such as pain from sinus, dental or other condition. Since the last compliance tour, the Department of Psychiatry had developed a campus-wide list of all individuals supported by psychiatry, and their DSM IV Axis I, II, and III diagnoses. The list was updated whenever a change in diagnosis was made by the treating psychiatrist. Regular tracking of this list should help to ensure diagnoses match the current version of DMS. Also, the Active Problem Lists (APLs) list all active health problems, and included the psychiatric problems that are the focus of treatment Each of the twenty records that	Noncompliance

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		were reviewed in regard to the Section J provisions had an APL that contained DSM IV psychiatric diagnoses.	
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 treatments and interventions were provided timely, there were instances in which they were delayed or were not changed when health or behavioral status changed. Furthermore, as identified in other Sections of this report, there were still gaps in completion of all required assessments, so treatments and interventions could not be based on those assessments. As completion continues, this should eventually no longer be an issue. None (0%) of the Section XI nursing summaries were adequately completed to effectively demonstrate individuals' heath status related to their identified nursing problems/diagnoses in terms of progress made toward the problems' established goals and objectives. Neither the effectiveness of Health Maintenance Plans (HMPs) nor any changes needed or made to the HMPs were summarized in a meaningful or useful way for the PST to use in measuring individuals health status progress annually and/or quarterly. As noted in Provision H1, programs and interventions to address target behaviors in some cases continued without revision for extended periods although data (clinical indicators identified in the PBSP as measures of progress) did not show progress.	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 interventions shall be determined in a clinically justified manner.	Facility clinicians stated they use standard clinical indicators for evaluating status of conditions for individuals. Physicians reported that they provided information, which was aggregated by the infection control nurse, but that they did not receive reports back for their review. They also reported that participation in the new risk process is helpful. There was no report through interview, presentation of status at visit entrance, or in the POI to indicate progress toward development or adoption of clinical practice guidelines. The process of developing guidelines was continuing at DADS. Some data that could be used to provide clinical indicators of efficacy had been implemented. The Aspiration Triggers Data Sheet had been implemented and was being completed. However, information from that sheet was not tracked and used, either for evaluation of efficacy of interventions for individuals or systemically, to evaluate efficacy of treatments and interventions. While PNMPs are reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk. For review of PNMPs. .There was no detailed comparative analysis of data or assessment findings.	Noncompliance

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H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	A new risk assessment process had been implemented but was still in early stages and did not fully result in accurate rating of risk nor in identifying frequency of monitoring based on level of risk. Nevertheless, staff reported that it assisted them to review health status in a more integrated manner. A policy/protocol that addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted does not exist at BSSLC. Lacking is: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician.	Noncompliance
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The Facility did not have clear guidance on the use of clinical indicators or on when treatments and interventions should be modified. In the medical arena, DADS is working on selecting or developing clinical pathways, which should include such guidance. There were examples in which clinical indicators that signaled a need for reassessment and possible modification of interventions did not lead to those actions. Examples, reported in Provision H1, include: • There was one instance in which a clinical indicator was determined to be inappropriate instead of leading to modification of the intervention. As reported in Provision H1, an individual experienced numerous documented aspiration trigger episodes of coughing. Instead of bringing this to the attention of the PST and requesting a new assessment, the Nurse who reviewed the information determined that coughing was an inappropriate trigger. • Data for behavioral interventions did not always lead to appropriate and timely assessment and program revision. Also, as noted in Provision J3, there was a lack of tracking of psychiatric symptoms to determine efficacy of psychotropic medications; similarly, Provision K4 reports that there were discrepancies in behavior data reported in psychology versus psychiatry progress notes, so the different clinicians were making decisions on the same interventions following review of discrepant data.	Noncompliance

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H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	The facility policy that governs integrated planning and services is the Personal Support Plan Process. In addition, the Facility developed a procedure to provide direction to physicians about integrated clinical services and minimum elements of clinical care--Physician Procedure and Best Practice Guidelines. Physicians had received the Supported Visions training on the PSP process. A draft DADS state policy was available and this was an improvement since the last onsite review. It addressed provisions G and H together. The policy was not yet completed or disseminated. The majority of the policy addressed section H and appeared to be a good start to providing the facility with some guidance and direction. It might be helpful to indicate how the contents of the policy related to each of the specific seven provision items of provision H. For provision item H1, the policy listed some details about the regulatory or statutory requirements for a nursing quarterly review, an annual dental exam, a review of behavior control drugs, an annual physical, and a review of risk status. There was nothing in the policy, however, regarding assessments and evaluations for psychiatry, psychology, pharmacy, physical therapy, speech and language therapy, dietary needs, occupational therapy, and respiratory therapy (in this policy, DADS added respiratory to the list of clinical services). Although the Facility had policies in place, they did not yet provide clear enough guidance, and implementation was not yet fully established. Furthermore, the DADS policy remains in draft form. Therefore, the Facility has not yet reached substantial compliance with this provision.	Noncompliance

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

1. Develop a process to track and ensure all required assessments are completed timely. (Provision H1)
2. Train staff, including clinical staff, in standards for reporting the occurrence of clinical indicators that should lead to reassessment. (Provision H1)
3. Either through adoption of clinical pathways or policy, address the monitoring process and provide clear direction regarding implementation (Provision H5)

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 006.1 At Risk Individuals (2/18/11) 2. BSSLC Plan of Improvement (7/12/11) 3. Integrated Risk Rating Form for Individuals #26 (6/23/11) and #181(7/5/11) 4. Nursing Care Plan to mitigate/manage risk for Individuals #42, #52, #86, #303, #470, and #545 5. Record reviews of Individuals #1, #7, #12, #42, #52, #56, #86, #89, #163, #165, #173, #291, #303, #413, #470, #545, and #591 **People Interviewed:** 1. Kim Littleton, Assistant Director of Programs 2. Kori Kelm, Director of Habilitation Therapies 3. Pam Boehnemann, Acting QMRP Coordinator 4. Susie Johnson, Settlement Agreement Coordinator **Meetings Attended/Observations**: 1. PST risk assessment meetings for Individuals #26 and #181 2. Facility Incident Management Team (7/25/11) 3. Quality Assurance/Quality Improvement Council (7/28/11) 4. Restraint Reduction Committee (7/27/11) PSP meeting for Individual #56 (7/27/11)
	Facility Self-Assessment: The Facility's self-assessment reported the BSSLC was not in substantial compliance with any provision or component of this section of the settlement agreement (SA). The Facility reported it had initiated and provided training on the revised risk assessment procedure and that procedures were in place to follow the revised State policy. The Monitoring Team's review substantiated this self-assessment.
	Summary of Monitor's Assessment: The BSSLC processes to demonstrate compliance with this section of the SA were insufficiently organized to achieve the desired results. The new statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated. However, in 76% of records sampled, risk assessments were not conducted within five working days of risk identification or a change in circumstances. Additionally, professional staff implementation of the Risk Assessment policy was inconsistent indicating a need for additional training and professional oversight. Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies was not apparent to the Monitoring Team. For example, in most records sampled, the Monitoring Team determined that assessments were not sufficiently comprehensive to enable interdisciplinary discussion. The lack of work flow organization, and professional oversight of the risk assessment process, prevents the BSSLC from identifying risk timely and appropriately, which in turn prevents the development of timely and appropriate risk mitigation plans.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The BSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The new statewide risk assessment procedure, with improved guidelines for rating risk, had been initiated. The Monitoring Team observed the one PSP meeting that was held during the week of the review. The Monitoring Team was unable to determine if staff present at the PSPs were the actual staff who worked with the individual. The individual was present at the meeting but only for a few minutes before choosing to leave. The PST used the Risk Level Guidelines established as part of the new state procedure for assessing and managing risk when determining risk levels. The PSP meeting observed by the Monitoring Team included a full and open discussion among PST members although discussion of risk assessment was superficial and not based on clinical data (except for one issue, for which a PST member looked through the individual's active record for information). Some risk levels were changed based on the discussion, but there was not any discussion addressing how risk impacted potential alternative placement, or affected the daily life of the individual. The team did not provide adequate justification of designated risk levels at the PSP meeting observed by the Monitoring Team, so there was no documentation to show appropriateness of the ratings of risk level. The PSP facilitator kept the team discussion focused, however, it was often necessary for the Monitoring Team to intervene to redirect focus to risk assessment requirements. The Monitoring Team requested that two PSTs participate in special meetings to go through their reviews of risk for an individual. Following this discussion, both teams revised risk ratings to reflect better the needs of the individuals for a heightened level of scrutiny for specific areas of risk. For one of these, the risks for the individual had been rated within the prior week but still were revised again although no changes had occurred in the individual's status. This might indicate that additional practice in implementing this relatively new risk assessment process may result in greater accuracy and usefulness of the reviews.	Noncompliance

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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.	BSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Review of 17 records for individuals initially determined by the PST to be at risk (Individuals #1, #7, #12, #42, #52, #56, #86, #89, #163, #165, #173, #291, #303, #413, #470, #545, and #591) showed there was documentation that the PST started the assessment process as soon as possible but within five working days of the individual being identified as at risk for four (24%) individuals. Records that did not contain documentation of this requirement included: Individuals #1, #7, #12, #42, #52, #56, #86, #89, #165, #173, #291, #413, and #545. The records of these 17 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There were examples of risk events or changes in status. There was documentation that the PST started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for four (24%) individuals. Records that did not contain documentation of this requirement included: Individuals #1, #7, #12, #42, #52, #56, #86, #89, #165, #173, #291, #413, and #545. Based on a review of records of six individuals (Individuals #42, #52, #86, #303, #470, and #545) for whom assessments had been completed to address the individuals' at risk conditions, three (50 %) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individuals #52, #303, and #545. The following provides an example of an assessment that was not comprehensive: Individual #590, a young female adolescent with a diagnosis of Vitamin D Deficiency was identified as low risk for osteoporosis and fracture. The risk should have been at least medium. Adolescent girls are at greatest risk due to the fact their bones are still developing and this requires not only the administration of Vitamin D supplements but also dietary intake rich in food containing Vitamin D as well as adequate exposure to sunlight. Without an adequate plan to address the Vitamin D Deficiency, this individual is placed at risk for the long term development of osteoporosis and related complication, such as fractures. Based on a review of records of three individuals (Individuals #163, #496, and #591) for whom assessments had been completed to address the individuals' at risk conditions, two (67%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. The following provides	Noncompliance

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		an example of an assessment that was not comprehensive: Individual #496 was identified as being at a "low risk" of aspiration but per guidelines should have been listed as a "medium risk." The PST has the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. Lack of critical clinical thinking and discussion was noted when the PSTs had to move beyond the guidelines. This lack of clinical judgment impacted the risk scores and increased the likelihood of inadequate supports being provided to the individual. Other risk issues identified by the Monitoring Team include: • Individual #413 was diagnosed with aspiration pneumonia on 4/14/11 and 5/12/11 with no evidence of discussion or assessment by the PNMT. The PST conducted a risk screening on 4/16/11 but there was no evidence of discussion regarding etiology of the event. • Individual #291 had aspiration pneumonia on 5/30/11 with no evidence of discussion or assessment by the PNMT or PST. • Individual #342 had aspiration pneumonia on 3/10/11 with no evidence of discussion or assessment by the PNMT or PST. Of particular concern was individual #60. Based upon review of the trigger data sheet, the individual experienced 77 episodes of coughing with struggle during the month of April 2011, 94 episodes of coughing with struggle during May 2011, and 181 episodes of coughing with struggle as well as 28 episodes of wet vocal quality during the month of June 2011. Documentation and communication surrounding this event were vague and at times nonexistent. For example: • DCPs were noting on the trigger sheet all the aspiration triggers but were not consistently documenting in the observation notes. • Nursing was signing off demonstrating that review of the trigger sheet was completed but did not follow up consistently with a note in the IPN or an assessment. Although the triggers were occurring throughout April, May and June 2011, the first note acknowledging this issue was not until July 3, 2011. A total of three nursing notes were noted in the IPNs related to this issue. There was no evidence that the information was shared with the physician. • Nursing note on 7/15/11 stated that although there was coughing, lung sounds were good and that coughing was not an appropriate trigger. This determination was made without PST input or assessment by Speech Therapy. • Physicians' note on 6/17/11 stated that DCP reported to him that Individual #60 had been coughing on Ensure for a while but he did not know how long this had been occurring although it had been identified on the trigger data sheet for months. Physician requested modified barium swallow study (MBSS) as soon as possible.	

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		• 6/28/11 Physician's order written for MBSS if SLP thought individual could tolerate. No SLP evaluation was provided until 7/17/11, therefore no MBSS was completed. • 7/17/11: SLP/OT evaluate individual and state that individual is in distress and "drowning" on liquids and needs to be admitted to hospital. Individual was admitted and returned to BSSLC with a g-tube. The above demonstrates a severe lack of communication between team members and an alarming lack of awareness regarding aspiration indicators and a lack of attention to how those indicators demonstrated increased risk. This is evident not only by what is stated above but also by the lack of PST intervention throughout the last three months. Refer to provision O.6 for more issues regarding lack of aspiration trigger notification. Based on a review of records of six individuals (Individuals #1, #7, #12, #89, #165, and #173) for whom assessments had been completed to address the individuals' at risk conditions, six (100%) included an adequate psychiatric assessment to assist the team in developing an appropriate plan.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	The RSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. Based on a review of 17 records for individuals determined to be at risk (Individuals #1, #7, #12, #42, #52, #56, #86, #89, #163, #165, #173, #291, #303, #413, #470, #545, and #591), there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in nine (53%)) cases. Records that did not contain documentation of this included Individuals #1, #7, #12, #42, #89, #165, #173, #303, and #545. ▪ Implemented a plan that met the needs identified by the PST assessment in 11 (65%) cases. Records that did not contain documentation of this included Individuals #7, #89, #163, #165, #303, and #545. ▪ Included preventative interventions in the plan to minimize the condition of risk in eight (47%) cases. Records that did not contain documentation of this included Individuals #1, #7, #12, #42, #89, #165, #173, #303, and #545. When the risk to the individual warranted (two cases), took immediate action in two (100%) cases. ▪ Integrated the plans into the PSPs in six (35%) cases. Records that did not contain documentation of this included Individuals #1, #7, #12, #42, #86, #89, #165, #173, #470, #545, and #591. In 14 (82%), the risk plans showed adequate	Noncompliance

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		integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did not contain documentation of this included Individuals #52, #303, and #470. In six (35%), appropriate functional and measurable objectives were incorporated into the PSP to allow the team to measure the efficacy of the plan. Records that did not contain documentation of this included Individuals #1, #7, #12, #42, #52, #86, #89, #165, #173, #303, and #470. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in eight (47%) cases. Records that did not contain documentation of this included Individuals #1, #7, #12, #42, #86, #89, #165, #303, and #470. The Monitoring Team was unable to identify risk management/mitigation plans that were comprehensive and individualized to the extent that if followed risk would be effectively managed or mitigated. For example, 19 individuals were identified at high risk in various health-related risks. The Health Maintenance Plans for these individuals were generic, not individualized, and lacked documentation from which their effectiveness could be measured. Another example of a plan that was inadequate to adequately address the at-risk factors was Individual #413 who was diagnosed with aspiration pneumonia on 4/14/11 and 5/12/11 with no evidence of discussion or assessment by the PNMT. The PST conducted a risk screening on 4/16/11 but there was no evidence of discussion regarding etiology of the event. Finally, Individual #1 was rated at high risk for polypharmacy due to administration of five psychotropic medications, and high risk for challenging behaviors due to an acute psychiatric status, emergency chemical restraints, and injuries to others. The Risk Action Plan did not address any specific interventions for these issues, and simply referred to ongoing PBSP support and psychiatric monitoring via observations and medication reviews.	

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

1. The Facility should assure all PSTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the new PSP process. QMRPs/Team leaders should be provided with competency based training and job coaching on implementation of the At Risk policy and its incorporation into the PSP process.

2. Ensure that appropriate and timely 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.

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:** 12. BSSLC Plan of Improvement (POI) 07/12/2011 13. DADS Policy 001 Use of Restraint 09/29/09 14. DADS Policy 008 Psychological and Behavioral Services 02/16/11 15. BSSLC Procedure III1.b ,Medical and Dental Restraint, updated on 12/10/201011 and including a. Exhibit A – Restraint Checklist b. Exhibit B – Pre/Active/Post Sedation Checklist c. Exhibit C –Medical –Dental Cooperation Procedures 16. BSSLC Form: Administration of Chemical Restraint Consult 17. BSSLC Flow sheet: BSSLC Pre-Treatment Sedation Process (revised 07/26/11) 18. BSSLC Flow sheet: BSSLC Restraint Process (revised 07/26/11) 19. BSSLC Nursing guidelines: Sedation (08/2010) 20. BSSLC Nursing forms: Pre Procedure Sedation and Post Procedure Sedation 21. BSSLC Nursing form: Post Anesthesia Care Vital Signs Flow Sheet 22. BSSLC Psychiatry Department worksheet: Psychoactive Medication Proposal (PMP) 23. BSSLC Form: Psychiatric Treatment Plan (PTP). Draft form that was newly in use was reviewed. 24. Curricula vitae, medical licensure and professional credentials, all Facility psychiatrists 25. A list of all individuals who receive psychiatric care, the current psychiatric diagnosis for each individual, and the name of the psychiatrist to whom each individual is assigned for care. 26. A list of any individuals for whom the psychiatric diagnoses have been revised, including the new and old diagnoses, and the psychiatrist's documentation regarding the reasons for the choice of the new diagnosis over the old one(s). 27. For the last six months, a list of all psychotropic medications newly approved for use by Positive Behavior Review Committee (PBSC) and Human Rights Committee (HRC), with the name of the individual for whom the medication was approved, the name of the psychiatrist assigned to the individual, and the date(s) of approval. 28. A spreadsheet of individuals prescribed psychotropic/psychiatric medication, that included: 1. Name of individual 2. Residence/home 3. Diagnoses; and 4. Medication regimen 29. A separate list of individuals who are prescribed each of the following: a. Anti-epileptic medications being used as a psychotropic medication b. Lithium c. Tricyclic antidepressants

	d. Trazodone e. Beta blockers being used as a psychotropic medication f. Clozaril/clozapine g. Mellaril h. Reglan i. Anticholinergic medications j. Benzodiazepines 30. A list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date. 31. Facility-wide data regarding polypharmacy, including intra-class polypharmacy. 32. For the past six months, minutes of the Psychoactive Medication Oversight Committee (PMOC), and the Pharmacy and Therapeutics Committee (P&TC). 33. For the following Individuals: #3, #11, #13, #61, #65, #75, #109, #120, #186, #264, #377, #381, #417, #471, #479, #490, #493, #511, #590, and #130 (Sample J.1): a. Demographic Information (e.g., Profile Sheet – Photograph and Identifying Information Sheet) b. Social History c. Most recent Personal Support Plan (PSP) d. Most recent Health Risk Assessment Rating – tool and team meeting sheet e. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors –Personal Support Plan Addenda (PSPA) plans to reduce risk f. Medical and/or dental plans to Increase cooperation/participation (hygiene, desensitization, etc) g. Most recent Positive Behavior Support Plan h. Most recent Safety Plan i. Most recent Functional Behavior Assessment j. Most recent Annual Medical Summary k. Most recent Annual Nursing Summary l. Most recent Annual Pharmacy Summary m. Most recent Annual Psychiatric Review/Psychotropic Medication Review n. Most recent Active Problem List (APL) o. Most recent Psychiatric Evaluation in SA Appendix B format p. All Psychiatric Medication Reviews for the past six months q. Most recent MOSES/DISCUS Side Effects Screenings r. Most recent Quarterly Drug Regimen Review (QDRR) s. Reiss Screen t. Most recent Neurology Consultation; u. For any new psychotropic medications prescribed for the Individual during the past six months and for annual renewals of psychotropic medications that have been in place: a. Medication Response Profiles (MRP) b. Consent for use of the Psychoactive Medication c. Behavior Support Review Committee and Human Rights Committee reviews of these medication(s)

	34. Psychiatry evaluations in the SA Appendix B format for the following individuals: #39, #61, #113, #167, #193, #221, #250, #259, #299, #304, #349, #372, #467, #490, #493 #496, #511, #536, #543, and #590 (Sample J.2): 35. A list from the dental clinic of all individuals who received oral pre-treatment sedation (oral or intravenous) or total intravenous anesthesia (TIVA) since the last compliance tour 36. Medical Restraint/pretreatment sedation records for individuals #538 (2/18/11), #490 (2/1/11), #332 (5/20/11), #574 (6/2/11), #75 (4/1/11), #462 (3/9/11), #102 (6/3/11), and #269 (6/10/11). Documents reviewed included restraint checklists, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring medical restraint, PSP information regarding the development and implementation of plans to minimize the use of medical restraint for the individual, including completed data sheets if a program was developed and implemented, documentation of review activity of the restraint episode, and other information provided by the Facility to help the Monitoring Team understand the circumstances associated with the restraint use 37. Chemical restraint records for individuals #490 (7/1/11), #9 (6/29/11), and #399 (6/29/11). Document reviewed included restraint checklists, face to face debriefing documents, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring chemical restraint (if applicable), documentation of review activity of the restraint episode, and other information provided by the Facility to help the Monitoring Team understand the circumstances associated with the restraint use. 38. Restraint episodes for individuals who experienced more than three episode of restraint in 30 days during the six months since the last compliance tour of the Monitoring Team, for individuals: #3, #9, #181, and #490. Documents reviewed included records of the Personal Support Team (PST) meeting that reviewed the circumstances of the restraints, the attendance sheet for the meeting, relevant physician orders, IPN notes, restraint checklists, face-to-face assessments, debriefing forms, any administration of chemical restraint consult forms, the Individual's safety plan, and any other materials provided by the Facility to help the Monitoring Team understand the circumstances associated with the restraint use 39. A list of all individuals who live at the Facility and have been screened with the Reiss screen 40. Reiss Screen information for all individuals admitted to the Facility since the last compliance visit 41. Reiss screen information and PST documents including psychiatrist's Integrated Progress Notes (IPN) regarding individuals #31, #121, and #130 42. A list of all individuals treated with Reglan 43. A list of all individuals screened for tardive dyskinesia (TD) 44. A list of all individuals diagnosed with tardive dyskinesia 45. Psychiatric Treatment Review (PTR), PBSP, medication consents and PBSC/HRC reviews for new medications for the following individuals: #9, #65, #75, #171, #181, #255, #377, #399, #400, #406, #412, #417, #479, #488, #490, and #493 (Sample J.3) 46. Copies of PTR notes, and neurology clinic notes for individuals who were seen in neurology clinic on 07/26/11, and who were reviewed for both neurological and psychiatric problems: Individuals #59,

	#170, #246, #332, #399, and #510 47. For Individuals #1, #7, #12, #89,#165, and #173, assessed to be at high risk for injury due to challenging behavior and/or polypharmacy: o A copy of the most recent Risk Assessment Tool o The individual's PSP prior to the risk assessment and/or any PSP change of status documentation o Documentation of assessments and other steps taken to develop an action plan to reduce the risk o The Action Plan to address the risks (either PSPA or new PSP) **People Interviewed:** 1. Reeba Chacko, MD, Consulting Psychiatrist 2. Caitlin Connor, Program Auditor 3. Steven Croft, M.D. Consulting Neurologist 4. Terry Hancock Ph.D., Chief Psychologist 5. Sergio Luna, MD, Staff Psychiatrist 6. Victoria Morgan, MD, Lead Psychiatrist **Meetings Attended/Observations:** b. PBSC meeting on 07/25/11 c. Restraint Reduction meeting on 07/26/11 d. Called PST-meeting regarding TIVA sedation for Individual #75, on 07/26/11 e. Called PST meetings, regarding episodes of aggression, Individuals #399 and #490, both on 07/26/11 f. Risk Assessment meeting for Individual #181, on 07/26/11 g. Risk Assessment meeting, for individual #26 on 07/27/11 Psychology/Psychiatry Workgroup meeting on 07/27/11-
	Facility Self-Assessment: The Facility reported that it was in compliance with the requirements of SA provisions J1 (qualified professionals), J11 (Facility oversight of psychotropic medications), and J15 (coordination of psychiatry and neurology). The Monitoring Team concurred, and found that the Facility was in substantial compliance in these areas. The Facility reported that it was in compliance with provision J7. The Facility reported that all individuals who lived at the Facility had received Reiss Screens and individuals who screened positive were assessed by psychiatrists. The Facility also reported that all individuals who were admitted had received Reiss Screen or psychiatric evaluations, as required. However, the Monitoring Team found that only about 55% of the individuals who lived at the Facility and who received psychotropic medications had received required psychiatric evaluations. The Monitoring Team found noncompliance for this provision. The Facility reported that it was in compliance with the requirements of SA provision J10 for Psychiatrist, PCP, and Nurse participation in deliberations about non-emergency administration of psychotropic medications. In the Self-Assessment the Facility reported that primary care physicians (PCPs) started to attend monthly PTRs, and this promoted integrated discussion of individuals' behaviors, medical status, laboratory results, behavior plans, and medications. The Facility also reported that it was in compliance

	with provision J12 regarding side effect monitoring. In the Self-Assessment the Facility reported improvements in the monitoring of side effects, for example by review of side effects in the Pharmacy QDRRs. The Monitoring Team concurred that there were improvements. However, in many cases the PCPs and nurses did not document their participation in decisions about psychotropic medications, and psychiatrists did not document their reviews of nurse ratings for side effects. For these reasons, the Monitoring Team found that provisions J10 and J12 were not in substantial compliance. The Facility reported that it was not in compliance with the provisions J14 (informed consent for medication). The Facility noted that processes were underway to improve tracking of consent information, and that the revised consent form was presented for review by various clinical disciplines. The Monitoring Team found the improvements in place since the last compliance allowed a finding of substantial compliance for this provision. The Facility reported that it was not in compliance with provisions J2, J3, J4, J5, J6, J8, J9, and J13. The Monitoring Teams concurred that there is remaining work in these areas, and that the Facility is not currently in compliance with these provisions.
	Summary of Monitor's Assessment: **For provision J1:** The provision was determined to be in substantial compliance: Psychiatrists were all board certified, and they actively and appropriately participated in the interdisciplinary process. **For provision J2:** The provision was determined to be not in compliance. Only about 55% of individuals who received psychotropic medication had received psychiatric evaluations. **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, the Monitoring Team's observations of meetings showed that there was active member participation. Improvements were noted in the psychiatrists' identification of the reason that each medication was used, and how it was linked to behavioral characteristics of the identified psychiatric disorder. However, the response to each medication treatment must be tracked with a least one measure that is linked meaningfully to the psychopathology targeted by the medication. **For provision J4:** The provision was determined to be not in compliance. The Facility has made significant improvements in the medical/nursing monitoring for safety during medical and dental pre-treatment sedation, but for oral and intramuscular pretreatment sedation the way this was done varied considerably from case to case. Many individuals did not have treatment plans to minimize or eliminate the need for the pre-treatment sedation, there was no process in place to evaluate the effectiveness of the plans, and no data on pre-treatment sedation rates was reviewed at the Restraint Reduction Committee. **For provision J5:** The provision was determined to be not in compliance. The Monitoring Team could not confirm that the Facility has sufficient psychiatric 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. Since the last tour, twenty five psychiatric evaluations in the Appendix B format had been completed, and twenty of these were provided to the Monitoring Team for review. The quality of these evaluations was high, and all met the requirements of the provision. However, a total of only 31 evaluations had been completed, and there were 168 individuals who needed them. **For provision J7:** The provision was determined to be not in compliance. A good process was in place to provide Reiss screens to individuals who required them. Only about 55% of individuals who receive psychotropic medication had received psychiatric evaluations. **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 substantial compliance. There was no process in place to determine which behavioral treatments were most likely to be most effective for individuals, and no clear process to assign treatment modalities accordingly. **For provision J10:** The provision was determined to be not in substantial compliance. PCP and Nurse participation in decisions about new medications was not properly documented. **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. Oversight of psychotropic medications practices was significantly enhanced by the development of a software program that tracks Facility use of all classes of psychotropic medications. **For provision J12:** The provision was determined to be not in substantial compliance. In many cases, physicians did not document their review of nurse ratings for side effects. **For provision J13:** The Facility was in the process of development of Psychiatric Treatment Plans that would provide required medication treatment plans, but these were not in place. **For provision J14:** The provision was determined to be in substantial compliance. New formats for informed consent demonstrated that medical decision makers (LARs) were provided with needed information about medications, and the process of consent typically included a conversation between the decision maker and the treating psychiatrist. **For provision J15:** The provision was determined to be in substantial compliance. Full time psychiatrists

	attended neurology clinics for selected individuals, review and oversight of medications prescribed by both neurology and psychiatry was in place, and a process to allow the contract neurologist to collaborate with the consulting neurologist is being developed.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The Facility continued to employ three psychiatrists. Dr. Victoria Morgan was the Lead Psychiatrist, Dr. Sergio Luna was a full time staff psychiatrist, and Dr. Reeba Chacko continued to work as a part-time contract psychiatrist. All three psychiatrists were board certified by the American Board of Psychiatry and Neurology. The three psychiatrists were interviewed during the tour. The Monitoring Team reviewed the psychiatrists' curricula vitae and they were interviewed in past tours regarding their experience in intellectual disability psychiatry. All three psychiatrists were determined to have appropriate experience and training. The Monitoring Team reviewed the psychiatrists' activities, to determine whether they appropriately participated in the interdisciplinary process. During the review period, the psychiatrists continue to be active in the interdisciplinary process and conducted psychiatric evaluations and re-evaluations, provided direct psychiatric services on a daily basis and provided PTRs that were attended by other individuals and colleagues from other disciplines including nurses, psychologists, pharmacists, direct care professionals and others. Psychiatrists participated in PST activities and reviews, they attended on campus treatment clinic appointments for the individuals they supported, for example in neurology clinics, and they participated with their medical colleagues in activities of the Medical Department. Psychiatrists participated in various Facility level committees and workgroups that are described elsewhere in this report. In the Self-Assessment, the Facility reviewed several expansions of psychiatrists' duties. As of June 2010, the psychiatrists are available via telephone for after-hours on call duties to include: • Review of credible suicide assessments with the on-call psychologist • Behavioral crisis assessment to include initiating orders for emergency chemical restraint • Consultation with the medical physician on call. Psychiatrists also extended their participation in the interdisciplinary process via regular	Substantial Compliance

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		participation in annual PSPs for individuals assigned to their care, and expanded their participation in efforts to reduce the use of restraints by increased participation in PSPAs and PSPA reviews of cases of the use of more than 3 episodes of restraint in 30 days. Psychiatry participated in a pilot for an additional review process that would occur several days after a restraint episode (please refer to Provision C1). The Lead Psychiatrist participated in this process via participation in the Restraint Reduction Committee. The committee reviewed the restraint several days after it had occurred, and the discussion was led by a psychologist who analyzed the details of the restraint with staff involved in the episode in a more comprehensive, reflective and integrated manner than is typically possible in the immediate aftermath of a restraint episode. In all these activities the psychiatrist contributed to the interdisciplinary clinical process via an increased emphasis on proactive clinical interventions that might reduce the need for future restraint. When new medications were proposed, psychiatrists contacted families/LARS/guardians to discussion the clinical needs and to provide information needed to obtain properly informed consent.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The Monitoring Teams reviewed the number of psychiatric hours of service provided by the Facility, to determine whether the Facility had sufficient psychiatric hours to ensure that evaluations and diagnoses could be done in a clinically justifiable manner. This issue had considerable overlap with other psychiatric staffing issues that were addressed under provision J5, and a combined discussion about staffing levels is provided under that provision. The Monitoring Team evaluated whether mechanisms were in place for medication to be used based on clinically justifiable diagnosis and evaluation. In order to use medications properly, clinically justifiable evaluations needed to provide credible diagnoses with behaviorally observable symptoms. Medications then needed to be linked to the diagnoses and symptoms, and a system needed to be in place to report those linkages. At the time of the compliance tour the Facility was in the process of developing treatment plans for new medications. That process will provide prospective information on the needed linkages (please refer to Provision J13). The system that was in place at the time of the compliance tour was that medication monitoring took place via PTRs, and the format for PTRs included an information table that reported information about the medication that in some cases was sufficient to establish the needed linkages. Some of that information was also contained in PBSPs, per DADS requirements. The Monitoring Team had three areas of concern about the process that was in place: • Many individuals lacked psychiatric evaluations to support the diagnoses that were used for the individuals: The Facility provided the Monitoring Team with a list of 168 individuals who received psychotropic medications, and who	Noncompliance

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		therefore needed to have psychiatric evaluations. At the time of the last compliance tour, evaluations were in place for seventy individuals who received psychotropics. Since then, three of those Individuals (# 23, #139 and #229) were placed in community settings, and five other Individuals (# 381, 379, #511, #590 and #130) were admitted to the Facility. All of the newly admitted Individuals received psychotropics. Individual #130 was admitted only weeks prior to the tour and was not included in the list of 168 individuals that had been compiled earlier. The Facility provided the Monitoring Team with twenty psychiatric evaluations that had been completed since the last tour. Ten of these were for individuals who had not previously been evaluated, and ten were updated evaluations for individuals previously evaluated. On the basis of the above, the Monitoring Team determined that only 92 of the 169 (about 55%) of the individuals who needed to have psychiatric evaluations had received them. • PTRs and PBSPs often did not have needed information on appropriate symptoms. For more detailed discussion, please refer to Provision J3. • PTPs that contained medication treatment plans were not in place. For more detailed discussion, please refer to provision J13. The Monitoring Team evaluated whether the evaluations that were in place were done in a clinically justifiable manner. At the time of the last tour the Monitoring Team reviewed all 70 evaluations that were available and determined that 58 of the evaluations were done in a clinically justifiable manner. The twenty evaluations done since then were all done in the SA appendix B format, and all were found to have been done in a clinically justifiable manner. Appendix B evaluations are the sole focus of Provision J6, and those evaluations are reviewed in detail under that provision. The Monitoring Team had concerns about the number of non-specific "not otherwise specified" (NOS) diagnoses that were used at the Facility. The Monitoring Team requested, and the Facility provided, a list of all individuals who received psychiatric support, and the individuals' DSM IV diagnoses. More than forty individuals had NOS diagnoses. Efforts should be made to resolve these diagnoses (see also comments made in discussion for Provision J6). A clinical note should be written whenever diagnoses are changed or updated, to clarify the basis upon which the diagnoses or re-diagnoses were made.	
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	The Monitoring Team assessed whether all individuals who were treated with psychotropic medications had treatment programs: The Facility provided a list of all individuals who received behavioral treatment programs and a list of individuals who received psychotropic medications. According to these lists, all individuals who received psychotropic medications had a treatment program. The twenty records of Sample J1	Noncompliance

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	a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	were examined, to verify that the record of each individual contained a treatment program. Each of these individuals was treated with psychotropic medications, and in each case the required program was located. The Monitoring Team evaluated whether all individuals who received psychotropic medications had a working psychiatric diagnosis, even if that individual did not have a full evaluation in place. For this purpose a working diagnosis was a DSM IV diagnosis that was listed in the psychiatric documentation in a consistent manner, that appeared to be generally consistent with the information provided in the record about the individual, and that appeared to be generally consistent with the psychiatric treatment decisions made by the treating psychiatrist. Since the last compliance tour, the Department of Psychiatry had developed a campus-wide list of all individuals supported by psychiatry, and their DSM IV Axis I, II, and III diagnoses. The list was updated whenever a change in diagnosis was made by the treating psychiatrist (further discussion of this matter is provided at the end of the discussion for this provision). Records for individuals in Sample J1 were examined for to see if the diagnoses listed in the campus wide list were present in the various psychiatric documents in the records, such as PTRs. The Monitoring Team also noted whether the diagnosis for each individual was based on a full psychiatric evaluation. Individuals #3, #11, #13, #61, #65, #75, #264, #377, #417, #471, #490, #493, #511, and #590 had psychiatric evaluations in place. Individuals #109, #120, #186, #381, #479 and #130 (very recently admitted) did not. The Monitoring Team examined whether medications were used as punishment or for the convenience of the staff: To do so the Monitoring Team reviewed a sample of chemical restraint records (Sample C.3, see Assessment of Status for Section – Protection from Harm-Restraints). The sample consisted of Individual #9 (06/29/11), Individual #399 (06/20/11), and Individual #490 (07/01/11). There was no evidence that medications were used as punishment or for the convenience of the staff. The Monitoring Team also sampled the psychiatric care of all individuals who had been restrained more than three times over a period of thirty days during the six months since the previous compliance tour. There were seven such individuals (Individuals #3, #9, #181, #399, #417, #488, and #490) and the Monitoring Team selected Individuals #3, #9, #181, and #490 for review. The selection was haphazard. The Monitoring Team examined the relevant episodes of restraint that were included in the 30 days period in question. The review included an examination of the details of the restraint including restraint checklists and debriefing of psychiatrist in both the management/oversight of the use of medications, and the psychiatrist's role as part of efforts to minimize the need for the use of chemical (and other) restraints. In these cases, too, there was no evidence that medications (or other restraints) were used as punishment or for the convenience of the staff.	

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		The Monitoring Team also reviewed all materials contained in Samples J1, J2 andJ3, to see if any information was contained that suggested that medications were used as punishment or for the convenience of staff. No such information was found. The Monitoring Team examined whether there was integration of psychiatry services with Psychology, Nursing and Medical to avoid use of psychotropic medication for punishment or convenience of staff. The Monitoring Team confirmed via documentation in the records and observations made by the Monitoring Team during meetings that clinicians from the relevant disciplines participated in many PST functions, including PTRs, PSPs, medical clinics, and PSPA meetings. Representatives of the clinical disciplines also participated in clinical oversight committees such as the P&T, PMOC, and Risk Reduction Committees (RRC), and activities of those committees included oversight to avoid prohibited use. Shared involvement of the various clinical disciplines in these activities was a valuable tool in assuring that there was no use of prohibited services. The Monitoring Team examined records for Individuals in Sample J.1, to determine if the records provided a rationale for the use of each medication. The Monitoring Team notes that an explicit statement about the rationale is part of the PTPs that are being developed by the Facility (see Provision J13) but they are not part of the records that are in place. However, medication information was provided in the PTR medication tables and in the PBSP. The information provided typically was the name and dose of the medication, the diagnosis, and the symptoms that were of interest to the psychiatrist. In most cases, the rationale was best explored by comparison of the medication and the diagnosis. In many cases the rationale could be understood simply by knowledge of the typical use of the medication and the target symptoms. Examples were: • Clonidine for hyperactivity (Individual #3) • Lithium for mood stabilization (Individual #11) • Guanficine for inattentiveness (Individual #11) • Ativan for anxiety (Individual #61) • Depakote for mood stabilization (# Individual #65) • Anafranil for compulsive and ritualistic behaviors (Individual #109) • Seroquel for psychotic statements (Individual # 186) • Ritalin for hyperactivity (Individual #264) • Zoloft for depressive symptoms (Individual #264) • Geodon for auditory hallucinations (Individual #490) In other cases, the rationale was not obvious. For example: • Lamictal for aggression, diagnosis of bipolar disorder (Individual #3).	

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		• Seroquel, Ativan and Prozac for self injurious behavior, diagnosis major depression (Individual # 493). The Monitoring Team examined records for Individuals in Sample J.1., to determine whether there were adequate linkages between the listed diagnoses, relevant behavior symptoms of the diagnosis, and psychotropic medications. Such concordance was best understood via examination of information found in PTRs (and sometimes PBSP) documentation. A total of 53 medications were reviewed for the 20 individuals. In some cases the linkages between the medication, the related diagnosis, and the targets for treatment were straightforward and clear. For example: • Individual # 11 was treated with Zyprexa for a diagnosis of Bipolar Disorder, and the identified targets were mood stabilization and psychotic symptoms. The same individual was also treated with Guanfacine for inattentiveness associated with Attention Deficit Disorder. • Individual #61 was treated with Seroquel for Schizoaffective Disorder and the identified symptoms were paranoia and depression. The same individual was also treated with Ativan for anxiety associated with the same diagnosis. • Individual #109 was treated with Anafranil for Obsessive Compulsive Disorder and the identified symptoms were compulsivity, ritualistic behaviors and lack of hygiene maintenance. • Individual #120 was diagnosed with Bipolar disorder and was treated with Lithium for mood stabilization. • Individual #186 was diagnosed with Schizoaffective Disorder, was treated with Seroquel, and the identified targets were psychotic statements, loud vocalizations, ritualistic behaviors, sleep disturbance, and refusals. • Individual #264 was treated with Zoloft for depressive symptoms associated with the depressed phase of Bipolar Disorder, and the same individual was treated with Seroquel for symptoms of explosiveness and mood lability, also associated with Bipolar Disorder. • Individual #417 was treated with Seroquel for psychotic symptoms (identified as hallucinations and delusions) associated with Bipolar Disorder, and with Lithium for manic symptoms associated with the same disorder. • Individual #471 was diagnosed with Generalized Anxiety Disorder and was treated with Ativan for symptoms of anxiety and repetitive talk. • Individual #479 was diagnosed with Bipolar Disorder and was treated with Depakote for mood stabilization. • Individual #490 was diagnosed with a mood disorder and treated with lithium for mood lability, assaultive behavior and suicidal statements. The Individual was also diagnosed with a psychotic disorder and was treated with Geodon for auditory hallucinations.	

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		However, review of the 53 medication treatments revealed that there were also many cases of individuals for whom the only identified targets were disruptive behaviors (such as aggression) that were not core symptoms of a psychiatric disorder. Examples include treatments with Lamictal (Individual #3), with Risperdal (Individual #13), with Seroquel (Individual #377), with Geodon (Individual #490), and with Abilify, and with Depakote (Individual #590). Records for twenty Individuals in Sample J.1 were reviewed to see if PST psychologists had provided a measure of treatment efficacy, to help determine whether the medication treatments were effective. When present, such measures were typically listed in an individual's PBSP. Chart reviews demonstrated that in some cases, tracking for efficacy was in place. For example: • Individual #264 was treated with Zoloft for depressive symptoms associated with Bipolar Disorder. Observable symptoms of depression were defined in the PBSP. They consisted of "crying, screaming, refusing meals, refusal to interact with peers, saddened facial features, self injurious behavior and lack of vocalization." Symptoms of depression ratings were reported on in PTRs, and thus provided guidance to the psychiatrist on the status of the symptoms that were being treated with Zoloft. However, in the large majority of cases there was no such tracking of appropriate psychiatric symptoms, even when the psychiatrist had identified those symptoms. Records for Individuals in Sample J.1 were reviewed to determine whether they identified the problems that were the focus of treatment. The records at the Facility contain APLs. The APLs list all active health problems, and included the psychiatric problems that are the focus of treatment. APLs were included as part of Annual (or Admission) Medical Assessments, completed by the PCP. Each of the twenty records that were reviewed had an APL that contained DSM IV psychiatric diagnoses. Since the last compliance tour, the Department of Psychiatry has developed a campus-wide list of all individuals supported by psychiatry, and their DSM IV Axis I, II, and III diagnoses. The list is updated whenever the treating psychiatrist makes a change in diagnosis. The Monitoring Team was given a copy of the list of diagnoses dated 06/08/11, and it was compared to the diagnostic information in the APLs. For ten of the individuals in Sample J.1, the information contained in the two sources was the same. For the other ten individuals (#3, #65, #75, #109, #186, #264, #417, # 471, #490, and #590) there were differences between the two lists. The Monitoring Team investigated the reasons for the differences, by review of the psychiatry and medical sections of the	

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		clinical record. In each case, the Monitoring Team learned that the APL had been correct when it was written, and the differences were the result of changes in the psychiatric diagnosis that were made at a later date. This emphasized the value of an actively maintained list of current psychiatric diagnoses across the campus. The Department of Psychiatry is commended for having developed this list and for maintaining it. The Monitoring Team trusts that the list will available to PCPs, so that Annual Medical Assessments will be updated with any changes in psychiatric diagnoses that may occur over the course of the year. In the POI the Facility described the ongoing development of PTPs that will address the deficiencies noted above. For information, see discussion for Provision J13.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the 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.	Eight individuals were reviewed for pretreatment sedation procedures. Four of the individuals had TIVA, and four individuals had oral or intramuscular pretreatment sedation. The Monitoring Team reviewed both the medical/nursing monitoring for safety related to the procedure. In addition, the Monitoring Team reviewed the status of plans for each individual, to reduce the need for pre-treatment sedations (via desensitization or otherwise). In the assessment of this provision, the medical monitoring aspects are reviewed first, followed by a review of the behavioral programs. <u>Medical/Nursing monitoring for safety.</u> Four individuals were reviewed for TIVA: Individuals #102 (06/03/11), # 462, (3/9/11), # 538 (2/18/11) and #574 (06/02/11). The Monitoring Team reviewed documentation provided for each individual for the presence of restraint checklists. These were provided for each individual. The checklists were then examined for the presence of the elements outlined in the Facility procedures (Medical and Dental Restraint III.1b, Step 1D. In one case (Individual #538) the post restraint assessment was not completed. In all cases the section for medical/nursing monitoring was not completed, since documentation of vital signs and related information was documented on other forms, mentioned in the next paragraph. Information about the medical/nursing monitoring was recorded on anesthesia records, post anesthesia vital sign flow charts, and IPNs that documented care on the home unit during the period before and after the anesthesia. The Facility provided the Monitoring Team with a document called post anesthesia care guidelines for TIVA. There were eight steps outlined. These included requirements for vital signs every 15 minutes for one hour, every 30 minutes for the next two hours, and after the return of the individual to	Noncompliance

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		the (home) unit, every shift for 72 hours. Documents provided to the Monitoring Team demonstrated that customary anesthesia records were maintained during the actual procedures for all four individuals. Post anesthesia flow sheets were provided for individuals #462, #538 and #574. These documented frequent vital sign and oxygen saturation measures that nonetheless did not fulfill the specific requirements of the post anesthesia care guideline document. The post anesthesia document was not provided for Individual #102. Documentation for (home) unit monitoring was often contained in IPNs that were provided to the Monitoring Team. For Individual #574, the post anesthesia flow sheet was also used to document vital signs for the 72 hours that followed the procedure. These documents demonstrated nursing attentiveness and physical monitoring. However, in no case was the Monitoring Team provided with sufficient details of nursing charting to allow confirmation that local guidelines for nursing care were followed. Four individuals were reviewed for oral pre-treatment sedation for medical procedures. They were Individuals #75, (04/01/11 – EKG), #269 (06/10/11, eye exam), #332 (05/20/11 – eye exam), and #490 (02/01/11- pelvic exam. The Monitoring Team reviewed documentation provided for each individual for the presence of restraint checklists. These were provided for each individual. Medical monitoring for safety was provided for each procedure, and a variety of forms were used for documentation. For individual #75 monitoring was provided with nursing pre and post sedation checklists (which included a set of vital signs prior to administration of the sedation) as well as with vital sign measures that are included on the restraint checklist. Nursing measures on the unit were also documented in IPNs. For individual #269 nursing measures were documented in IPNs, and on the restraint checklist. For individual #332 a pre-procedure sedation checklist was used, but not the post-procedure sedation checklist. Instead a form (partially handwritten) called "Post Sedation Monitoring Vital Signs Flow Sheet" was used. For Individual #490 pre and post sedation checklists were used as well as the restraint checklist and IPNs. Efforts of the Monitoring Team to determine whether medical/nursing monitoring was provided was compounded not only by the varying patterns of documentation, but also by the presence of two different local protocols that appear to provide different guidelines for medical nursing monitoring for safety. One protocol was called "Sedations Guidelines" (updated 08/10) and it detailed the use of nursing forms "pre-sedation checklists" and "post-sedation checklists" described above. A second set of guidelines was described in a flow sheet called "BSSLC Pre-Treatment Sedation" process (most recent revision, 07/26/2011). Per the documents submitted for review, nursing monitoring for safety during and after	

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		procedures appeared to have improved since the last tour. However, for each kind of procedure (for example, oral pretreatment sedation) the Facility should choose a single appropriate protocol for the monitoring, and then use that protocol consistently. Details of safety monitoring during pretreatment sedation procedures will be reviewed with the Facility Nursing Department at the next compliance tour. <u>Review of plans to reduce the need for pre-treatment sedation.</u> For each individual reviewed for pretreatment sedation, the Facility was asked to provide plans to reduce the need for the use of the sedation. A plan was listed for four of the eight individuals reviewed: Individual #75: No plan provided Individual # 102: Walk into dental office for 10 seconds Individual #269: No plan provided Individual # 332: Medical – respond to touch 100% of trials Individual #462: No plan provided Individual #490: No plan provided Individual # 538: Sit in dental chair Individual # 574: Sensory Touch Plans and data sheets for all relevant behavioral plans were requested but not received.	
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.	There were three psychiatrists at the Facility. Drs. Luna and Morgan worked on a full time basis and Dr. Chacko worked about 6 hours per week. The combined staffing for psychiatry was 2.15 full time equivalents (FTE). At the time of the tour there were 168 individuals under the care of facility psychiatrists, so that each FTE psychiatrist provided ongoing psychiatric care for 78 individuals. Each psychiatrist was also available to other individuals across the campus for needed consultations and unanticipated emergencies. The psychiatrists were asked about whether they had sufficient time to ensure the provision of services. BSSLC psychiatrists noted that despite the added psychiatric time provided by Dr. Luna, there remained many time consuming tasks required by SA requirements. The Facility continued to struggle to keep pace with tasks that must be completed by the psychiatrists, some of which were newly added. The responsibilities and added tasks included: • Deployment of Appendix B psychiatric evaluations across the campus (see Provisions J2 and j6) • Addition of on call duties (see Provision J1)	Noncompliance

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		• Fuller participation of each psychiatrist in the annual PSPs for individuals under his/her care • Participation of psychiatrists in the psychiatry/psychology monthly meetings and the psychology/psychiatry workgroup to integrate care and develop combined assessments and case formulations (see Provision J8). • Participation of psychiatrists in neurology clinic appointment for selected individuals under their care. • Enhance monitoring (by PMOC) of psychotropic medication use in individuals diagnosed with tardive dyskinesia • Participation in the Pre-treatment Sedation workgroup • Ongoing work of the Lead Psychiatrist in campus wide activities including continued development of PMOC, including the development of a process for the PMOC to make specific recommendations for clinicians and for clinicians to review/respond to the recommendations (see Provision J11), the pilot for enhanced review of episodes of restraint in RRC (see Provision J1), an increased participation of psychiatry in PBSC, the development of PTPs (see Provision J13), the development of Department of Psychiatry tracking systems for psychiatric information including updated diagnoses, (see Provision J3), and for campus wide tracking of patterns of psychotropic medication use for fifteen defined classes of medication (see Provision J11). The Monitoring Team again explored the issue of whether the psychiatrists had sufficient time to complete the required tasks. One measure was the psychiatrists' clinical caseload, which remained high. During the last tour the Monitoring Team reported that each FTE psychiatrist was responsible for the psychiatric care of 84 individuals. This caseload was higher than at some similar DADS facilities. In the opinion of the Monitoring Team, although Drs. Chacko, Luna and Morgan were highly qualified and hard working psychiatrists, a shortage of psychiatric time impeded needed progress on items required by the SA. The clearest example of this was the slow pace at which psychiatric evaluations could be completed: Although Appendix B psychiatric evaluations were needed for 169 individuals, only about 30 had been completed. At this point the Monitoring Team continued to be unable to 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	The Monitoring Team assessed psychiatric assessments that used the Appendix B format. Twenty evaluations were done since the last compliance tour (Sample J.2). Dr. Luna	Noncompliance

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	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.	completed sixteen of the evaluations, and Dr. Chacko completed four. The evaluations varied in length from three to ten single spaced pages. All evaluations followed the required outline and they all provided information that was appropriate to the section in question. The evaluations contained information that was current, accurate, and had complete clinical and behavioral data. The sections that required assessment and case formulation were thoughtful and complete. All evaluations clearly met and typically exceeded the core requirements of the provision. The evaluations that were reviewed contained not only elements needed to fulfill the requirements for the various sections of the appendix B format; they contained information needed to comply with requirements of other section J provisions. Examples of good practices follow: <u>Useful accounting of past treatment history:</u> • Individual # 39: A history was provided for a positive treatment response with Paxil (listed in recommendations). • Individual # 167: The past psychiatric history and medication history sections contained many examples of past treatment failures. Knowledge of that information will help avoid unhelpful repetition of those treatments. There were also reports of some treatment successes (e.g. Carbatrol). While that particular treatment was stopped due to side effects, the information can be used to develop treatment trials for medications that have similar indication, but which come from other medication classes and which are unlikely to cause the same side effects. <u>Helpful discussion about the reasons for diagnosis:</u> • Individual #467: The psychiatrist clarified the reason that the individual was best diagnosed with both Pervasive Developmental Disorder and Attention Deficit Disorder. • Individual # 511: The psychiatrist discussed how the Individual met the diagnostic criteria for autism, and provided specific behavioral characteristics from each of the required symptom clusters. • Individual #543: The presentation contained a very clear discussion about the symptoms of vocal tic and the history of its response to pharmacotherapy. The comments make clear that in the opinion of the psychiatrist, the individual's thinking processes have improved significantly as have his social skills. This seems to be related to the use of a medication. Since its use the individual is said to be able to take the time to think and interact. These statements provided a focus for continued discussion about possible additional diagnoses and treatments	

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		Specific symptoms that will prove useful for tracking efficacy of treatment 1. Individual #39: The evaluation identified anxiety compulsive behaviors such as playing with string, mood, characterized by a replacement of a distressed or neutral affect, with a bright and animated (for the most part) mood. 2. Individual #61: The mental status documented delusions, lack of interest, lack of motivation, variably increased sleep 3. Individual #167: The Mental Status Exam identified pressured speech, delusional statements, and highly variable mood Treatment Recommendations: 1. Individual # 113: The discussion contained helpful discussions of pharmacological and non–pharmacological intervention. The discussion provided needed groundwork that will allow for discussion regarding the validity of the diagnosis of bipolar disorder. 2. Individual # 259: This was an individual who had a diagnoses in the NOS grouping, for whom there was no clarity as to either the diagnosis or any demonstrable benefit from medication treatment. The psychiatrist's presentation began with a discussion about whether any diagnosis was appropriate, and discussed that since the individual had been on psychotropics for many years, it would be clinically unsound to abruptly discontinue the medications without a careful and slow taper. The clarity of the analysis and solid clinical planning for the coming period was helpful. 3. Individual #349: There was a good discussion about the reasons for the diagnosis. 4. Individual # 490: The recommendations were clear about which class of medication has been most helpful. 5. Individual # 543: The evaluation contained a good discussion about the rationale for the use of Risperdal. Although the overall quality of the evaluations was good, six of the twenty evaluations (30%) had NOS diagnoses; these were for Individuals #113, #259, #304, #490, #496, and #543. Psychiatrists should revisit these evaluations and attempt to resolve the NOS diagnoses. Overall, the Monitoring Team found that the Appendix B evaluations were strong and reflected the professionalism and high standards of care provided by the psychiatrists. Nonetheless, less than 20% of the individuals who require evaluations have had them and this was not a sufficient number to demonstrate that a credible and sufficient process was underway to complete the required evaluations. The Facility should explore ways to increase the pace at which Appendix B evaluations are completed.	
J7	Commencing within six months of	The Monitoring Team reviewed new admissions to the Facility. There were five	Noncompliance

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	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.	admissions in 2011. All five individual had psychiatric diagnoses and received psychotropic medications. Two of the Individuals (#511 and #590) received detailed psychiatric evaluations in the SA appendix B format. Two other Individuals (#381 and #479) had not had full evaluations; however, the treating psychiatrist had dictated a detailed note that contained many of the elements of the evaluation and contained a (preliminary) psychiatric diagnosis. In both cases the notes (one of which was titled "initial psychiatric consultation," and the other "psychiatric consultation") were done soon after admission. The notes provided guidance toward initial treatment efforts. Although the fifth Individual (#130) had been admitted only weeks before the monitoring tour, treatment had already been initiated by all relevant disciplines. The psychology department provided the Monitoring Team with a spreadsheet of Reiss Screen scores for 189 individuals. The spreadsheet contained the scores of each individual on various scales of the screen, and it reported the aggregate score for the screen. In the Self-Assessment the Facility reported that two individuals exceeded the clinical cutoff scores and that a third approached, but did not reach, the cutoff. The three individuals were identified by the Facility. Individual #31 had a total Reiss Screen score of 10 (cutoff value for total score was 9); Individual #121 had a total score of 18, and scores of 4.5 on two sub-scales 9 (cutoff value of 4.5). On the spreadsheet, the values for individual #330 were blacked out. This was likely a Microsoft Excel artifact that can occur when additional data are added without a re-format. Per the above, Individual #330 must have been the individual who approached but did not exceed the cutoffs. The three individuals were evaluated further by the PST psychologist and then the fuller PST. The latter deliberations were joined by a Facility psychiatrist who had reviewed the relevant documents and who then offered an opinion regarding whether a full psychiatric evaluation was appropriate. PSPA documents described the evaluation process and the recommendations regarding future care. In each of the three cases further behavioral treatment was suggested and initiated, but not psychiatric evaluation and treatment. Based on the documents provided, the Monitoring Team found no fault with the clinical recommendations, but per SA requirements, a face-to-face psychiatric evaluation was required for Individuals #31 and #121. The required evaluations should be conducted for these Individuals. The Facility provided a written communication to the Monitoring Team as part of the document request VII.14 for the current tour. In that document the Facility stated that in the future, Reiss Screens will be done as part of the pre-admission screening for any individuals considered for admission. The Reiss Screen will be done by caregivers who know the individual well. The Monitoring Team reviewed the list of individuals who lived at the Facility who had a psychiatric diagnosis or received psychotropic medication. Those individuals need to	

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		have a psychiatric assessment and diagnosis. As reviewed under Provision J2, 92 of 169 individuals (about 55% of the individuals who needed to have psychiatric evaluations) had received them. A process was underway to provide psychiatric evaluations for all these individuals, but the number of evaluations that was in place was not sufficient to allow a finding of substantial compliance.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The Monitoring Team examined the system in place to integrate pharmacological treatment with behavioral and other interventions through combined assessment and case formulation, This was done by review of the records in Sample J.1 and J.2, by consideration of PST processes such as PTRs and PSPs, by evaluation other clinical activities (such as neurology clinic), by consideration of Facility level meetings such as the psychiatry/psychology workgroup meetings, and by consideration of the activities and work products of Facility Committees such as PBSC. The determination about compliance was made by examination of the following aspects of integrated care: • <u>The Facility's system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation:</u> The review demonstrated that there were many multidisciplinary assessment processes – for example the sharing of information by psychology at PTRs. However, there was little evidence that a process was in place that went beyond coordination and collaboration. The Monitoring Team did not witness a clinical process or see clinical documents that attempted to synthesize and document a common understanding of the individual and his/her needs that transcended any discipline-specific product. The above notwithstanding, individual clinicians sometimes demonstrated a comprehensive understanding of individuals that integrated information from their own discipline with information usually presented by other disciplines. For example, in the PBSP, psychologist for Individual #109 discussed in detail how the Individual's repetitive behaviors were best responded to with an understanding of the setting and the functions of the behavior and also the underlying psychopathology. Similarly, the psychiatrist for individual #543 discussed that the Individual's unpleasant vocalizations could be both learned behaviors or symptoms of a tic disorder, and discussed the role of medication given that understanding. In both cited examples, a member of one discipline showed an understanding of the sister discipline, and used that understanding to provide an overall summary which combined perspective of both disciplines. But these examples reflect (only) the work of individual clinicians; there was no assurance that the psychologist's opinion was	Noncompliance

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		shared by psychiatrist assigned to that case, or vice-versa. There should be a place in the Facility evaluation process where the PST Psychiatrist and Psychologist (along with others) come together to discuss, develop, and articulate the overall PST's integrated understanding of the individual's behavioral healthcare needs. In the Self-Assessment, the Facility stated that it had initiated a number of work processes that will facilitate the further integration. They are: i. Monthly combined discipline workdays ii. A focus on developing integrated assessment during the third quarter of the annual cycle, to provide formulations in time for individual's PSPs iii. A worksheet to integrate DSM diagnoses consistently across disciplines. The Monitoring Team noted that the Facility indeed had many work structures that could be used to generate the needed case formulations. Combined formulations could part of an agreed upon document that is retained/updated (annual evaluation, PBSP, etc), and the formulation could be updated as the clinical circumstances warrant. • <u>The role of behavioral data in decisions regarding pharmacological treatments:</u> There was no doubt that behavioral data were considered when decisions were made about pharmacological processes. This was particularly evident in both the structure and the function of PTRs. Psychologists were always present and they prepared presentations of behavioral data on the individuals being discussed. However, the data that was presented were typically the data being collected to guide the broad behavioral treatment plan, rather than the particular data needed for the pharmacological decision making. For details, see Provisions J3 and J13. In addition, the graphic presentation of the data was often poor. This made appropriate decision- making at PTRs much more difficult. Good graphic presentations are needed, to allow decisions makers to analyze changing patterns of complex behavioral data sets with medication dosing details. For details about what is needed in graphic presentations, see Provision K10. • <u>Interviews of nurses and psychologists to ascertain the process of collaboration:</u> Nurses and psychologists were interviewed during current and previous tours and asked about collaboration. The Monitoring Team also explored these areas by observing meetings (in the most recent tour, several called PSP meetings, the risk assessment meeting, the risk reduction meeting, and the joint psychology/psychiatry workgroup) and by review of many PBSPs, PTRs, and related documents. The Facility was doing well in regard to collaboration. The relationships between the various Facility providers were collegial, the various disciplines were working well together to support PSTs, and there was eagerness amongst the staff to do whatever was deemed necessary, to improve collaborative processes.	

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		• Evidence of coordinated care when psychiatric illness occurred in conjunction with maladaptive behaviors, and integration of pharmacological and behavioral treatments: Information was exchanged in meeting such as PTRs, and PBSC, PMOC, and joint psychiatry/psychology workgroup meetings. However, there was often no commonly accepted understanding of the individual, the resulting discussions consisted only of exchanges of information, and the treatments were not integrated. Overall, The Facility provided good multidisciplinary processes for behavioral health evaluations. However, as outlined in item (1) and (5) true interdisciplinary formulations remain elusive, and neither a clinical process nor a work product were evident. The product should be a statement, jointly "owned" by psychology and psychiatry, which articulates the behavioral healthcare team's overall understanding of the individual and his/her needs. That common understanding of the individual will be the basis for the treatment assignments that are the focus of Provision J9.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the	The Monitoring Team Reviewed the process of PBSP development. To do so the Monitoring Team examined lists provided by Facility that provided the names of individuals who had psychiatric care and all individual who had PBSPs. The Monitoring Team also reviewed the records of individuals in Samples J.1 and J.2. Records that were particularly helpful were those of Individuals #381, #479, #511 #590 and #130. Those five individuals were admitted to the Facility over the six months prior to this compliance visit, and their PBSPs were in the process of active development. The Monitoring Team reviewed the list of individuals who received psychiatric support and confirmed that each of the individuals had a behavioral support plan. The Monitoring Team reviewed clinical processes in which the psychiatrist was involved. There was evidence of timely provision of a psychiatric evaluation or preliminary consultation. As was discussed in detail under Provision J7, psychiatrists provided timely evaluations (final or preliminary) for newly admitted individuals, PTRs took place, and psychiatrists participated in PSPAs. Nonetheless, there was no single meeting for these newly admitted individuals which was dedicated to the process of interdisciplinary integration of information needed to formulate a combined clinical approach. In routine clinical terms such a clinical case conference might have been no different than the clinical discussion that takes place at PTRs. However, for a newly admitted individual (or any individual for whom a new PBSP is being developed) the discussion would probably have been expanded. Participation would have been broader, a more detailed discussion would have ensued, and perhaps a common statement or combined case analysis would have been written (or at least initiated). In	Noncompliance

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	degree possible.	the Self-Assessment, the Facility already broached the question of when discussions about combined formulation would take place for individuals who receive ongoing care: It would be during PST deliberations for the third quarter of the annual cycle, as part of the preparation for annual review of the PSP. The Monitoring Team reviewed how PSTs determined that the least intrusive and most positive interventions were made to treat the behavioral or psychiatric condition. Facility PBSPs contained language that stated that PSTs made these determinations. However, the manner in which the actual PSTs made those decisions was less clear. The Monitoring Team reviewed how the PST determined whether individuals were best served primarily through behavioral, pharmacological or other interventions, in combination or alone. In essence, this was the process of clinical assignment to treatment modalities. None of the records reviewed showed that PSTs made such determinations, although PSPs invariably documented the treatments that were in place. The PST determinations should be made easier by the combined case formulations that are required by Provision J8, but these were not in place. The documentation does not need to be either lengthy or complex. For example, a hypothetical individual's assessment might conclude that the PST determined that the individual was understood to have autism with prominent sensory features and an unrelated psychiatric co-morbidity such as a mood disorder. That individual might be best served through a combination of medication (to treat symptoms of the mood disorder), a behavioral plan (to address challenging behaviors associated with both autism and the mood disorder), and an occupational therapy intervention for sensory modulation. The Monitoring Team reviewed PST specification of non-pharmacological treatments for individuals who received medication treatment, to minimize the need for medication. PBSPs and PSPs provided information on the required non-pharmacological treatments. In summary, there was a need for the Facility to improve the process under which treatment assignment decisions were made. There are many ways to do this, and the clinical process needed for initial treatment assignments for newly admitted individuals might be different from the clinical process needed for periodic assessments of ongoing treatment programs.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency	In order to understand how PSTs made the determinations required by the provision, the Monitoring Team reviewed PST information for the last ten newly prescribed medications, as reported by the Facility. These were medications for Individuals #9 (Lithium), #65 (Geodon), #75 (Trileptal), #181 (Seroquel), #255 (Tenex), #377 (Luvox),	Noncompliance

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	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.	#406 (Zyprexa), #488 (Ativan), and #493 (Ativan and Prozac). The Monitoring Team examined PTRs, medication consent forms, and PBSC/HRC review forms. Discussions about non-emergency psychotropic treatments typically took during PTRs. The psychiatrist's dictation for the PTRs typically included a good discussion of the medication, its proposed use (for example, Individuals #9 (Lithium), #377 (Luvox), #406 (Zyprexa), and #488 (Ativan). The template used at the Facility for the PTR had a section on risk vs. benefit, but not for alternative treatment strategies. Alternative treatment strategies were sometimes included in the psychiatrist's dictated notes (for example, Individuals #65 (Geodon), #377 (Luvox), and #406 (Zyprexa) but this was variable. The provision required participation of the Nurse, Psychiatrist and PCP in the discussion about medication risk /benefit and alternative treatments However, The PTR report did not always make clear who had participated in the discussion about the new medication. The Psychiatrist was always present at PTRs. Nursing participation in PTRs was required but PCP participation was not. In the Self- Assessment the Facility indicated that PCPs had begun attending many of the PTRs. The PTR form contained a line for the PCP to sign if he/she attended, and this was done for Individuals #9 and #181, but not the others. There was no place for nurses to document their participation. The Lead Psychiatrist told the Monitoring Team noted that when the PCP could not attend the PTR, the psychiatrist typically discussed the medication with the PCP by telephone, but the Monitoring Team could not located documentation for this. During the tour the Lead Psychiatrist noted that the PTPs contained information about the new medication, (for details, see J13) and that PTPs would be reviewed by PBSC and HRC. The Lead Psychiatrist identified the PTP as a place to document the PCP's inclusion in the deliberations (either at the meeting or telephonically). The Monitoring Team noted that if the PTP will be the focus for all medication related information, (including possible treatment alternatives), should be listed on the PTP. Also, arrangements should be made to document the nurses' participation in the deliberations.	
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	Materials reviewed for determination of continued compliance with this provision included: A list of all psychotropic medications newly approved for use by PBSC and HRC, a spreadsheet of individuals prescribed psychotropic/psychiatric medication, and a separate list of individuals who are prescribed each of the following: a. Anti-epileptic medications being used as a psychotropic medication b. Lithium c. Tricyclic antidepressants d. Trazodone e. Beta blockers being used as a psychotropic medication	Substantial Compliance

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	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.	f. Clozaril/clozapine g. Mellaril h. Reglan i. Anticholinergic medications j. Benzodiazepines Other documents reviewed were a list of individuals prescribed intra-class polypharmacy, including the names of medications prescribed and each medication's start date, Facility-wide data regarding polypharmacy, including intra-class polypharmacy, and the last six month's minutes of the PMOC and P&TC. Since the last tour the PMOC had developed a format via which the committee will provide feedback to the treating psychiatrist, after review of an individual's care. PMOC recommendations will be reviewed with the PST at the PTR. The Facility reported that at the time of the compliance visit there were 168 individuals who received psychotropic medications. Of these, 30 received intraclass polypharmacy (two or more from the same class) and 63 received interclass polypharmacy (three or more psychotropics in any class). Reviews of the use of particular medications, and medication classes had already taken place during PMOCs, for example for atypical antipsychotics, mood stabilizers. PMOC now has the capacity to monitor psychotropic medication use across campus with software developed by Caitlin Connor, Program Auditor and Kerry Weyand, data analyst. Individual data review continued on a monthly basis, for individuals with complex medication regimes. PMOC also monitored for completion of MOSES and DISCUS forms. During the May PMOC Dr. Morgan noted that several MOSES that were completed in 2011 lacked physician signatures and efforts to achieve complete compliance were reviewed. PMOC was assisted by an excellent P&TC review of Clozapine use. PMOC reviewed intraclass use of mood stabilizers (01/12/11); use by any individual of 5 or more psychotropics (02/23/11); antidepressants (03/30/11) and intraclass anxiolytic/sedative hypnotic (05/04/11). The reviews were done individual by individual, and contained detailed commends and recommendations. During the next compliance tour the Monitoring Team will request information about whether the increased attention across the campus over the past 18 months has resulted in lower rates of interclass and/or intraclass polypharmacy.	

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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.	Continued compliance with provision requirements was monitored by review of the most recent DISCUS and MOSES forms in the records for Individuals in Sample J.1. Individuals #511 and #130 were newly admitted and did not yet have side effect ratings. The remaining eighteen individuals all had a MOSES and DISCUS form in place. The ratings were all done by nurses; information about the rating (date of ratings, name of the nurse doing the rating, and the actual rating) were done electronically. In all cases the rating on the DISCUS form was "zero," which is somewhat surprising. Additionally, for nine of the eighteen individuals (50%) there was no physician review/signature of the findings. These were Individuals #13, #109, #186, #381, #417, #471, #479, #490, and #590. It is possible that the Monitoring team received only the computer generated forms and that other copies were reviewed and signed by the physicians. An additional set of MOSES and DISCUS forms were also reviewed by the Monitoring Team (refer to Provision N5). The Monitoring Team requested and received a listing of all individuals screened for dyskinesia, and a list of individuals taking Reglan, a non-psychotropic medication that can be associated with dyskinesia. Individuals taking Reglan were properly screened. The Facility provided a list of individuals known to have tardive dyskinesia, and these individuals – for whom a greater degree of oversight is needed regarding the use of medications that can aggravate the dyskinesia – were known to PMOC and their use of psychotropic medication was monitored. The Facility had made considerable progress with a Facility level monitoring of the results of DISCUS ratings via PMOC. Physicians must make sure to document their reviews of the nurse's ratings.	Noncompliance
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline	Materials reviewed for this provision were the thirty three new medications that were started during the past six months, for the sixteen Individuals in Sample J.3. Information reviewed included PTRs, informed consent for the medication, PBSC/HRC review forms, PBSP, and IPNs that were provided by the Facility to explain the reasons that the medications were selected. The assessment of status was done by answering the following questions: • <u>Was there a treatment plan for psychotropic medications?</u> The Facility did not have a document titled medication treatment plan, but since late 2010 informed consent forms for medication have included MRPs that listed:	Noncompliance

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	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.	o Medication Name o (Related) Psychiatric Diagnosis o Targeted symptoms (for the medication) o (Timeline for) Expected Drug Response o Common Side Effects o Adult medication dose Chart (dose range) The completed consent forms were presented to the PBSC/HRC as part of the medication approval process. The Monitoring Team examined the consent forms for thirty three new medications that were started during the past six months, for the sixteen individuals who were part of Sample J.3. On each of the consent forms, information for each of the six information items listed above was provided. • <u>Did the treatment plan identify a clinically justifiable diagnosis or specific behavioral-pharmacological hypothesis?</u> The Monitoring Team found that in all cases the information was provided. • <u>Did the treatment plan identify the expected timeline for the therapeutic effects of the medication to occur?</u> The Monitoring Team found that in all cases the information was provided. • <u>Did the treatment identify the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy?</u> Yes, although in some cases the symptoms listed by the psychiatrist were not appropriate markers for the diagnosis. For example: 1. Individual #9 was treated with lithium, the diagnosis was Mood Disorder, and the only symptom identified was aggression. 2. Individual # 479 was treated with Abilify, the diagnosis was Bipolar Disorder and the only symptom identified was aggression. 3. Individual #490 was treated with Geodon, the diagnosis was Psychosis NOS and the only symptom identified was aggression. For symptoms that were appropriate for the diagnosis, the Monitoring Team explored this issue further, and looked at whether the tracking had started and results reported in PTR. The results varied. In some cases, appropriate psychiatric symptoms/behavioral characteristics were identified by the psychiatrist in the informed consent form, and data on those measures was provided by the psychologists in PTRs, for assessment of treatment efficacy. For example:	

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		1. Individual #75 was treated with Trileptal, the psychiatric diagnosis was Bipolar Disorder, and the target symptoms were hypomania and depressive symptoms. Data on these were collected by the psychologists, and were defined in the PBSP as "hypomania – making loud noises, laughing loudly, walking around and stomping his feet. Depression – crying, refusing meals and work." 2. Individual #406 was treated with Zyprexa, the psychiatric diagnosis was schizophrenia, and the target symptom was delusional talk. The psychologist collected data on this symptom, and the PBSP defined delusional talk. 3. Individual #412 was treated with Trazodone, the psychiatric diagnosis was insomnia, and the psychologist provided data on the amount of sleep. 4. Individual #417 was treated with Ativan, the diagnosis was psychosis NOS, and the psychiatrist identified that the target symptoms were aggression, self injury and symptoms of psychosis. The PBSP included measures of all three, and defined psychotic statements. In other cases, however, the psychiatrist identified target symptoms for the medication treatment, but the Monitoring Team found no evidence that data were collected or reported. This was the case for Individual #417 (target symptoms listed as "manic symptoms" were not reported), Individual #479 (no data were reported for hyperactivity) and Individual #488 (no data were reported on the target symptom of "anxiety"). Examination of the data revealed that tracking was done when the symptoms selected by the psychiatrist were already being monitored by psychologists for other reasons. The Monitoring Team looked at the symptoms that were identified by the psychiatrists but for which no data collection was started. Often, targets as "manic symptoms" or "anxiety" were clinically appropriate, but there were no operational definitions (or ratings scales, or other behavioral markers) that were necessary to set up behavioral tracking. Although the psychiatrist had taking the first step by identifying a broad target symptom, the steps that should have followed (such as discussions with the psychologist on what the agreed upon measure should be) did not take place, and the monitoring had not been established. • Did the treatment plan identify by whom, when and how the monitoring would occur? From the examples provided in (4) above, it was clear that this monitoring was not in place. • Was ongoing monitoring provided as often as necessary, and no less often than quarterly? From the examples provided in (4) above, it was clear that this monitoring was not in place.	

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		In the POI, the Facility had acknowledged that it was not in compliance with requirements for medication treatment plans. The Monitoring Team, agreed, although it found that some progress had been made, by the addition of the MRP section of medication consent form, which included needed details about the medication and its side effect profile. In the POI the Facility also addressed the need to bring all the various pieces of information about medications into the overall planning process. This included information about medication risk vs. benefits, about alternatives to the medication treatment, (see provisions J10), and about the rationale for the use of the medication, (addressed under a variety of provisions). To consolidate all information about medication treatments, the Facility started to pilot the use of a Psychiatric Treatment Plan (PTP). As explained to the Monitoring Team, the PTP will be a single psychiatric document that will update all psychiatric information in the PBSP, and it will be presented for review of PBSC and HRC whenever a new medication is put in place The Monitoring Team witnessed early use of the PTP: During the PBSC meeting attended by the Monitoring Team, a PTP was presented for a new medication for individual #252. The PTP was titled: "Psychiatric Treatment Plan – July 2011 PSPA Addendum – New Medication (Zyprexa), PBSP update." There were a number of issues related to the future use of the PTP that were still under discussion at the Facility. One possibility was that the PTP would be a permanent addendum to the PSP that would contain the psychiatric data pertinent to the individual. If so, the PSP-PSPA would be updated as the needs arose. Alternatively, the PTP information would be merged into the PBSP itself or perhaps other enduring documents maintained by psychology such as the Structural and Functional Analysis (SFA). If so, a determination will need to be made as to whether the documents would be merged every time there was new psychiatric information, or perhaps at the time of the annual review of the PBSP and SFA. During the monitoring tour the Facility discussed with the Monitoring Team how required information about medication is best presented in PBSPs (or other enduring document, such as the SFA). Integration of clinical and administrative processes seemed to be best achieved when the psychiatric information was presented in the PTR's and PBSPs in a similar format, so as to allow comparison of current and past information. PTRs all had a useful table of key medication information and some PBSPs contained (somewhat) similar information. Examples were the PBSPs of Individuals #65, #120, #471, #479, #490 and #130. In the judgment of the Monitoring Team, a good graphic presentation of the data was essential for the PTR, and it may be useful in the PBSP (or	

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		per above, other documents maintained by psychology). For more detailed comments about graphic presentations, see discussion for Provision K10.3).	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The Monitoring Team examined informed consent documents and PBSC/HRC reviews for 33 new medications for the sixteen individuals in Sample J.3. All consents were obtained, and committee reviews took place, between December 2010 and June 2011. The consents for all 33 medications were obtained using the form "*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 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. The process under which informed consent was obtained had not changed since the last tour of the Monitoring Team, and the flow (dated September 2010) that outlined the steps taken to obtain consent for new psychotropic medications continued to be followed. Following the recommendation of the psychiatrist for a new medication, a PSP meeting (attended by psychiatry, psychology, medicine, nursing, pharmacy and Qualified Mental Retardation Professional (QMRP) was held. During the meeting, the PST 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.	Substantial Compliance

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		Review of the 33 consent forms demonstrated that in all written consent of the LAR/Guardian was in place. The informed consent form included the name of the medication, psychiatric diagnosis, target symptom, expected drug response, common side effects and the dose range of the medication. In four cases verbal consent was obtained to allow initiation of the medication for urgent indications. These were for Individuals #9 (Lithium), #75 (Trileptal), #181 (Seroquel), and #488 (Ativan). In these cases there were signatures for two witnesses. During the tour, the Monitoring Team discussed with the Lead Psychiatrist the importance of a telephone conversation between treating psychiatrist and the LAR, during which the pertinent information about the medication and its use was reviewed. Such contact was important, since it assured not only that the LAR was provided with the key information about the medication, but also that the LAR had the opportunity to discuss any information about the medication and its proposed use with the person best suited to provide whatever information might be of interest to the LAR. The Lead Psychiatrist assured the Monitoring Team that these conversations were the routine practice at the Facility, but they were not documented on the consent form. In summary, the Monitoring Team found that adequate information was provided to the LAR about diagnosis, purpose of medication, expected benefits and side effects, that documentation of review by the human rights committee was present, and that associated risks were identified. The Facility should clarify, however, how the routine telephonic conversation between the psychiatrist and LAR is documented.	
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.	Materials reviewed for this provision included pharmacy lists of anticonvulsant medications used for neurological indications, for psychiatric indications such as mood stabilization, and for both. Coordination of care between the consulting neurologist, treating psychiatrist, and PCP was reviewed by examination of neurological consultation in the records of individuals #3, #11, #13, #61, #65, #75, #109, #120, #186, #264, #377, #381, #417, #471, #479, #490, #493, #511, #590, and #130. A key function promoting integration was the face to face consultation between the three specialties that took place during scheduled neurology clinics at the time of the appointment for individuals. The clinic continued to take place at least monthly, and typically more frequently than that. A neurology clinic had been scheduled for 07/26/11, and the Monitoring Team observed the clinic. Twenty-one individuals were scheduled for review during the clinic. Six of the individuals seen during the clinic were reviewed for both neurological and psychiatric care and the psychiatrist (and in several cases, the PCP) participated. These were Individuals #59, #170, #246, #332, #399, #510. The Monitoring Team later also reviewed the consultation forms written by the consultant during the clinic.	Substantial Compliance

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		Per routine, these notes were routed to Facility physicians for review. Issues reviewed included: Individuals #246, #332, and # 399 were medicated with anticonvulsant medications for both epilepsy and for psychiatric indications. The two physicians coordinated the shared care as was required by the provision. Individuals #170 and #510 were treated with anticonvulsants for epilepsy, not for psychiatric indications. The anticonvulsants in question, however, had significant psychiatric effects. In such cases coordination of care was not mandated by this provision, but was it was essential for overall integration of care. Individual #59 was under psychiatric care and was seen in the neurology clinic for deterioration in gait. For that individual, collegial discussion between the physicians represented good quality care. In addition to the visit to the neurology clinic, the Monitoring Team also assessed the status of cooperation between psychiatry and neurology by examination of the list of individuals for whom psychotropic medications were used to treat both seizures and a mental health disorder, and by examination of neurology clinic notes for Individuals #3, #11, #13, #61, #65, #75, #109, #120, #186, #264, #377, #381, #417, #471, #479, #490, #493, #511, #590, and #130. These showed that individuals taking "dual purpose" medications were properly tracked and written communication took place between psychiatrists and the neurologist via the consultation form.	

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

1. Medication treatment plans should be put in place, and required information about medication should be tracked in PBSPs (or other enduring documents maintained by psychology (Provision J13).
2. Departments of Psychology and Psychiatry should improve behavioral tracking for medication treatments, to provide data about treatment efficacy (Provision J3).
3. Departments of Psychiatry and Psychology should improve the processes under which combined assessments and case formulations are generated (provision J8), and treatment assignments are made (Provision J9).
4. PCPs and nurses should document their participation in required deliberations about new medications (provision J10), and psychiatrists should document their reviews of MOSES and DISCUS exams (Provision J12).
5. Consistent procedures should be established for safety monitoring during pretreatment sedation (Provision J4).
6. Plans to minimize the need for pretreatment sedation should be developed for individuals who need them, and plans for tracking those plans for efficacy should be developed (Provision J4).

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. BSSLC Plan of Improvement (POI) 7/12/11 2. BSSLC July 2011 Presentation notes 3. BSSLC Policies and Procedures: Counseling Policy undated 4. Minutes for the Positive Behavior Support Committee (1/1/2011 – 07/01/2011) 5. Minutes for Behavior Services departmental meetings (1/1/2011 – 07/01/2011) 6. Curriculum materials for the Q Construction Training 7. Review of Proposed Positive Behavior Support/ABA Plan tool undated 8. Contracts for professionals providing external peer review, intellectual and adaptive assessment, and counseling 9. 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, #5, #9, #11, #12, #15, #20, #27, #51, #57, #60, #65, #84, #120, #151, #181, #181, #255, #259, #314, #342, #349, #381, #390, #399, #400, #412, #417, #425, #467, #478, #479, #484, #488, and #490. **People Interviewed:** 1. Terry Hancock, PhD, BCBA – Chief Psychologist 2. Shawn Cureton, MS – Psychology Manager 3. Kathleen Williamson, MEd – BCBA Behavior Analyst 4. Melissa Waters, MBS – BCBA 5. Kim Littleton – ADOP 6. Vickie Morgan, MD – Lead Psychiatrist 7. Andrea Miller – Director of Program Services 8. Pam Boehnemann – QMRP Coordinator 9. Michael Doebler – Vocational Services 10. Cheryl Powell –Human Rights Committee 9HRC0 Chair 11. Ric Savage –Training Consultant 12. Active Treatment Monitors 13. Direct Care Professionals – Vocational Settings, Programs Services, Bowie, Childress and Driscoll **Meeting Attended/Observations:** 1. Risk Management Meeting – 7/26/2011 and 7/27/2011 2. PSP for Individual #390 – 7/26/2011 3. Restraint Reduction Committee – 7/26/2011 4. Positive Behavior Support Committee – 7/25/2011

	5. Psychology – Psychiatry Workgroup – 7/27/2011 Human Rights Committee – 7/28/2011
	Facility Self-Assessment: BSSLC reported in the Self-Assessment that substantial compliance had been achieved for K2 and K13. The Monitoring Team agreed that K2 was in substantial compliance with the SA. In regard to K13, however, the documentation provided by the Facility did not support the assertion of substantial compliance. The Facility did employ sufficient total psychology staff to meet the required ratio of one professional for every 30 individuals. Provision K13 required, however, that the ratio include only those psychology staff who were demonstrably competent in applied behavior analysis. Given that the Facility employed only four BCBAs, the 1:30 ratio was not met. The Facility also indicated that progress had been achieved in relation to Psychological Assessments, Counseling, Peer Review, and integration between Psychology and Psychiatry. The Monitoring Team agreed that progress had been achieved in these areas, but that noted weaknesses continued to prevent substantial compliance with the SA.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 7/25/2011 through 7/29/2011. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that one Provision, K.2, was in substantial compliance with the SA. Despite the lack of substantial compliance with other Provisions, the review process did reflect that the Facility had achieved considerable progress in many areas. One area in which the Facility achieved progress involved the peer review process. Steps taken by the Facility included enhancing the documentation and review of internal peer review, the addition of the "First Reviewer" process to internal peer review, and the contract with Texas State University to provide external peer review. In addition to peer review improvements, the Facility had ensured that all PBSPs were reviewed by a BCBA on a monthly basis. These efforts greatly improved the potential for more sophisticated and effective behavior interventions. BSSLC also entered into a contractual agreement for the provision of intellectual and adaptive testing. The review indicated that testing was progressing at an adequate pace, and that the testing reports included information that could be beneficial to the development of skill acquisition programs. Despite the progress achieved by the Facility in several areas, substantial limitations were noted during the review. Several of these limitations considerably inhibited the delivery of essential services to people living at the Facility. Perhaps most noteworthy was the failure of the Facility to use available data to revise behavior interventions promptly and effectively. For example, 32% of reviewed PBSP progress notes reflected that undesired behaviors, including self-injury and aggression, were allowed to continue for several months without the PBSP being revised. Similarly, 44% of the reviewed records revealed that individuals had made no progress in developing replacement behaviors. Without adequate monitoring of interventions, individuals living at the Facility were potentially placed at risk from dangerous behavior.

	The Facility also reported that a majority of Behavior Services staff lacked the skills necessary to develop adequate behavior interventions. This was disconcerting, as the Facility had invested considerable resources toward achieving demonstrable competence in applied behavior analysis among the staff in question. When combined with the documented weaknesses in monitoring progress for behavior interventions, the ability of the Facility to ensure adequate intervention was brought into question. The site review revealed that the Psychology and Psychiatry disciplines were working more closely than in the past. This was a positive achievement. There continued to be several limitations, however, in this integration. Record reviews reflected that symptoms of mental illness were seldom incorporated into the behavior assessment process. In addition, discussions between Psychology and Psychiatry staff often lacked an evidence-based approach to assessment and intervention; mental illness diagnosis and psychotropic medication decisions were often based upon subjective opinion rather than objective data. It was evident during the site visit that BSSLC is progressing toward compliance with the SA in several areas. Issues that overlap several provisions of the SA, however, such as staff competence in the development of both PSPs and skill acquisition training programs, treatment monitoring, and evidence-based practices remain to be addressed before substantial compliance can be achieved.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>K1</td><td>Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>During the baseline site visit, BSSLC employed no Behavior Services staff who were certified as a behavior analyst. Two members of the department were in the process of completing the course work and/or supervision required for certification. A third individual had obtained a graduate degree from a behaviorally-oriented program but was not pursuing certification.

At the time of the current site visit, BSSLC had increased the number of BCBAs to four; however, one of the four had not yet begun work at the Facility. Furthermore, seven additional Behavior Services staff were enrolled in BCBA classes or supervision. The increase in the number of BCBAs and staff pursuing board certification reflected substantial progress by the Facility. A total of 15 Behavior Services staff met the qualifications for becoming board certified.

<table><tr><td></td><td>01/2010</td><td>7/2011</td><td>Change</td></tr><tr><td>Total number of BCBAs</td><td>0 (0%)</td><td>4 (27%)</td><td>27%</td></tr><tr><td>Total staff engaged in BCBA classes or supervision</td><td>2 (13%)</td><td>7 (47%)</td><td>34%</td></tr><tr><td>Total staff with BCBA in process or completed</td><td>2 (13%)</td><td>11 (74%)</td><td>61%</td></tr></table>
Despite the noted increase in staff pursuing credentialing as a behavior analyst, the Facility indicated that Behavior Services staff continued to produce behavior assessments and interventions that were inadequate. It was stated during interviews with Behavior Services</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		administrative staff that, despite training, mentoring, and supervision, the majority of non-BCBA staff were not yet consistently able to develop intervention plans that reflected the basic principles of applied behavior analysis. It was therefore determined by the Facility that only BCBAs were to be assigned the task of writing PBSPs. This new process was scheduled to begin in August 2011. By limiting development of PBSPs, to those staff whom the Facility had identified as having adequate skills in applied behavior analysis increased the probability that future PBSPs would reflect the necessary components and produce substantial changes in undesired behavior. The new process introduced, however, additional challenges to the intervention development process, such as the substantially increased responsibilities for a small pool of individuals. Whether the process will satisfy the SA will require review during additional site visit reviews.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	At the time of the 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 had earned board certification as a behavior analyst. Based upon her credentials and demonstrated competence, the employment of Dr. Hancock by BSSLC satisfies this Provision of the Settlement Agreement.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The role of the peer review committee has been briefly defined in the professional literature as follows. *"In cases in which withholding or implementing treatment involves potential risk, Peer Review Committees and Human Rights Committees play distinct roles in protecting client welfare. Peer Review Committees, comprised of experts in behavior analysis, impose professional standards to determine the clinical propriety of treatment programs." (The Right to Effective Behavioral Treatment. Van Houten, R. et.al. 1988. Journal of Applied Behavior Analysis, 21, 381-384.* In order to meet these goals, an organization or Facility must ensure that the necessary resources are available, policies and procedures are implemented, and demonstrably competent staff participate. In addition, steps must be taken to ensure that the implementation of peer review does result in interventions that adhere to acceptable practices. It was noted during the January 2011 site visit that progress had been made regarding peer review, but that substantial limitations continued. Specifically, the Peer Review Committee	Noncompliance

#	Provision	Assessment of Status	Compliance
		often failed to recognize the need for and require the application of a consistent and empirical model for behavior assessment and intervention. 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. Furthermore, the external peer review process was put on hiatus following the departure of Dr. Don Williams in October 2010. Based upon direct observation and a review of records at the time of the current site visit, the following conditions were noted in regard to internal peer review. • The Facility had in place a policy regarding the organization and function of internal peer review. • The Positive Behavior Support Committee (PBSC), which provided internal peer review, was comprised of BCBAs, as well as other disciplines directly associated with behavior assessment and intervention such as a pharmacist, psychiatrist, program compliance auditor, nurse and speech pathologist. All disciplines were routinely represented at PBSC meetings. • In the 27 weeks since the previous site visit, the PBSC had met on 19 occasions; approximately once every 10 days. Although PBSC meetings did not occur on precisely a weekly basis, there were no indications of a failure to review intervention plans in a timely manner. The current procedure for PBSC allowed for the review of each PBSP on a minimum frequency of once per year, and allowed for multiple reviews when warranted by changes in behavior. • Observations conducted during the current site review reflected that all members participated in the review and discussion process. o For Individual #151, nursing staff recommended that a new Risk Assessment be completed based upon the nature of self-injurious behavior and potential medical factors contributing to the behavior. o For Individual #27, the psychiatrist expressed concern that psychotropic medications were tied to behaviors such as aggression rather than symptoms of a mental illness. • The Facility had implemented a new "First Reviewer" procedure for all interventions submitted to the PBSC. This procedure required a review by a BCBA utilizing the Review of Proposed Positive Behavior Support/ABA Plan tool developed by BSSLC. This tool provided a structured rubric that encompassed the essential practices of applied behavior analysis that all PBSPs should include. PBSPs that met all conditions specified in this tool would be likely to meet the requirements of the SA. Copies of the Review of Proposed Positive Behavior Support/ABA Plan completed during the First Reviewer process were provided to PBSC members prior to each meeting. Minutes and observations reflected that these materials were routinely discussed by the committee.	

#	Provision	Assessment of Status	Compliance
		The continued progress by the Behavior Services department at BSSLC addressed several of the weaknesses documented from the previous site visit. Especially noteworthy were the steps taken by the Facility to address weaknesses in internal peer review. Steps taken by the Facility to improve the process included the following. • The implementation of the First Reviewer process. • The expanded monitoring of the application of applied behavior analytic principles using the Review of Proposed Positive Behavior Support/ABA Plan tool. • Enhanced documentation of the peer review meeting and process. Observations and documentation reflected more detailed minutes of the PBSC meeting. Once meeting minutes were typed, all attending committee members are required to review the minutes and indicate by signing that the minutes accurately reflected proceedings of the meeting. • For all presented interventions, the Review of Proposed Positive Behavior Support/ABA Plan tool and reviewer notes were provided to all members of the PBSC committee. • For PBSPs that were approved with revisions, the Facility had established a specific process that required the PBSC Chair and First Reviewer for the PBSP to provide follow-up review of revisions to the PBSP before the intervention was implemented. Observations and document reviews also reflected that the Facility had progressed regarding external peer review. On June 17, 2011, a contract was signed with Texas State University for behavior consultation and external peer review services. At the time of the current site visit, Texas State University had provided only peer review services. Dr. Hancock indicated, however, that preliminary steps had been taken to establish procedures for consultation, as well as for an internship program for Texas State University behavior analysis students. By the time of the current site visit, only a limited number of interventions had been provided external peer review. These reviews had been completed by Russell Lang, PhD, BCBA-D, a professor within the Applied Behavior Analysis program at Texas State University. Two individuals whose PBSPs were provided with external peer review, Individual #181 and Individual #381, were reviewed by the Monitoring Team. The following features were noted in the review. • Peer review had been completed by a BCBA. • The review process included the Review of Proposed Positive Behavior Support/ABA Plan tool. • The reviewer recognized and discussed positive elements of the PBSP. o For Individual #181, the reviewer praised the use of treatment fidelity measures. o For Individual #381, the reviewer commended the inclusion of functional communication training in the intervention.	

#	Provision	Assessment of Status	Compliance
		• Where necessary, the reviewer discussed potential limitations of interventions in detail and provided references to help illustrate the comments offered. The steps taken by BSSLC since the previous site visit to address peer review weaknesses were robust and comprehensive. The primary factor remaining to be addressed involved and adequate outcome measure for the process; the implementation of PBSPs that reflect the principles of applied behavior analysis and are comprised of evidence-based intervention strategies. The Facility reported to the Monitoring Team that the majority of PBSPs written since the previous site visit were inadequate and that corrective measures were to be implemented in August 2011. Determination of substantial compliance will therefore require additional review at future site visits.	
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 both the baseline visit and first compliance visit, it was noted that data collection for PBSPs at BSSLC consisted primarily of narrative reporting and was inadequate to the task of measuring behavior and determining the need for or benefit from interventions. At the time of the second compliance site visit, BSSLC had implemented substantial changes to the data collection and monitoring process. A new data collection form and process had been implemented using partial-interval data collection rather than narrative reporting. While it was noted that the change reflected progress, reliance upon only partial-interval data presented limitations. 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 strategy provided valid measures for all targeted behaviors due to the wide variation in the characteristics of even the most common target behaviors. It was recommended at that time that BSSLC continue to add to the available data collection tools and procedures. However, partial-interval recording remained the usual way of gathering data. During the current site visit, the Facility indicated that Behavior Services staff continued to produce behavior assessments and interventions that were inadequate. As a result, beginning in August 2011, all PBSPs were to be developed by a BCBA. Based upon these circumstances, it was unlikely that current PBSPs and related data collection procedures would readily compare with PBSPs and data collection arising from the new process. In order to assess the monitoring of PBSP progress, the records of 25 individuals with PBSPs developed or revised during the previous six months were selected for review. During the review, the following positive elements were noted. • 25 of 25 records (100%) were reviewed on a monthly basis. • 25 of 25 monthly reviews (100%) were completed by a BCBA.	Noncompliance

#	Provision	Assessment of Status	Compliance
		The review of records during the current site visit also revealed a variety of weaknesses in the PBSP monitoring process. • QMRPs reported that efforts to have DSP staff available at PST meetings were at best inconsistent. No data were available regarding the frequency or duration of attendance by DSPs. • Eight of 25 records (32%) revealed prolonged elevations in target behaviors without changes in treatment having been assessed or attempted. o Individual #60 presented a 2063% increase in the target behavior of "Mouthing" between February and June 2011. Progress notes revealed no consideration of PBSP revision. o Individual #15 presented increases in physical aggression (302%), self-injury (1807%), foraging (460%), and pica (18%) over four months. No revisions in treatment were attempted. • 11 of 25 records (44%) revealed a prolonged lack of replacement behavior development. As the increase of functionally related replacement behaviors is essential to the decrease of undesired behavior, the lack of progress in teaching replacement behavior would inhibit the efficacy of the noted PBSPs. o For Individual #399, zero displays of replacement behavior were recorded from January through June 2011. o For Individual #5, zero displays of replacement behavior were recorded from January through June 2011. • Four of 25 records (16%) included discrepancies between behavior data reported in Psychology progress notes and data on the same targets provided in Psychiatry progress notes. 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 the current site visit, data and progress reports at BSSLC did not focus upon specific behavior or functional classes, 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. Based upon the factors presented above, it was not clear at the time of the current site visit that BSSLC had implemented a comprehensive, evidence-based approach to monitoring and	

#	Provision	Assessment of Status	Compliance
		revising behavior interventions. Although not always the case, several examples were encountered in which individuals were allowed to continue potentially dangerous behaviors for several months. This presented an unwarranted level of risk to the people living at the Facility.	
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.	In July 2010, it was noted that neither adaptive nor intellectual assessments were conducted at the Facility. This was attributed to the fact that BSSLC did not employ a psychometrist or psychologist with the credentials necessary for intellectual or adaptive assessment. In January 2011, BSSLC reported no substantive improvements since the previous site visit in relation to psychological evaluation reports. The Facility did indicate, however, that a contract providing for the services of a Psychologist to conduct intellectual assessments and develop psychological evaluation reports had been submitted for final approval. During the current site visit, BSSLC indicated that a contract with Robert Guercio, MA, a DADS certified Psychologist, had been approved and implemented. Since the implementation of that contract, Mr. Guercio had completed 60 intellectual and adaptive assessment reports. A review of a sample of 12 reports (20%) revealed the following. • 12 of 12 reports (100%) included either a review of an intellectual assessment completed within the past five years or the findings of a newly administered intellectual assessment. • 12 of 12 reports (100%) included the findings of a newly administered adaptive assessment. • 12 of 12 reports (100%) included interpretations of the scores obtained from the intellectual and adaptive test administrations. The efforts by BSSLC to ensure assessment of intellectual and adaptive abilities of individuals living at the Facility reflected substantial progress in this area. During the first two site visits to BSSLC, Behavior Services staff had not routinely employed strategies of assessing behavior that comported with acceptable practices within applied behavior analysis. In January 2011, the Facility demonstrated substantial progress in revisions to the Structural and Functional Assessment format. At the time of the current site visit, BSSLC indicated that further revisions had been made to the process of assessing behavior and mental illness. The changes included the following. • The addition of sections to the SFA for summarizing setting events, precursor behaviors and formal preference assessments. • The addition of categories to the physiological section of the SFA. • The addition of the Psychiatric Treatment Plan as an addendum to the PBSP.	Noncompliance

#	Provision	Assessment of Status	Compliance
		To assess the quality of the updated SFA, the 5 most recently completed SFAs were reviewed. These SFAs involved Individuals #390, #400, #412, #479 and #488. The findings of the review are presented below.	

	1/2010	7/2011	Change
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis.	0 of 15 (0%)	5 of 5 (100%)	100%
The process or tool utilizes both direct and indirect measures.	0 of 15 (0%)	5 of 5 (100%)	100%
Identification of setting events and motivating operations relevant to the undesired behavior.	0 of 15 (0%)	4 of 5 (80%)	80%
Identification of antecedents relevant to the undesired behavior.	0 of 15 (0%)	5 of 5 (100%)	100%
Identification of consequences relevant to the undesired behavior.	0 of 15 (0%)	5 of 5 (100%)	100%
Identification of functions relevant to the undesired behavior.	0 of 15 (0%)	5 of 5 (100%)	100%
Summary statement identifying the variable or variables maintaining the target behavior.	0 of 15 (0%)	5 of 5 (100%)	100%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior.	0 of 15 (0%)	5 of 5 (100%)	100%
Identification of preferences and reinforcers.	0 of 15 (0%)	5 of 5 (100%)	100%

Based upon the record review, BSSLC had achieved progress over performance observed during the previous site visit and over baseline. The five most recent SFAs reflected a more empirical, evidence-based approach to the assessment of environmentally-based behavior than previously noted. In addition, formal preference assessments were integrated into the SFA, and the four-term contingency for undesired behaviors was sufficiently explored.

One area of continued weakness was noted in relation to assessment and the SFA. The review of the five most recent SFAs revealed only minimal attention was directed toward integrating environmentally-based behavior and the symptoms of mental illness into the assessment process. Five of the five individuals targeted by the review were prescribed psychotropic medication and had been diagnosed with at least one mental illness. None of the five SFAs (0%), however, attempted to identify the influence of environmental variables

#	Provision	Assessment of Status	Compliance
		upon mental illness or explore how mental illness might affect learned behavior. As a result, the information provided by the SFAs was of limited benefit as all factors had not been fully explored. Since the January 2010 site visit, BSSLC had implemented a recurring, joint meeting of Behavior Service and Psychiatry staff, known as the Psychology/Psychiatry Workgroup. The purpose of the group was to review and discuss the integration of behavior disorders and mental illness in terms of assessment and intervention. During a meeting of the Psychology Psychiatry Workgroup on July 27, the following examples were observed. • When reviewing Individual #342, much of the discussion emphasized resolving the psychiatric diagnosis of the individual and managing psychotropic medication. Although anecdotal assessment findings were presented suggesting a tangible function for aggression, these findings were not given substantial consideration. Furthermore, when discussing medication management, statements were often based upon subjective information. The plan for challenging one specific psychotropic was developed without discussion of objective outcome measures or treatment expectations. • When reviewing Individual #57, the discussion reflected subjective opinion rather than objective assessment. There was concern voiced regarding which variant of ADHD should be diagnosed, as well as how to address the individual's parent's opinions about assessment and treatment that differed from those of the Facility. It was positive to see that the Facility had taken steps to ensure that Psychiatry and Behavior Services worked more closely. In order to satisfy the SA, however, the Facility will need to provide a more objective and evidence-based foundation for review and discussion. Without reliance upon objective data, the efforts of the Psychology Psychiatry Workgroup may produce different interventions but not necessarily better interventions. Based upon observations and record reviews, it was obvious that BSSLC had achieved substantial progress in most areas relating to the assessment of behavior. Until the Facility can encapsulate information regarding operant behavior and mental illness into a coherent assessment process, however, substantial compliance with the SA cannot be achieved.	
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,	Based upon the information presented in K5, documentation in the record continued to reflect that, despite substantial progress, psychological assessments were not based upon complete clinical and behavioral data.	Noncompliance

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<tr><td></td><td>and complete clinical and behavioral data.</td><td></td><td></td></tr>
<tr><td>K7</td><td>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.</td><td>Since the previous site visit in January 2011, the Behavior Services department had implemented substantial changes in the assessment process for newly admitted individuals. First, as documented in K5, the Facility had entered into a contract with Robert Guercio, MA to complete intellectual and adaptive assessments. Individuals admitted to BSSLC since the implementation of this contract were provided with testing of intellectual and adaptive ability.

In addition, the Behavior Services department initiated a pre-admission behavior assessment process. This process involved a visit to the individual's home by a BCBA; anecdotal and direct observation assessment in that home setting, as well as school or vocational settings if feasible; and a comprehensive review of available records. Behavior Service staff reported that the information obtained by this process proved valuable, not just in developing necessary interventions, but also in establishing beneficial relationships with parents and caregivers.

The changes made by the Facility reflected a diligent effort to improve the assessment process for individuals being admitted to BSSLC. Due to the specific limitations in the assessment process, noted in K5, however, the Facility could not ensure that the assessments reflected complete clinical and behavioral data.</td><td>Noncompliance</td></tr>
<tr><td>K8</td><td>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.</td><td>On April 1 2011, BSSLC entered into a contract with a Licensed Professional Counselor, Hazel Leigh McRae. The contract with Ms. McRae involved the provision of counseling services for individuals living at BSSLC. At the time of the current site visit, BSSLC identified 10 individuals as being involved in counseling: Individuals #9, #11, #12, #20, #399, #400, #417, #467, #479, and #490.

A review was conducted of the Treatment plans for each of the 10 individuals involved in counseling. The results of the review are presented below.

<table><tr><th></th><th>Count</th><th>Percentage</th></tr><tr><td>Needed services (other than PBSPs, e.g. counseling) identified in the psychological assessment are implemented within 6 weeks of the assessment.</td><td>10</td><td>100%</td></tr><tr><td>Service/treatment plan includes initial analysis of problem or intervention target, and a plan of service (e.g., curriculum or approach, frequency or planned number of sessions, statement of skill or intervention target)</td><td>0</td><td>0%</td></tr></table></td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance

Services are goal directed with measurable objectives and treatment expectations.	0	0%
Services reflect evidence-based practices.	0	0%
Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session.	0	0%
Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention.	0	0%
Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate.	0	0%
Service is identified in PSP and, if applicable, PBSP.	10	100%
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	10	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists.	0	0%

Based upon the results of the review of counseling services, it was evident that substantial weaknesses existed in those services.

- The therapist provided a brief summary of the behavioral and emotional status of the individual, including the focus of other behavior interventions at the Facility. Documentation did not reflect, however, that formal assessments were conducted of skills or behaviors to be enhanced during counseling. Without objective assessment upon which interventions and outcome measures can be based, the ability of the therapist to measure treatment efficacy is substantially limited.
- The therapist identified skills and behaviors to be enhanced by the counseling process. These skills and behaviors were not operationally defined, however, allowing for a subjective determination of treatment success.
    - For Individual #20, one goal of counseling was to, "utilize one or more of the anger management tools on the anger management list to control her behaviors when she is angry." The behaviors which the individual was to avoid were defined only as "physical aggression or self-harming behaviors."
    - For Individual #9, one goal of counseling was to, "enhance her self-esteem by journaling and by creating a list of positive qualities." No further definition of positive qualities was provided.

#	Provision	Assessment of Status	Compliance
		• The therapist provided session notes for each counseling session. These notes, however, did not reflect objective and measurable outcomes. o The most recent session note for Individual #12 provided no data. The goal of the session was to "color a heart in a way to represent personal feelings." It was not evident from the narrative of the note if the individual had performed the task. o The most recent session note for Individual #11 provided no data. The individual was described as engaging in the "color the heart" activity, but the narrative of the note did not reflect if the individual completed the task. It was a positive step that BSSLC had made counseling services available to the individuals recommended for counseling. In order for the counseling services to comply with the SA; however, the Facility must make the services reflect the provision evidence-based counseling approaches..	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	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. • 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. At the time of the current site visit, the Facility indicated that substantial limitations existed in the PBSPs; specifically it was reported that PBSPs had not improved since the previous site visit in January 2011. During that previous site visit, the following weaknesses had been identified by the Monitoring Team. • Zero of five PBSPs (0%) included a rationale for selection of the proposed	Noncompliance

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<tr><td></td><td></td><td>intervention. Several of the PBSP 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.
• Zero of five PBSPs (0%) included strategies addressing setting event and motivating operation issues.
• Zero of five PBSPs (0%) included strategies addressing antecedent issues.
• Zero of five PBSPs (0%) included strategies to weaken undesired behavior.
• Zero of five PBSPs (0%) included a specific description of data collection procedures.
• One of five PBSPs (20%) included baseline or comparison data.

Due to the continued weakness in the PBSPs, the Facility indicated that, beginning in August 2011, BCBAs would be solely responsible for developing PBSPs. Because of the Facility's change in process regarding the PBSPs, it will be necessary to delay review of the PBSPs until the next site visit.</td><td></td></tr>
<tr><td>K10</td><td>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.</td><td>All PBSPs at BSSLC included a data collection process to measure treatment efficacy. In the majority of PBSPs the data collection utilized partial-interval procedures. As indicated in Provision K.4, partial-interval data collection is an appropriate methodology for some behaviors, but is not suitable for measuring all types of behavior.

At the time of the current site visit, BSSLC had completed initial inter-observer agreement (IOA) and treatment integrity measures for a sample of the individuals living at the Facility. Individuals were selected for the sample based upon recent increases in undesired behavior or having been identified as being behaviorally at high risk. The Facility planned to begin conducting IOA and treatment integrity measures for all individuals with a PBSP in August of 2011. A system was not yet in place to track the results of the IOA and treatment integrity measures.

BSSLC ensured that data graphs were available for all PBSPs. Except for the presentation of IOA data, the data graphs were of excellent quality. This reflected continued improvement by the Facility. Requirements for graphs and the percentage of graphs in compliance from a sample of 25 individuals are presented below.

<table><tr><td>Graph Element</td><td>1/2010</td><td>7/2011</td><td>Change</td></tr><tr><td>The graph is appropriate to the nature of the data.</td><td>75%</td><td>100%</td><td>25%</td></tr></table></td><td>Noncompliance</td></tr>
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<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>Horizontal axis and label</td><td>75%</td><td>100%</td><td>25%</td></tr>
<tr><td>Vertical axis and label</td><td>75%</td><td>100%</td><td>25%</td></tr>
<tr><td>Condition change lines</td><td>75%</td><td>100%</td><td>25%</td></tr>
<tr><td>Condition labels</td><td>75%</td><td>100%</td><td>25%</td></tr>
<tr><td>Data points and path</td><td>75%</td><td>100%</td><td>25%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>75%</td><td>100%</td><td>25%</td></tr>
</table>

The Behavior Services department at BSSLC displayed a robust ability to graphically present data. The basic structural components of data graphs were incorporated into the reviewed progress notes. In addition, when needed for peer review or enhanced treatment monitoring, BCBAs were able to generate sophisticated graphs of research or publication quality. This ability provided an essential resource for treatment monitoring. The final requirement the Facility must complete to demonstrate substantial compliance was the full implementation of IOA and treatment integrity measures, and the documentation of those measures on the data graphs. As noted previously, however, the graphical presentation of data was not consistently used to ensure that individuals were provided with timely and appropriate behavior interventions.
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<tr><td>K11</td><td>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.</td><td>As described elsewhere in Section K, during the current site visit substantial changes were taking place in regard to PBSP development. These circumstances rendered a review of previous practices unhelpful while preventing an accurate assessment of practices under development. Further review will be conducted at the next scheduled site visit.</td><td>Noncompliance</td></tr>
<tr><td>K12</td><td>Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of</td><td>At the time of the site visit, the Facility had not fully implemented a competency-based approach to staff 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 August 2011. A review of this process will be conducted during the next site visit.</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	those plans.		
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 four staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 79 individuals residing at the Facility and fell 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 23 individuals residing at the facility. BSSLC currently employs 7 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: The following recommendations are offered for consideration by the State and the Facility:

1. It is essential that a process be implemented for effective monitoring of behavior interventions so that ineffective programs can be revised or replaced in a timely manner.
2. The process of integrating behavioral and psychiatric services requires greater adherence to evidence-based practices.
3. In order to provide effective intervention, counseling services should utilize more objective measures and reflect more evidence-based practices.
4. The Facility should act to ensure that all staff are trained regarding behavior interventions for individuals and to ensure that interventions are implemented as written.
5. It is vital that the Facility take steps to ensure that behavior interventions are implemented correctly and that behavior data are valid and reliable. The full implementation of systematic measurement of treatment integrity and data reliability is essential to this process.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI) 7/12/11 2. BSSLC policy Physician Procedures and Best Practice Guidelines, undated 3. BSSLC Administrative Death Review Committee Policy, I.4.b, no date 4. BSSLC Clinical Death Review Committee Policy, I.4 c, no date 5. Client injury report and supporting documents dated July 25, 2011 for Individual #478 6. Community Living Discharge Plan dated July 27, 2011 for Individual #102 7. Annual Personal Support Plan packet, dated July 27, 2011 for Individual #56 8. Integrated Risk Rating Form, dated July 22, 2011 and revised version dated July 27, 2011 for Individual #56 9. Active Clinical Records for Individuals: #102, #478, #56, #557, #84, #291, #381, #83, #129, 334, #325, #24, #48, and #312 10. Hospital records for Individuals: #291, #381, #83, and #129 11. April 11, 2011 through April 13, 2011 Medical Provider Quality Assurance Audits for Individuals: #575, #89, #190, #112, #413, #79, #303, #567, #557, #272, #5, #377, #78, #154, #139, #186, #411, #323, #598, #169, and #39 12. BSSLC Department of Health and Human Services – Center for Medicare and Medicate Services (CMS) Survey Report, CMS-2567, Date: 3/25/2011 13. BSSLC Deaths/Causes/Past Year Report, Date: 6/8/2011 14. BSSLC Administrative Death Review and Clinical Death Review Committee Reports and related clinical records for Individual #85, Individual #358, and Individual #589 15. BSSLC Death Review Tracking Process and Form, Draft, Date: 7/28/2011 **People Interviewed:** 1. Dr. Adolfo Carvajal, MD, Staff Physician 2. Dr. Mary Ann Brett, MD, Staff Physician

	3. Dr. Malcolm Lochiel, MD, Staff Physician 4. (State Office Clinical Coordinator) 5. Mr. Ham, Facility Superintendent 6. Jill Quimby, RN, Quality Assurance Nurse 7. Brandy Todd, LVN, Quality Assurance Nurse **Meeting Attended/Observations:** 1. Observation of Individual #478 at Day Program on July 26, 2011 2. Observation of Individual #56 at Living Area Program on July 26, 2011 3. Observation of Individual #102 at Living Area on July 27, 2011 4. Annual Personal Support Planning Meeting for Individual #56, July 27, 2011
	Facility Self-Assessment: The Facility had experience the resignation of its Medical Director, subsequently, the Facility had not made the progress that it had intended since the last compliance meeting. The Facility reported that they have posted the position for a new Medical Director and updated their policy on "Physician Procedures and Best Practices Guideline". The Facility underwent a comprehensive "Medical Provider Quality Assurance Audit" on April 11, 2011 through April 13, 2011. Following the audits, the Facility conducted quality improvement measures. The Facility also reported that the State Office continues to develop algorithms for clinical care. The Facility reported to have improved on its mortality review process by ensuring that a non-facility physician participate at mortality reviews and had attempted to ensure that autopsies are completed for each death. Following its self-assessment, the Facility had determined that it remained out of compliance with Section L of the Settlement Agreement.
	Summary of Monitor's Assessment: Following review for Provision L.1, of the Settlement Agreement, the Monitoring Team had identified significant improvement in many areas. All diagnostics, including laboratory studies were commented upon. Documentation by the Clinician had significantly improved. Follow-up to acute medical conditions, that were reported to the Clinician, had improved. Documentation of hospital admissions had also improved. The following issues were determined by the Monitoring Team to require continued enhancement: On-going follow-up and documentation of chronic care issues remains an area that requires continue enhancement. System issues, especially the ability to track medical conditions and treatments, and enable effective scheduling of consults, diagnostics and follow-up on medical issues, continue to be major barriers to the provision of medical services at the Facility. The ability of direct care staff to identify signs and symptoms of medical exacerbations and report to nursing staff and nursing staff ability to perform meaningful assessments and appropriately report medical conditions to physicians also remains a barrier to the delivery of health appropriate care by the Clinician. The Monitoring Team has determined that that

	the Facility remains out of compliance with Provision L.1, of the Settlement Agreement, and concurred with the Facilities self assessment. The Monitoring Team compliments the State Office and Facility for developing and implementing a Medical Provider Quality Assurance Audit process. The process enables the State Office and Facility to identify many compliance issues associated with Clinicians at the Facility and will enable quality enhancements system wide. The State Office and Facility continue to develop a mechanism that will enable the assessment of standard of care practices of Clinician Staff by incorporating standard of care benchmarks to the assessment process. Following discussion with leadership at the Facility and the State Office Clinical Coordinator, the Monitoring Team is hopeful that a fully developed quality assessment process will be fully operational within six months. Given its findings, the Monitoring Team had concluded that the Facility remains out of compliance with Provision L.2, of the Settlement Agreement, and concurred with the Facility's self assessment. The Facility had not developed a mechanism to assess medical quality outcome measures at the Facility. Following discussion with the Facility's Clinician Staff, the Facility is cognizant of the issue and remedy. The Monitoring Team is hopeful that significant progress will be achieved during the subsequent six months. At the time of the review, the Monitoring team had determined that the Facility remains out of compliance with Provision L.3, of the Settlement agreement and concurred with the Facility's self assessment. The Facility continues to work with the State Office to develop Standard of Care Algorithms for common and serious medical conditions. These algorithms had yet to be fully implemented and are under current review by the State Office. The Facility had updated their Physician Procedures and Best Practice Guidelines policy, which was reviewed by the Monitoring Team. The Monitoring Team concurs with their new guideline and believes, when incorporated with the pending algorithms and fully implemented, it will support compliance for Provision L.4. At the time of this review, the Monitoring Team determined that the Facility remained out of compliance with Provision L.4, of the Settlement Agreement and concurs with the Facility's self assessment.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The	To determine if standard of care practice was provided to individuals at the Facility, the Monitoring Team assessed the following Individuals: Individual #478 The Monitoring Team observed Individual #478 on July 26, 2011 at the Facility's Day Program. The Individual was noted to have and open and bleeding wound on his right wrist that resembled a bite type lesion. In additional similar, albeit chronic wounds were noted on the same location. Direct care staff who were supervising the individual were not aware of the lesion or active bleeding until the Monitoring Team brought it to their	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	attention. Direct care staff commented that the individual has a history of biting himself. Review of nursing and direct care staff notes indicated that staff were aware of biting behavior; however, behavior tracking sheets indicated that staff are to monitor for rectal digging, and pica but not biting. Review of the active record indicated that the physician had not addressed the behavior. While observing Individual #478, the Monitoring Team also noted an abrasion to the individual's chin and right cheek. A client injury report was completed on July 25, 2011 that documented an injury to the chin, knees, right cheek, left middle finger and right shoulder, following a fall, while attempting to get into a vehicle. A nursing assessment documented that a "visual assessment" was completed; however, a focal, physical assessment, was not completed by the nurse, nor was a physician notified of the incident. Following its observation of Individual #478, review of the client injury report dated July 25, 2011, discussion with direct care staff, and review of the active clinical records, the Monitoring Team had concerns over the Facility's ability to assess and appropriately triage injuries. The Monitoring Team also had concerns of the Facility's ability to recognize, report, assess, treat and monitor behavior issues. Individual #56 Following review of the active clinical record, personal support plan dated July 13, 2011 and July 30, 2010, and the Integrated Risk Rating Form dated July 22, 2011, the Monitoring Team attended the Personal Support Meeting (PSP) for Individual #56 on July 27, 2011. The Monitoring Team was present throughout the meeting. Following the meeting, the Monitoring Team had concerns over the lack of understanding and integration of medical and dental issues by the team. Important health care issues, such as the diagnosis of cerebral palsy, management of spastic quadriplegia, scoliosis, tibia torsion and incontinence were not overtly addressed in the clinical record, nor known by the PST. At the time of the PSP meeting the fracture history, and significant oral hygiene, dental and periodontal issues, were also not known by the PST Subsequently it was apparent to the Monitoring Team that important medical and dental issues were not actively addressed by health care providers at the prior quarterly review meetings and were not considered in preparation for the annual PSP meeting. Importantly, the Integrated Risk Rating Form did not reflect specific risks of the person served, until the Monitoring Team prompted discussion. For example, aspiration risk was determined to be low, despite a known diagnosis of oral dysphagia; and fracture risk was rated as low despite a significant gate abnormality, known history of cerebral palsy with quadriplegia, administration of medications that predispose to falls and known history of falls and fractures in the past. Most important, was the fact that significant risk factors and potential complications were not presented to the Legally Authorized Representative (LAR) for the individual during the PSP meeting.	

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		All clinicians must ensure that an accurate reflection of the individual's clinical conditions and needs be overtly known to the team, family/LAR, and, in the event of possible community placement, to the accepting agency. Failure to provide complete and accurate information may result in serious and potentially life threatening consequences. Individual #102 The Monitoring Team conducted a review of the active clinical record and the most recent community living discharge plan as of July 27, 2011 for Individual #102. Following its review, the Monitoring Team noted that the past two annual physical assessments were not complete and appeared identical, despite being completed by two different physicians. Given that a complete physical examination was not documented two years in a row, the Monitoring Team had concerns that underlying medical conditions were not accurately reflected in the record, nor known to the PST as it considered community transition. By review of the active clinical record, and by direct observation of the individual by the Monitoring Team, the Monitoring Team determined that the individual was known to have an abnormal gait, which was broad based and spastic and that exacerbated when the individual increased the rate of his gait. This issue was not accurately reflected in clinical record, annual physical assessment or nursing assessments, nor was the issue accurately reflected in the community living discharge plan. The MOSES dated March 11, 2011, was not completed by the prescriber. The individual was observed to have sialorrhea, which was documented and for which he was treated with medication. The extent of his sialorrhea places the individual at risk for aspiration; however, this issue was not addressed in the clinical record, nor was it addressed within the community living discharge plan or risk assessment. The risk assessment commented on a high risk for falls but a low risk for fracture. Given the individual's high risk for fall injuries and prolonged use of antiepileptic medications, the individual is at risk for potential fractures. The individual experienced seizure activity as a child during a febrile event. The Facility commented that the individual has not had a seizure for over five years. The clinical record did not explain rationale for not considering a medication taper except by indicating that he is "at high risk of having seizures. " Following its review and observation of Individual #102, the Monitoring Team had concern that the individual's health care issues and support needs were not accurately reported in the clinical record, known to the team and not accurately reflected in the	

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		Community Living Discharge Plan. For successful community transition, the receiving agency must be acutely aware of all clinical issues and support needs. Lack of a meaningful Community Living Discharge Plan places the individual at serious risk of injury, adverse consequences and possibly death. Individual #160 The Monitoring Team reviewed the active clinical record of Individual #160. Despite a diagnosis of diabetes mellitus, which was determined on March 4, 2011 the current health risk assessment as of October 28, 2010 was not updated to include diabetes as a high risk. Aspiration and choking were also determined to be at low risk; however, the individual had a known diagnosis of oropharyngeal dysphagia, which would place the individual at moderate or possibly severe risk for aspiration and choking. The individual had an active diagnosis of constipation; however, the risk assessment indicated that the individual was at low risk for constipation. Importantly, the individual had a barium swallow test on October 12, 2010, which identified GERD and the potential for silent aspiration. This issue was not addressed in the PST or PSP, nor was the etiology of the GERD assessed clinically. CT scan completed on November 22, 2005 and a chest x-ray completed on June 23, 2011 both identified scoliosis and "other osseous changes." These conditions were not identified on the problem list, nor were they followed up upon. The current problem list documented that the individual had a congenital anomaly of the left foot and the diagnosis of spastic quadriplegia, however, there was no evidence to indicate that these conditions were regularly monitored for progression, nor was the need for further evaluation entertained. The individual was noted to have a rash of unknown etiology. Importantly, Lamotrigine, a medication that can manifest serious and potentially life threatening rash and system illness, was not considered as part of a differential diagnosis. All individuals who are administered Lamotrigine and who develop a skin rash must be assessed for this drug allergy. Initial assessment and treatment of diabetes mellitus was considered by the Monitoring Team to be excellent. Documentation and follow-up of other acute medical issues were noted to be of professional standard of care. It was apparent to the Monitoring Team that documentation and follow-up care for chronic conditions was less then optimal. The Monitoring Team considers system issues, specific to scheduling of follow-up care, as being a primary contributing factor to this issue.	

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		Individual #557 The Monitoring Team observed Individual #557 at the living area sitting in her wheel and hitting the right side of her face with her left wrist. The Monitoring Team notified staff of this behavior and the need to better support the individual. Direct Care staff informed the Monitoring Team that this individual periodically hits herself for no reason. Observation of the individual's face demonstrated ecchymosis and the left wrist was not to have a large callus, indicating chronic irritation. Despite observing this behavior and staff's understanding of the behavior, review of the behavior-tracking sheet did not list hitting as a behavior that required tracking and analysis. Review of the Active Record did include evidence to support that this behavior was assessed for a possible underlying medical conditions, such as pain from sinus, dental or other condition. Individual #332 The Single Patient Intervention Report provided to the physician by the Pharmacist for this individual indicated that the individual had a blood pressure of 160 to 170 systolic over 110 diastolic and the physician ordered Clonidine to help lower the blood pressure. The pharmacist alerted the physician that there is a reported risk of severe hypertension if Clonidine is abruptly discontinued while on Atenolol (Individual #332 was on Atenolol 50mg bid) and that if Clonidine was administered that close monitoring of blood pressure was needed, especially if Clonidine was to be discontinued in the future. The Pharmacist also recommended rescheduling Atenolol from 50mg bid to 100mg daily in the AM. The Pharmacist documented that the Physician continued Clonidine because "the benefit outweighed the risk" and that close monitoring of the blood pressure and rescheduling of Atenolol to 100 mg per morning would be accomplished. Review of the physician orders for this issue indicated that the Clonidine was prescribed as a STAT medication for severe hypertension. In fact, the physician order stated "Emergency", at 11:25 a.m. At 2:25, pm, after the Pharmacist issued her recommendations, the Physician wrote orders to: 1. Discontinue Atenolol 50 mg BID 2. Start Atenolol 100 mg PO Am, beginning 7/15/11 3. Check BP every morning for one week and report findings to the physician The issue of concern was that the individual had experienced a medical emergency, with a blood pressure of 170/110. Blood pressure values of this level could result in significant and potentially life threatening consequences if not appropriately managed. A comprehensive exam, including kidney function, fundoscopic examination and possibly an EKG should be obtained. Exceptionally close monitoring of blood pressure is required and at a minimum, should have been obtained every hour for the first few hours following the hypertensive event and then three times per day to confirm stability. Many	

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		individuals with intellectual disabilities cannot report signs and symptoms, such as headache, dizziness, palpitations and chest pain. On occasion, medication doses are known to be missed, and individuals cannot report missing their medications. Also, individuals may, at times, not actually ingest their medication. For these reasons, such medications and medication combinations should require daily blood pressure evaluation. Individual #84 Individual #84 was observed upon entering her living area to be sitting in a wheel chair, in her room and unassisted. The individual was in a position that was not supported by her Personal Support Plan (PSP). In this situation, the individual's arm was not maintained in position by the necessary adapted device and she was hunched forward, making very difficult to adequately respire. The Monitoring Team notified living area staff, which then assisted the individual. Review of the individual's active Clinical Record, indicated that the individual's significant musculoskeletal conditions were not actively monitored, or assessed for the need of additional diagnostics or possible treatment. It was evident that the PST and PSP process did not assertively address her musculoskeletal conditions. The Monitoring Team did note that physical therapy did provide adequate and specific instructions, which included photographs, for proper positioning. The Monitoring Team requested a list of all individuals at the Facility who had a diagnosis of spasticity. A list of 42 individuals was provided. The Monitoring Team observed the following individuals to have spasticity; however, they were not on the list: Individuals #56, #557 and #160. Based on anecdotal observation and understanding of the significant number of individuals with neuromuscular and musculoskeletal conditions at the Facility's, the Monitoring team raised concerns of under diagnosis and treatment of such conditions at the Facility. All diagnostics, including laboratory studies were commented upon. Documentation by the Clinician had significantly improved. Follow-up to acute medical conditions that were reported to the Clinician had improved. The following issues were determined by the Monitoring Team to require continued enhancement: On-going follow-up and documentation of chronic care issues remains an area that requires continue enhancement. For example, all chronic conditions require regular follow-up. Follow-up for chronic conditions should follow standard of care practice. Individuals with spasticity, contractures and other progressive neuromuscular and musculoskeletal conditions should be seen periodically by the Clinician to ensure appropriate management of such conditions. When documenting a progress note, an assessment should include a diagnosis or differential diagnosis and there should be a corresponding plan for these diagnoses. Acute issues must be followed-up until full resolution. When	

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		possible, the underlying etiology of a condition should be determined. This is especially important for conditions such as recurrent pneumonia, choking and aspiration, functional decline, progress gait abnormalities, recurrent emesis, constipation and obstruction, and dysphagia. The Facility clinicians need to look more thoroughly for etiologies and root causes of conditions in order to ensure appropriate treatment is provided. To assess medical follow-up for hospitalizations, the Monitoring Team reviewed the clinical records, integrated progress notes and hospitalization records of Individuals #291, #381, #83 and #129. The Monitoring Team also requested trend analysis for all hospitalized individuals for the period April 1, 2011 through July 28, 2011; however, the Monitoring Team was informed that the Facility does not track hospitalizations for trend analysis. The Monitoring Team determined that Clinician follow-up of post hospitalizations was well within standard of care practice. Clinicians assessed individuals upon return from the hospital and, when appropriate, communicated with hospital staff physicians. An example of exemplary follow-up was that of Individual #83. In this case nursing staff carefully monitored the individual and reported concerns to the physician. The Physician assessed and triaged the individual promptly. The physicians performed a comprehensive clinical assessment and appropriately documented his assessment and plan by dictating notes. To assess the integration of medical and dental services into the team process, the Monitoring Team reviewed the active clinical record of the following Individuals: #102, #478, #56, #557, #84, #291, #381, #83, #129, 334, #325, #24, #48, and #312. The Monitoring Team observed the PSP meeting for Individual #56 and reviewed the Discharge Planning packet for Individual #102. For all cases reviewed, the Monitoring Team determined that there is a pervasive lack of meaningful integration of medical and dental issues into the PST process. Clinical issues, including all known diagnoses, recent illnesses and injuries were not appropriately identified and communicated to the Team, and specific supports and services were not identified and communicated to the Team. The PSP process did not assertively address clinical issues. To assess preventative health care, the Monitoring Team requested a copy of the Facility's policy and procedure for preventive health care. The Monitoring Team was provided an undated copy of the Physician Procedures and Best Practice Guidelines, which contained a section on preventative health. This procedure stated that the Facility shall adhere to all U.S Preventive Services Task Force Guidelines screening examinations and diagnostic testing and the American College of Obstetricians and Gynecologists guidelines for cervical cancer screening, and the American Cancer Society guideline for	

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		breast cancer screening. Adherence to the recommendations by these organizations would ensure standard of care practice in the area of preventive health. During discussion with the Departments Clinical Coordinator, the Monitoring Team was informed that systems were being developed statewide to ensure that such practices will be in place.	
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.	Medical Provider Quality Assurance Audits for Individuals #575, #89, #190, #112, #413, #79, #303, #567, #557, #272, #5, #377, #78, #154, #139, #186, #411, #323, #598, #169, and #39 were reviewed for the audit period April 11, 2011 through April 13, 2011. The Monitoring Team compliments the State Office for initiating a system wide, standardized approach to review standard care of practice of clinicians. The audit form identifies many important physician functions. The audit process does not enable the assessment of the clinicians ability to provide standard of care practice – assessing performance against currently accepted benchmarks for specific conditions, are required when assessing the clinicians' ability to practice at the level of professional standards. Of the 21 completed audit forms reviewed, five (Individuals #112, #413, #190, #89 and #575) appeared to be less complete, when compared to the other completed forms. Audit forms for Individuals #39, #598, #323, #186, #557, #79, and # 575 were not dated. Importantly, the Facility did not conduct a trend analysis of the audit findings. The Monitoring Team was informed that trend analysis was to be completed by the State Office and that a report was not yet available. Without collecting and analyzing data from the audits, the Facility and leadership will not be able to identify positive and adverse system issues that require attention. The Monitoring Team appreciated the Facility's incorporation of a staff debriefing following the audit process. The debriefing included general areas of compliance and areas of concern, along with an action plan. Although action items were identified, the Medical Provider Quality Assurance audit documentation did not verify that all action items were attended to and completed by the appropriate Clinician. Any review system needs to include a process to close the loop by ensuring the required actions are taken and are effective.	Noncompliance
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends;	The Facility reported that they have not developed a mechanism to maintain a medical quality improvement process. The Facility did not have supporting documentation to demonstrate compliance with Provision L3. During the Monitoring Team's meeting with physicians, it was discussed how the Facility should begin developing a meaningful quality assurance process that includes identifying standardized benchmarks for common medical conditions and conditions that are known to occur commonly in people with developmental disabilities (osteoporotic fractures, pneumonia, dysphagia, and constipation/obstruction, urinary tract infections, dehydration and sepsis). Other	Noncompliance

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	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	important benchmarks that should be included in a quality assurance process include trend analysis for mortality reviews, hospitalizations, adverse drug reactions, and medication variances. <u>Mortality Reviews</u> An important part of a medical quality improvement process is the completion of thorough mortality reviews, as well as follow-up with regard to the resulting recommendations. The purpose of a mortality review process is to ensure that individual and system issues are identified and promptly addressed, and that lasting remedies are implemented. The Monitoring Team spent considerable time reviewing the Facility's approach to reviews of death at the Facility by reviewing policies, interviewing personnel, assessing forms, and conducting reviews of clinical records of individuals who recently died. Following the review, the Monitoring Team concluded that the Facility did not follow its own policies and procedures in conducting mortality reviews by not consistently completing the Clinical Death Reviews in a timely manner. There was general improvement in the quality of the Clinical Death Review Reports. There was no formalized process in place to track recommendations from the Clinical or Administrative Death Review Committees or to provide on-going follow-up to ensure that when system enhancements are developed and implemented, that they are sustainable and efficacious. The failure of the Facility to comply with its policies and procedures was further validated by the review of CMS-2567 Report, dated 3/25/2011. 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 and Administrative Death Reviews and related clinical records of individuals who recently died at the Facility. In the past 12 months, from 7/2010 through 5/2011, seven deaths occurred at the Facility. The average age of the seven individuals who expired was 47 years; this falls significantly below the average age expectancy of the general population and below the average age of death for individuals with intellectual disabilities (55 years for people with profound disabilities and 75 years for individuals with mild to moderate disabilities). There were three deaths at the Facility from 1/2011 through 5/2011. There were no autopsies performed on the four deaths occurring from 7/2010 through 11/2010. An autopsy was performed on one of the deaths occurring from 1/2011 through 5/2011. Although clinical information might indicate certainty as to the cause of death, autopsies should be encouraged as a clinical tool to provide evidence of the many pathophysiological conditions and their effect at the time of death, as a method to verify the cause of death, and to ensure quality healthcare was provided. Of the deaths	

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		occurring over the past 12 months, the primary cause of death reported for three deaths was aspiration pneumonia; two deaths were due to other pneumonia/respiratory conditions; one death was due to cachexia; and one death due to acute peritonitis. The continued high rate of pneumonia related deaths and the death associated with cachexia was alarming to the Monitoring Team. The Monitoring Team reviewed the three deaths occurring during the past six months 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 days 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 the 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	

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		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. The Clinical Death Reviews and Administrative Death Reviews for the three deaths that occurred from 1/2011 through 5/20/2011 were made available for review during the onsite visit: <u>Clinical Death Review Committee Reviews</u> • There was one autopsy performed on the three deaths occurring from 1/2011 through 5/2011. • Three of three (100%) of the Clinical Death Review Committees had the required membership present; including an external physician, except State Office Medical Coordinator or designee whom the QA Nurse reported was usually present via teleconference. There was no documented evidence on the participation sign-in sheet that the State Office Medical Coordinator was present via teleconference. • Two of three (66%) of the Physician Death Discharge Summaries were not completed within the required five working days. • Two of three (66%) of the Clinical Death Review Committees were not convened within the required 14 working days. • Three of three (100%) of the Clinical Review Committees' reports were 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> • Three of three (100%) of the Administrative Death Review Committees were 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 three deaths, occurring from 1/2011 through 5/2011,to DADS Medical Coordinator. There was documentation that the QA Nurses had sent the Nurse's Death Investigation Reports for the three deaths to the State Office Nursing Coordinator.	

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		The Monitoring Team's review of the three deaths identified the failure of the Facility to consistently comply with Clinical Death Review Committee Policy regarding completing specified timelines for Clinical Death Review Reports and convening Committee meetings. The quality of the Clinical Death Review Reports some showed improvement from the last monitoring review. It was positive to find that an autopsy had been completed on one death that was unexpected. The QA Nurse completed the Nurse Death Investigation Summaries consistently, in less than five days, and made appropriate recommendations to the Clinical Death Review Committee. The recommendations derived from Clinical and Administrative Death Reviews for the three deaths occurring from 1/2011 through 5/2011 appeared appropriate and practical. There was no formalized process in place to track recommendations through to resolution. However, there was validation that all recommendations were completed except for one where the Facility was seeking a formal contract with an external physician to serve permanently on the Clinical Death Review Committee. Nevertheless, there was documentation that an external physician attended the three Clinical Death Review Committee Meetings. The Monitoring Team interviewed the Quality Assurance Nurse who explained the procedure for follow-up to Nurse Death Review Summary findings and recommendations, as well as recommendations from the Clinical and Administrative Death Review Committees. During and/or upon completion of the Nurse Death Review Summaries, 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 QA Nurse also sends the recommendations from the Clinical and Administrative Death Review Committees to the Nursing Department who establishes plans of correction when indicated. The Quality Assurance Nurse follows-up to see that any corrective action plans resulting from the death reviews, if any, were satisfactorily implemented and carried out. If not, the Quality Assurance Nurse makes suggestions and/or requests for improvement. Although there was an informal process in place, the Monitoring Team discussed the need for a formalized process for tracking recommendations through to resolution. Before the end of the monitoring review the QA Nurse developed a comprehensive process and tracking tool to track all timelines required by policy, as well as recommendations through to resolution. This process should assist the Facility with compliance with the death review policies and procedures.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18	The Monitoring Team met with physicians at the Facility and the Departments Clinical Coordinator to discuss progress in achieving compliance with Provision L.4. It was reported to the Monitoring Team that the State Office continues to develop standard of	Noncompliance

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	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.	care practice guidelines; however, they are not ready for distribution to the Facilities. Given the recent changes of clinical leadership at the State Office and Facility, little progress had been made since the last compliance visit. The Facility had updated its policy on "Physician Procedures and Best Practice Guidelines," which was undated. The Monitoring Team reviewed this policy and concurs with its practice recommendations. The Facility had yet to fully implement the policy. No other information was presented for review to determine compliance with Provision L.4. Given its findings, the Monitoring Team determined that the Facility was not in compliance with Provision L.4, of the Settlement Agreement.	

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

1. Nursing staff must perform a "focused physical nursing assessment" of all traumatic injuries, and notify the physician when signs and symptoms warrant additional evaluation.

2. Ensure that all behavior exacerbations have been assessed by physicians to exclude an underlying medical condition. Primary physician staff should actively address behavior issues during Personal Support Team Meetings.

3. It is essential that the Facility ensure that each individual is appropriately assessed for medical and dental issues and that these issues are well documented in the clinical record, including in the problem list and physical assessments. Specifically, but not exclusively, the facility must better address neuromuscular and musculoskeletal conditions, such as scoliosis, cerebral palsy, spasticity, contractures, arthritis and other congenital and acquired anomalies.

4. Clinicians must be better engaged in the team process. It is critical that the team understands all of the known clinical issues of an individual and how such conditions impact his/her life and to ensure that all necessary supports and services have been identified and incorporated into the PST and PSP.

5. All Direct Care Staff and non-physician clinical staff, including nurses, therapists and psychologist must collaborate with physicians and ensure that all relevant information is appropriately communicated to the physician in a timely, efficient and professional manner. Direct care staff requires significant training, assessment and continued monitoring to better enable them to identify signs and symptoms of medical and behavioral exacerbations.

6. The Facility should develop and formalize written procedures and expectations that ensure clinical staff follow up on acute conditions until full resolution, and for the on-going management of chronic care issues.

7. Clinicians must document assessment all diagnoses to determine the underlying etiology of such condition. Understanding the etiology of a condition is essential in providing the best possible care and treatment for any given condition.

8. The Monitoring Team strongly recommends that routine training be provided to staff, including clinicians, specific to common and serious drug

allergies and side effects of commonly administered drugs. This is especially important for medications with a narrow window for toxicity and for medications with the potential for serious and potentially life threatening side effects.

9. Physicians must identify and report all clinical issues and the necessary supports and services needed for each clinical issues to the PST, including risks associated with all clinical conditions must be identified and reported to the team.

10. Develop and incorporate clinical benchmarks into the Medical Provider Quality Assurance Audits.

11. Develop a mechanism to archive and perform trend analysis on data from Medical Provider Quality Assurance Audits.

12. Deficiencies identified by Medical Provider Quality Assurance Audits must be corrected timely and when necessary, remediation action provided to the Clinician.

13. The Medical Quality Assurance review process should lead to system changes as well as corrective actions for specific cases and physicians. Relevant findings must be acted upon through system improvements, such as policy change, staff training, and continued monitoring for expected improvements.

14. Nursing staff must perform focused nursing assessment, that includes a nursing physical assessment, for all acute conditions, and medical and behavior exacerbations. The nurse must also effectively communicate relevant medical information to the Clinician.

15. The Facility must develop a process to collect, track and analyze mortality review issues, such as cause of death, age, race, sex, type of disability, level of disability, treating physician, living area, hospitalizations, admission date to the Facility, underlying medical and psychiatric conditions, and contributing factors. Mortality rates should be determined and tracked longitudinally

16. Given recent change in medical leadership at the Facility, the Facility should consider assistance from Central Office to re-review the past six months deaths and ensure that appropriate standard of care practices are in place, especially in the area of aspiration, aspiration pneumonia and pneumonia in general.

The following are offered as additional suggestions to the Facility:

1. Physicians should dictate their notes. Dictation enables template to be developed that will help to ensure appropriate documentation and improves on communication of important clinical issues.

2. Hospitalization data should be collected on all hospitalized individuals. Admitting and discharge diagnosis, dates of admission and discharge, hospital physician, Facility Physician and home are important data points to collect and analyze over time. This would enable the Facility a better understanding of hospitalization patterns. The Facility could identify recurrent clinical issues more readily and establish possible trends that could be addressed to help mitigate hospitalizations and recidivism to the hospital.

3. Because of the high frequency of neuromuscular and musculoskeletal conditions, constipation with obstruction, metabolic syndrome, and aspiration pneumonia, the Facility may consider incorporating routine screening for these conditions, as part of their preventive health screening process.

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. BSSLC Plan of Improvement (POI) 7/12/2011 2. BSSLC Section M Presentation Book 3. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: At Risk Individuals, Policy Number: 006.1, Date Approved: 12/29/2010, Implementation: 1/1/2011, 4. BSSLC All State Nursing Policies, Procedures, and Process 5. BSSLC Nursing Guidelines, Revised: 5/6/2011 1. Assessment of Individuals 2. Charting Guidelines 3. Bowel Management 4. Do Not Resuscitate (DNR) Status 5. Emergency Equipment 6. Staff Present During Exams 7. Staffing 8. Flow Sheets 1. Needle Sticks 2. Abuse and Neglect 3. Sexual Incidents 4. PICA 5. Bites 6. Choking Incidents Flow Chart 9. Program Services Guidelines 10. Oxygen Tank Guidelines 11. Medication Error Guidelines 6. Texas Department of Aging and Disability Services, State Supported Living Centers (SSLC) Nursing Protocol: Pre-treatment and Post-Sedation Monitoring, Date: 2/2011 7. Texas Department of Aging and Disability Services, SSLC Nursing Protocol: Seizure Management Guidelines, Date: 2/2011 8. Texas Department of Aging and Disability Services, SSLC Nursing Protocol: Vagal Nerve Stimulator, Date: 2/2011 9. Texas Department of Aging and Disability Services, SSLC Nursing Procedure: Management of Acute Illness and Injury, 2/2011 10. BSSLC Policy: At Risk Individuals, no date 11. BSSLC Infection Control Reference Manual, First Edition, 2011 12. Human Resource Development, Texas Department of Mental Health and Mental Retardation, Infection Control Training Manual, Revised 2003 13. BSSLC Addendum to Infection Control Class Presentation, Dated: 3/15/2011 14. BSSLC Employee Control Program Policy, no date

	15. BSSLC Infection Control Requirements, Revised: 7/2011 16. BSSLC Medical Services/Infection Control: Employee Infection Control Policy, no date 17. BSSLC Competency Training and Development, Infection Control Due/Delinquent Report, Printed: 7/26/11 18. BSSLC Tuberculosis Past Positive and New Converters List, 5/31/2006 through 6/2011 19. BSSLC Infection Control Spreadsheet for Contagious Diseases, 20. BSSLC Infection Control - Handwashing/ Hand Sanitizer/Glove Use Observation Guidelines, Effective Date: 6/1/2011 21. BSSLC Infection Control – Handwashing Guidelines - Update, 5/27/2011 22. BSSLC Medication/Enteral Medication Administration Observation Guidelines, Revised: 4/7/2011 23. BSSLC Quality Assurance (QA) Medication Room Checklist: Corrective Action Plan Guidelines, Revised: 4/20/2011 24. BSSLC Injury Report Follow-up Audit: Corrective Action Plan Guidelines, Revised: 4/20/2011 25. BSSLC QA Enteral Medication Observation Guidelines: Corrective Action Plan Guidelines, Revised: 4/20/2011 26. BSSLC Medication Administration Record (MAR) Audit: Corrective Action Plan Guidelines, Revised: 4/20/2011 27. BSSLC Post Sedation Chart Review: Corrective Action Plan Guidelines, Revised: 4/20/2011 28. BSSLC Medical Services/Nursing Policy: Hydration, Revised: 3/16/2010, Next Review Date: 3/2011 29. Texas Department of Aging and Disability, State Supported Living Centers Policy: 044 Medical Emergency Response, Date: 7/21/2011 30. BSSLC Cardiopulmonary Resuscitation (CPR) Committee Guidelines, Draft, no date 31. BSSLC CPR and Automated External Defibrillator (AED) Training Curriculum, Revised: 5/19/2010 32. BSSLC Competency Training and Development (CTD) Due/Delinquent List for Basic CPR Training and Healthcare Provider's CPR Training, Printed 7/25/2011 33. BSSLC Mock Medical Emergency Drill Schedule and Completed Mock Medical Emergency Drill Sheets, 1/2011 through 6/2011 34. BSSLC Monthly Emergency Equipment Checklists for Residential Units and Health Services Center, 1/2011 through 6/2011 35. BSSLC Emergency Equipment Checklists Re-training Material and Signed Training Rosters, 1/2011 through 6/2011 36. BSSLC Emergency Competency Checklist and Training Curriculum 37. BSSLC CPR Committee Minutes, 2/2011, 4/19/2011, and 7/11/2011 38. BSSLC CPR "Special Meeting" Committee Minutes, 6/3/2011 39. BSSLC Standardized Abbreviation List 40. BSSLC Nursing Organizational Chart, Revised: 6/1/2011 41. BSSLC Nursing New Orientation Training, List or Topics Presented 42. BSSLC Nursing Competency-based Testing for New Nursing Policies and Required Training Reports for the last six months 43. BSSLC Nursing Training Tracking Log 1. Job Specific Training for Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) 2. Job Specific Training for LVNs

	3. Job Specific Training Testing for RNs and LVNs 44. BSSLC Agency Nurse Packet/Orientation Training 45. BSSLC Nursing Staffing Policy and Procedures, no date 46. BSSLC Nursing Staffing List for RNs and LVNs 47. BSSLC Nursing Ratios – Direct Care Nurses for each Shift, 5/2011 48. BSSLC Nursing Ratios – Case Managers, 5/2011 49. BSSLC Nursing - Diabetic Individuals Attending Brenham Program Services Report, 7/2011 50. BSSLC Shift Managers' Staffing Report, 1/2011 through 5/2011 51. BSSLC Nursing Monitoring Tools (blank copies) and Guidelines 52. BSSLC QA Data Reports for Nursing Monitoring Tools, 1/2011 through 6/2011 53. BSSLC Other Nursing Monitoring Tools Completed by the QA Nurses, 1/2010 through 6/2011, Included: 1. Nursing Care Plan Monitoring 2. Medical Chart Audit – Weight Management 3. Post Sedation Chart Review 4. Medication Administration 5. Enteral Feeding/Enteral Medication Observation 6. Medication Administration Observation 7. Medication Room Checklist 54. BSSLC Infection Control Committee Minutes, 12/29/2010 and 3/29/2011 55. BSSLC Decubitus Ulcer Reports, 9/2010 through 5/2011 56. BSSLC Infections by Type Reports, 9/2010 through 6/2011 57. BSSLC Trend of Employee Infections, 2/2011 58. BSSLC Environmental/Safety Committee Meeting Minutes for the past six months 59. BSSLC Nursing Meeting Minutes (all levels) 1/2011 through 5/2011 60. BSSLC Personal Support Plan Schedule 61. BSSLC Pharmacy and Therapeutic Committee Minutes, 1/13/2011, 4/28/2011 62. BSSLC Summary of Medication Error Report, 1/2011 63. BSSLC Medication Error Committee Minutes, 3/30/2011, 4/28/2011, 5/31/2011 64. BSSLC Emergency Room and Hospitalization Visit List 65. BSSLC Medication Administration Observation Tool, Revised: 6/1/2011 66. BSSLC Enteral Medication Administration Observation Tool, no date 67. BSSLC Medication Room Checklist Tool, no date 68. BSSLC Injury Report Follow-up Audit, Revised: 4/21/1011 69. BSSLC Medication Administration3149 Record Audit Tool 70. BSSLC Medication Administration Record Tracking Tool 71. BSSLC Nursing Care Plan Monitoring Tool: Corrective Action Plan Guidelines, revised: 4/20/2011 72. BSSLC Nursing Care Plan Monitoring Tool, Reviewed: 5/17/2011 73. BSSLC Post Sedation Chart Review Tool, no date 74. BSSLC Nursing Monitoring Tool Schedule 75. BSSLC Quarterly Medication Administration Observation Schedule for all Units 76. BSSLC Nursing Medication Administration Monitoring Reports, for the past six months

	77. MAR, Medication Room Checklist and Medication, Quarter Report: April, May, and June 78. BSSLC Records Reviewed for At Risk Individuals: #26, #181, #86, #52, #42, #303, #545, and #470 79. BSSLC Community Discharge Plan for Individual #102 80. BSSLC Clinical Records Reviewed for Nursing Practices and Integrated Services for Individuals: #59. #191, #38, #96, #422, #554, #557, #83, #291, #412, #39, #24, #163, #270, #576, #69, #66, #305, #165 81. BSSLC Clinical Records Reviewed recently admitted Individuals: #381, #479, #511, and 590 82. BSSLC Annual and Quarterly Comprehensive Nursing Assessment for Individuals #411, #361, #408, #81, and #149, completed by RNs who recently completed the mandated Physical Assessment Class 83. BSSLC Clinical Record and Community Living Discharge Plan (draft) for Individual #102 **People Interviewed:** 1. Valarie Kipfer, RN, State Office Nursing Coordinator 2. Debra Williams, RN, Chief Nurse Executive (CNE) 3. Sara Colvin, RN, Nursing Operations Officer (NOO) 4. Jill Quimby, RN, Quality Assurance (QA) Nurse 5. Brandy Todd, LVN III, QA Nurse 6. Joanne Guard, RN, Infection Control Nurse 7. Nikki Gertman, RN, Nurse Recruiter/Infection Control Nurse 8. Wendy Jackson, RN, Hospital Liaison Nurse 9. Leona Sian, RN, Shift Manager/Durable Medical Equipment Nurse 10. Tina Guilotte, LVN, Staffing Coordinator/Program Services Nurse 11. Johanna Schroder, RN, Nurse Educator 12. Johnnie Johnson, RN, Nurse Manager, Childress 13. Johanna Montgomery, RN, RN Case Manager, Cottages 14. Virginia Burton, RN, RN Case Manager, Childress 15. Linda Wellmann, RN, RN Case Manager, Childress 16. Numerous Staff Nurses **17.** Numerous Direct Care Professionals/Home Leaders **Meeting Attended/Observations:** 1. Meeting with Nursing Administration and QA Nurses, 7/25/2011 2. Hospital Visit with the Hospital Liaison Nurse, 7/26/11 3. Meeting with Infection Control Nurses, CNE, and QA Nurses, 7/26/2011 4. Death Reviews with the QA Nurses, 7/26/2011 5. Team At Risk Meetings7/26/2011 and 7/27/11 6. Medication Administration Observations in Driscoll D, at 4:00 p.m., 7/26/2011 7. Meeting with Valarie Kipfer, RN State Office Nursing Coordinator and CNE, 7/27/2011 8. Medication Error Committee Meeting, Colorado Room (CTC 518), 7/27/2011 9. Pharmacy and Therapeutic Committee Meeting, 7/28/2011 Tour of Childress, Fannin, and Cottages A, B, and E, 7/27/2011
	Facility Self-Assessment: BSSLC Plan of Improvement, dated 7/12/2011, provided comments/status for Sections M.1 through M.6 of the Settlement Agreement. The Facility indicated in was noncompliance with provisions M.3, and M.5 and

	in compliance with provisions M.2, M.4, and M.6. This was inconsistent with the Monitoring Team's findings as only provisions M.4 and M.6 were found in compliance. BSSLC stated they were in compliance with provision M.4 due to all core State and Facility Nursing Policies, Procedures, and Processes had been finalized, 100% of the Facility nursing staff trained on all policies, procedure, and processes; and they had all been implemented. The Monitoring Team agreed with Facility findings. The Monitoring Team did not agree that provisions M.1, and M.2, met compliance, as described below in the Monitor's Assessment. Most of the self-assessment information presented in the provisions to demonstrated compliance was repeated in each provision. The Nursing Department should only include self-assessment information that demonstrates compliance with the specific provision.
	Summary of Monitor's Assessment: **Provision M.1:** This provision was determined not to be in compliance. This provision contained a number of sub-sections that addresses various areas of compliance. The sub-sections include: staffing, quality enhancement efforts; nursing assessments; availability of pertinent medical records; infection control; and the Facility's medical emergency response systems. The sub-section of this provision for staffing was found to be in compliance because the Facility had maintained a stable nursing staff. The staffing ratio of nurses to individuals was consistently met during the past six months. There was evidence that the Facility continued to evaluate staffing needs and to realign nursing assignments when needed to strengthen nursing services. The sub-section for Quality Assurance efforts were still evolving and being refined. All 12 nursing monitoring tools were being completed by the various nursing administration and management nursing staff. Plans of correction were being implemented as deficiencies were identified on the monthly audits, on a unit by unit basis by the Nursing Managers. The quality assurance data from the monitoring tools were not aggregated, analyzed and trended campus-wide in order to identify systemic nursing deficiencies and develop systemic plans of correction. The Quality Assurance Nurses had begun conducting inter-rater reliability checks on the 12 nursing monitoring tool and this process was still evolving. The availability and organization of the clinical records had continued to improve. However, there was a delay in filing medical records received in the health clinic from outside providers. The assessment and documentation of individuals with acute changes in status was found the least compliant of the sub-sections in this provision. At the time of the review, 36 RNs had completed the mandated Physical Assessment Class. As the RNs complete this class, their enhanced knowledge and skills should improve nurses' assessment, management, and documentation of individuals with acute changes in status. The infection control sub-section of this provision also needs continued improvement in reporting, tracking, aggregating, analyzing, and trending infection control related data in order developing systemic plans of correction for identified trends. The infection control nurses need technical assistance to assist with developing a standardized and effective infection control program. The Facility had established an Emergency Response Committee to critique quarterly mock medical emergency drills and actual code blue events when they occur. The committee was chaired by the Chief Nurse Executive with participation of a physician as well as other relevant disciplines. The quality of the mock emergency drills need improvement. This provision cannot be achieved until all sub-sections of this provision meet compliance.

	Provision M.2: This provision was determined not to be in compliance. Although great strides had been made to improve the quality of the nursing assessments, the nursing summaries need continued improvement to critically analyze clinical data derived from the assessments, for each identified nursing problem/diagnosis, to accurately reflect whether individuals' health status was improving, maintaining, or regressing. As the RNs complete the Physical Assessment Class, their enhanced knowledge and skills should improve nurses' ability to critically analyzed clinical data and summarize it to accurately reflect individuals' health status. **Provision M.3:** This provision was determined not to be in compliance. There was evidence that a concerted effort had been put forth to ensure that the direct care professionals were trained on health maintenance and acute care plans. Each home had a Pink Care Plan Book for the direct care professionals to refer to that contained each individual's care plans. Interviews with a few direct care professionals demonstrated that the nurses had trained them on individuals' care plans. Health maintenance and acute care plans continued to need to be individualized to meet individuals' unique health care needs. **Provision M.4:** This provision was determined be in compliance. There was evidence that all core State and Facility nursing policies, procedures, and processes had been finalized. The Facility had trained 100% of the nursing staff on all policies, procedure, and processes; and they had all been implemented. **Provision M.5:** This provision was determined not be in compliance. The nursing staff had been trained on the At Risk Individual Policy and Procedures and the Aspiration Tracking Tool. The RN case managers were completing the heath/medical risk criteria and presenting their finding at the At Risk meeting for PST to review and rate levels of risk. The nurses need to collaborate with the physicians who hold joint responsibility for completing the health/medical risk assessments, as well as with other relevant disciplines to ensure that all related health/medical issues were identified and considered in determining risk ratings before the risk assessments were presented at the At Risk meetings for the PST to review. This was an evolving process and it was too soon to determine the status of compliance. **Provision M.6:** This provision was determined to be in substantial compliance. The Facility had developed and implemented an exemplary Medication Error Database to track, analyze and trend medication errors using a root cause analysis approach. It was readily apparent the Nursing Department had put forth considerable effort to reduce the incidence of medication errors. A review of medication error data indicated there had been a progressive reduction of medication errors over the past six months. The findings from the most recent quarterly report for the MAR and Medication Room Checklist audits indicated that the Facility fell significantly short of compliance in these two critical areas of medication administration practices; however, the Facility had a process in place that identified these issues and took effective action.

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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 The Monitoring Team found that the sub-section of this provision met substantial compliance. At the time of the review, the Facility census was 317. There had been five new admissions, three deaths, 13 community placements, and one transfer to another facility. The Nursing Department had a total of 118 allotted nursing positions with 13 vacancies, four Registered Nurses (RNs) and nine Licensed Vocational Nurses (LVNs). Of the allotted nursing positions, 20 were RN Case Managers and eight were Nurse Administrators. One LVN position was lost due to a decrease in census. Several nursing positions had been realigned to strengthen nursing services. One Nurse Shift Manager also serves as a Durable Medical Equipment Nurse. The purpose of adding this additional responsibly was to centralize ordering of durable medical equipment due to the high volume and complex equipment needs, develop a par-level ordering system to track, and trend utilization of such equipment. She will be responsible for ordering equipment and supplies for the nursing staff. She will also assist with nursing education for the nursing staff and direct care professionals, and to conduct "spot checks" nursing audits. The Nurse Recruiter's responsibilities were expanded to serve as a part-time Infection Control Nurse. The Nurse Staffing Coordinator's responsibilities were expanded to provide nursing services at the two off-site Program Services areas. The Nursing Department continued to supplement staffing with a group of agency nurses who had been working at the Facility for an extended period of time. The Chief Nurse Executive (CNE) reported that the agency nurses used were familiar with the individuals who live at the Facility, and were competent and flexible in scheduling their working hours. In order to further strengthen the agency nurses' competencies, they had begun receiving the total Nursing New Employee Orientation. A Shift Manager was assigned to oversee the agency nurses. The Shift Manager ensured that agency nurses received a competent orientation. She followed-up on performance issues, maintained on site personnel files, and coordinated services and scheduling with the agency management. In addition, the CNE stated that the Nursing Department continued to build staffing through a strong relationship with the local nursing school. Approximately 70 nursing students had rotated through the Facility since the last monitoring visit. Of the nursing students who had rotated through and became RNs, two had been hired. There was a graduating nursing class in August, from which it was hoped to get some recruits. The CNE explained that the challenge in retaining nursing staff was due to the long distance some nurses had to travel to the Facility. The Monitoring Team's review of staffing documentation confirmed that the nursing staffing patterns had remained relatively stable. The Nursing Department had continued	Noncompliance

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		efforts to build a sound and sustainable infrastructure regarding scheduling and nursing staffing. Nursing Staffing Policies and procedures had been developed and implemented. The CNE stated that the improvements in maintaining stable staffing was attributable to Nursing Department's Nurse Staffing Coordinator who managed scheduling, reviewed the schedules several times during the day, filled shifts as call-ins occurred, arranged coverage, and kept all members of the nursing team informed. The Nurse Managers and Shift Nurse Managers also reviewed scheduling daily for all shifts and ensured that the established minimum nursing ratios were consistently met. The Nurse Managers reviewed and approved requests for time-off prior to submitting the requests to the Nurse Staffing Coordinator. After hour, weekend, and holiday shift staffing were maintained by the Nurse Shift Managers who reviewed the schedules and filled open shift as they occurred. The CNE stated a new process had started whereby the first of each month nursing staffing ratios were compared with the current census and staffing adjustments were made as needed. The Monitoring Team reviewed all residential units daily shift reports and validated nursing's established staffing patterns had not fallen below the minimum staffing requirements for the past six months. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Nineteen clinical records (Individuals: #59. #191, #38, #96, #422, #554, #557, #83, #291, #412, #39, #24, #163, #270, #576, #69, #66, #305, and #165) were reviewed for compliance with the Nursing Department's Management of Acute Illness and Injury Procedures, Nursing Documentation Guidelines, and evidence of integrated services. Since the last review, little progress had been made in this sub-section of the provision. Consistent with previous findings, there continued to be significant problems regarding the nurses' competency in assessment and documentation in following areas: • Due to the lack of documentation, it was often not possible to determine when changes in health status were initially occurring. • A lack of complete and appropriate nursing assessments in response to presenting signs and symptoms of changes in status; and/or changes in vital sign and oxygen saturation measurements. • A lack of follow-up from issues noted in previous nurses' progress notes. • A lack of specific description of physical appearance, size, and location of skin rashes, injuries and/or bruises. • No documentation of individuals' activity tolerance for activities during the day, particularly for individuals' experiencing or recovering from an acute illness or injury. • A lack of lung sounds assessed and documented for respiratory issues. • Inadequate documentation of the administration and follow-up for PRNs (as needed medications). • A lack of mental status assessment documented during status changes and/or	

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		specific description when individuals were engaging in maladaptive behaviors. • Significant gaps in documentation when the nurses' notes stated, "will continue to monitor". The nurses consistently failed to state what would be monitored and the frequency of the monitoring. • Physicians were not notified timely of change in status, primary due to nurses' inadequate follow-up. • The method temperatures taken were rarely documented. • No documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking, or skin breakdown, or having frequent falls or other related PNMP issues. • Lack of analysis of contributing problematic issues affecting changes in status. • A lack of adequate documentation regarding individuals' assessment and status at the time of transfer to the emergency room or hospital. • Lack of documentation of notification to the PSTs of individuals' transferred to the emergency room or hospital. • Inconsistent documentation that an information packet was sent to the receiving hospital at the time the individual was transferred. • Inconsistent documentation of the time, date, mode of transport and staff accompany the individual to the transferring emergency room or hospital. • Inconsistent documentation regarding nurse-to-nurse communication with the transferring emergency room or hospital. • Lack of regular follow-up for symptoms related to reasons for the emergency room or hospital. • Inconsistently developed and implemented Acute Care Plans for acute changes in status. • Annual and Quarterly Comprehensive Nursing Assessment were not revised to reflect significant changes in status or new problems until the next assessments were completed. • Lack of updated Health Maintenance Plans to reflect changes in status or new interventions. • Occasionally inappropriate and unapproved abbreviations were used. • Dates and times of entries were not consistently documented for progress notes. • Many nursing progress notes, nursing signatures, and titles were illegible. Many of the deficits in nurses' clinical competency to provide adequate nurse care for acute conditions, identified above, were validated in review of Individual #24' clinical record for the past six months. • On 1/19/2011 at 9:10 a.m. the Physical Therapist reported to the RN Case Manager that Individual #24 complained of pain in the "crotch" and that he could not urinate. It was not until 1/20/2011 at 7:30 a.m., almost 24 hours later, that a nurse followed-	

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		up on his urinary complaint. The nursing assessment only stated, "Urinating without difficulty". The nurse failed to complete an assessment of the urinary system or to take vital signs to rule out any urinary problems. There was no further documentation on this issue. • On 1/29/2011, the nurse documented that Individual #24 had white areas between the toes on both feet and peeling on the heel of the right foot. He was seen in sick call on 1/31/2011, diagnosed with tinea pedis (athlete's feet), with Lamisil cream twice a day for two weeks, and was to return to sick call in three weeks. The order was noted as transcribed by a nurse. However, there was no documentation in the INP that the treatment of Lamisil cream to the feet was or an Acute Care Plan was initiated, or was it documented on the Medication Administration Record. There was no further assessments and documentation regarding the effectiveness of the treatment for tinea pedis of the feet or if the problem was resolved. There was no documentation that Individual #24 returned to sick call for physician follow-up in three weeks. • On 5/26/2011 at 10:15 a.m., the nurse noted that the direct care professional reported that Individual #24 having a small amount of urine with blood. There were no vital signs taken or an assessment of the urinary system to rule out urinary problems before calling the physician. The nurse notified the physician who ordered a urine culture. The nurse stated in she would continue to monitor but failed to state what she would monitor and how frequently the monitoring would occur. There was no further documentation until 5/27/2011 at 0015, when the note (combined with another problem) reported that a urine specimen had been put on ice for culture. There was no further documentation indicating whether the urine was sent to the lab for culture or the status of the urinary problem. • On 5/27/2011 at 0015, the nurse noted that Individual #24 complained of stomach pain and right leg pain. The nurse assessed vital signs and the right leg and reported it was red with 4+ pitting edema with capillary refill present. The physician was notified at 0055 and gave telephone order to send Individual #24 to the emergency room. Individual #24 was sent to the emergency room. There was no note regarding the mode of transportation or the staff who accompanied him to the emergency room or documentation that a nurse to nurse telephone called was place to the receiving emergency room. There was no documentation that the QMRP or PST was notified for the emergency room visit. Individual #24 returned from the emergency room at 0730. A comprehensive nursing assessment was completed upon return. The note indicated that post discharge orders and hospital labs were returned from the emergency room. The nurse said she would send him to sick call that morning. Until the 5/27/11 progress note, there had been no nursing progress notes written since 5/12/2011. It was puzzling how Individual #24 could have suddenly developed 4+ edema without any staff noticing.	

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		• There were no further documentation in the IPN that Individual #24 was assessed by nursing or a physician until 5/30/2011, two days later (over the weekend). The nurse reported there were no Physician Order's on the chart after the emergency room visit, and that he was to be re-evaluated tomorrow, 6/2011. There was no documentation the nursing staff had contacted the physician of Individual #24's return from the emergency room during the weekend to secure follow-up orders. The nursing staff continued to assess Individual #24's right leg daily on 5/30/2011 and 5/31/2011. • On 6/1/2011, the physician saw Individual #24 in sick call. The physician reported that Individual #24 had been sent to the emergency room last week for suspicion of a DVT but that the Doppler Studies were negative. The emergency room physician thought he had cellulitis and recommended antibiotic therapy. The Facility physician did not agree that he had cellulitis and decided to "just" watch him. The physician acknowledged she did not write a note when she saw him but did not indicate when he was seen after the emergency room visit. At this sick call visit the physician diagnosed Individual #24 with cellulitis and prescribed antibiotic therapy for 10 days. The nursing staff failed to establish an Acute Care Plan for the cellulitis. However, the nursing staff instructed the individual and direct care staff to keep his legs elevated. The nursing staff continued to assess Individual #24 at least once each shift while he received the 10 days of antibiotic therapy. The documentation of the nursing assessments did not consistently include vital signs for this infectious process. Individual #24 was evaluated by the physician on 6/9/2011; when it was determined that the cellulitis was "resolving nicely" and he would be followed-up as necessary. • On 6/11/2011 the nurse documented that the antibiotic therapy was completed and no further follow-up was needed. While the nursing assessment of the right leg was assessed at least daily during the antibiotic treatment, the response to the antibiotic therapy was not consistently documented, the physical assessment and physical appearance of the right leg were not adequately described, and the vital signs were not consistently taken. • On 7/10/11 at 2050, the nurse noted that the right leg was more reddened, accompanied by edema and felt tight to touch. When the area below the calf was touch Individual #24 stated it felt sore. The physician saw Individual #24 in sick call on 7/11/2011, and documented that his right leg had moderate swelling and diagnosed him to have chronic swelling of the right lower extremity with no treatment needed. There were no further nursing assessments completed on the right leg until 7/13/2011 at 10:10 a.m., when he was seen again in sick call, was diagnosed with recurrent cellulitis, and prescribed another 10 day round of antibiotic therapy. The nurse initiated the antibiotic therapy on 7/13/2011 and assessed Individual #24 daily, except on 7/17/2011 (Sunday) through to	

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		7/21/2011. There were no further nursing notes documented regarding the status of Individual #24's cellulitis. The antibiotic therapy was due to be completed on 7/23/2011. The last note documented was on 7/26/2011 indicating Individual #24 was NPO (without oral intake) for lab work. Consequently, there was no resolution note regarding the status of the cellulitis. An Acute Care Plan was not established for the recurrent cellulitis. The nursing assessments did not demonstrate any better quality than those documented in the previous treatment of cellulitis. • In addition, on 7/12/2011 at 8:30 a.m., a nurse noted that individual #24 had a "drastic" change in weight from the last month. He was reported to weigh 196.4 pounds. There was no comparative weight documented for the last month nor were there any precipitating causes documented that the nurse had explored the rationale for the "drastic" weight loss. The nurse noted that she had notified the RN Case Manager to let the physician know of the weight loss. On 7/13/2011 at 5:50 p.m., the RN Case Manager documented that Individual #24 had a weight loss of 13 pounds. There was no further assessment of the weight loss documented in this note or following notes. It was doubtful that his weight loss was addressed. Review of this individual record clearly pointed out many of the deficits in nursing's competency to manage and document acute conditions, as did the issues identified above in all 19 records reviewed. The Monitoring Team did not find the Facility in substantial compliance with this sub-section of the provision. In order for the Facility to meet substantial compliance with this sub-section of this provision, the nursing Department must significantly improve the competency of the nursing staff to manage and document acute care conditions. The Physical Assessment Class, mentioned in Section M.2 and M.3 should go along way toward improving nursing competency, but other strategies should also be considered. The most positive finding in the section related to the Hospital Liaison Nurse who made daily visits and/or telephone contacts, through weekdays, when individuals were admitted to the local hospital, and weekly to individuals receiving care in a hospital or long term acute care facility outside of the area. The Hospital Liaison Nurse typed hospital visits and/or telephone contact notes onto the Integrated Progress Notes (IPNs) and placed them chronologically in the individuals' medical records. The Hospital Liaison also placed a copy of the IPNs on the S drive for all PST members to review. She also attended the daily morning medical meetings and provided an up date on the health status of individuals who were in the hospital or long term acute facility. The documentation of the Hospital Liaison Nurses' visit reports were further validated through a review of IPNs for the recently hospitalized Individuals #554, #557, #83, and #291. The Monitoring Team accompanied to the Hospital Liaison Nurse to the hospital to visit Individual #291. She had good rapport with the hospital personnel and was able to freely access hospital records and to interview the staff regarding Individual #291's	

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		hospital course. Availability of Pertinent Medical Records The availability and accessibility of the records had continued to improve since the previous reviews. The Medical Record, Nursing Section, was better tabbed which made it easier to locate the various nursing related documents contained in this section. Occasionally a missed filed document was found and a wrong individual's record was filed in individual's the records. The primary problem expressed repeatedly by the QA Nurses, Infection Control Nurses, Nurse Managers, and RN Case Manager was the delay in filing clinical reports such as, consults, laboratory and diagnostic test results, and information from emergency room and hospital visits. Infection Control The BSSLC POI self-assessment for infection control information was located in Section M.5 of their report. They indicated they were not in substantial compliance with any of the items specific to infection control. The Monitoring Team concurs that that the Facility was not in substantial compliance specific to infection control. Since the last review some improvements had been made in the Infection Control Program although substantial compliance had not yet been met. • The Facility had reallocated a part-time RN to assist the Infection Control Nurse. The part-time Infection Control Nurse's responsibilities include: Assisting the Infection Control Nurse in conducting audits on Handwashing, Skin Integrity, Environmental Surveillance, and other infection control issues; entering information into Infection Control databases, and individuals' laboratory results for the Antibiogram; Administering Tuberculosis Skin Tests and administering Hepatitis immunizations to new and current employees. When the Infection Control Nurse is not available the part-time Infection Control Nurse provides training on Infection Control at New Employee Orientation. There continued to be no clerical staff assigned to assist the Infection Control Program with data entry, as had been recommended in past reviews. Because of competing priorities, there was limited time available for the Infection Control Nurses to enter data, which was an important but time consuming task. Therefore, the lack of clerical support limited the Infection Control Nurses' ability to timely and completely enter infectious and communicable disease data into the Infection Control Database, as well as other required data entry. Timely reporting of infection control data is essential to quickly identifying problematic issues/trends and in maintaining an effective Infection Control Program. The use of clerical staff should expedite data entry, as well as free up time to attend to functions that can only be performed by the Infection Control Nurses. The Facility should weigh the cost and benefits of utilizing a clerical level staff for entering infection control data against the use of RN level Infection Control Nurses.	

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		• The Immunization Tracking Report, capable of tracking immunizations through the Infection Control Database had not been fully populated. Such a tracking system is an essential tool for the clinical staff to use in order to check and up date individuals' immunization status. The Facility should continue to develop and implement a system to ensure that all individuals are current regarding their immunization status, in accordance with the requirements of the Settlement Agreement. • It was positive to find that the Infections by Type Report was beginning to track various types of infection by unit and campus-wide, and to calculate the number and percentage of occurrences for each type of infection reported in each unit and for the Facility. Data were represented in pie and bar charts. However, there was no analysis of data to identify whether infectious trends were emerging within the units and/or campus-wide. Without analyzing the data to identify infectious trends and develop plans of correction, if infectious trends were identified, the raw data is of no value to preventing the spread of infections. From review of the last six months' Infection Control raw data, it appeared that the required routine and/or periodic observations, meetings, reports, and tests were being completed, but this could not be substantiated because there were no summary reports verifying that the required functions had been completed according to schedule. The reports were entered on various spreadsheets. None of the reporting data were summarized, aggregated, analyzed and trended, or presented in a useful and meaningful manner for the clinical disciplines, other disciplines, departments, and/or the Facility to use in making decisions for improving health and environmental services. Neither could it be discerned how or by whom or if any of the raw data were being used. • The Facility continued to track reportable communicable diseases in the areas of Methicillin-resistant Staphylococcus aureus; Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); Human Immunodeficiency Virus; pneumonia, urinary tract infections; and any antibiotic use. There were no summary reports available for review indicating that these data were analyzed, trended, and rates computed for infectious and/or communicable diseases to identify any trends occurring in individual units and/or campus-wide, or the origin/location, and incidences of occurrence, e.g., facility acquired verses hospital acquired. Neither was there information regarding contributing factors that might have caused the occurrence or measures that might have been put in place to prevent or eliminate reoccurrence. These are issues that the Infection Control Nurse should monitor, track, analyze, trend, and establish rates of occurrence; and develop plans of correction when applicable trends are identified.	

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		It was positive to find if an individual had converted Tuberculin Skin Tests they were tested using the Tuberculin Gold Test. In the past six months there were six cases of Methicillin-resistant Staphylococcus aureus; and two cases of Clostridium difficile (C-diff) reported. There were no training records available to review that indicated whether support staff received training on these two contagious diseases. The Infection Control Nurses should ensure when contagious diseases are reported that the responsible support staff are adequately trained in standard precautions and any other special preventive measures necessary to prevent the spread of disease. There continued to be no formalized process in place to ensure infectious and communicable diseases were reported accurately and completely, including all individuals who had either a chronic or acute infectious or communicable disease processes. As noted in the previous report, ensuring the reliability of the infection data is essential. The Facility should develop a procedure outlining the specific process to ensure data reliability for infection control, including how discrepancies in the data are reconciled and tracked. This will require collaboration with the Pharmacy Department, Medical Department, as well as residential services. The procedures should address specific information, such as when data are collected from each system, how discrepancies between the systems are tracked and reconciled, and where unit reporting falls into the data collection system. Without reliable infection control data, the Facility cannot accurately identify trends requiring timely plans of correction, ensure that appropriate treatment is administered and effective, and that support staff are adequately trained. • Infection Control Requirement Instructions had been established for the Infection Control Nurses to follow for routine and/or periodic observations, meetings, reports, and tests. It was positive to find that the Infection Control Nurse had formalized guidelines, 7/2011, for completing Handwashing and Environmental Surveillance Observations. The procedure included handwashing observations and quarterly environmental observations with quarterly analysis of data, and requirements for plans of correction. The above information was reported to the QA Nurse. Since these processes had only been implemented July 2011, no reports were available for review. For the past six months, completed raw monitoring data sheets were reviewed for Handwashing and Environmental Surveillance audits that indicated observations were being done to some degree. Staff retraining in hand washing techniques or corrective actions for environmental issues were documented on the observation forms as having been taken on the spot. However, these data were not summarized, aggregated, analyzed and trended to identify systemic deficiencies that may require systemic plans of corrections. It is expected that the newly established and	

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		implemented guidelines for Handwashing and Environmental Surveillance Observations will improve the quality of the observations, reporting, analyzing, and trending this data to effectively identify deficiencies and take appropriate corrective action. • Monthly incidents and status of Skin Integrity/Decubitus issues were tracked by the Infection Control Nurses according to standardized grading and reports. The last reported data available for reviewed was for May 2011. At that time the Facility reported one unstageable pressure ulcer due to eschar and one Stage II healed pressure ulcer. As was found with all other reporting data, there were no summary reports indicating that an analysis and trending of the Skin Integrity/Decubitus had been completed to identify trends occurring in individual units and/or campus-wide or the origin/location and/or incidence of occurrence of the skin breakdown, e.g., facility acquired verses hospital acquired. Neither was there information regarding contributing factors that might have caused skin breakdown or measures that might have been put in place to prevent or eliminate the occurrence of skin breakdown. These are issues that the Infection Control Nurse should monitor, track, analyze and trend, and develop plans of correction when applicable trends are identified. • The Monitoring Teams reviewed the 3/29/2011 Infection Control Committee Minutes and found little substantive information. They did not contain quarterly reports for the rate of infections, incidents and status of Skin Breakdown/Decubitus, or Handwashing and Environmental Surveillance audit results, or other relevant routine infection control reports that would have an impact on the Facility's infection control practices. The June 2011 quarterly Infection Control Committee Minutes were reported as missing. • Since the last review, the State-wide Infection Control Nurses' Workgroup had finalized the Infection Control Reference Manual. The Manual was placed on the S-drive and copies of the Manual were distributed to each unit. The Infection Control Nurse Workgroup did not develop a training component for the Manual nor had the Facility. Consequently, no training on the Manual had been provided to the nursing staff or other relevant staff. It is important that the nursing staff and other relevant staff receive training on changes in current infection control practices, regulations/standards, e.g., Centers for Communicable Diseases (CDC), Occupational Safety and Health Administration (OSHA), and other changes inherent for managing an infection control program that affects long term care facilities. The need for such training was discussed with the State Office Nursing Coordinator and CNE. The Infection Control Training Curriculum, revised 2003, that the Facility was required to use developed by the State's Human Resource Development, Texas Department of Mental Health and Mental Retardation, is seriously outdated. Many changes in Infection Control practices and regulations/standards have changed since	

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		it was developed. This training curriculum needs to be updated. This was discussed with the State Office Nursing Coordinator. The Infection Control Nurse had developed and implemented an addendum to the Infection Control Training Curriculum, 3/15/2011. The additional training material included topics on pinworms, scabies, head lice, body lice, bed bugs, shingles, pandemic flu, handwashing, gloves, and hand sanitizer use. The CTD Infection Control Training Due/Delinquent Report, printed 7/26/2011, reported that 15 employees were delinquent in Infection Control training. The Infection Control Nurses should monitor the CTD Infection Control Training Due/Delinquent List and work with the relevant disciplines/departments directors or designee to ensure that employees remain current in Infection Control Training. • The Facility had purchased the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) Manual. The lead Infection Control Nurse stated she planned to take the Infection Control Certification Examination within the next year but had not had the time to study the Manual in depth. Since the last review, there had been minimal progress made toward meeting substantial compliance with this sub-section of the provision. As noted in previous reports, additional expertise in Infection Control is needed to summarized, aggregate, and analyze and trend infection control data to identify individual as well as systemic trends that require plans of correction, and to implement systems to maintain an efficient and effective Infection Control Program in alignment with standard Infection Control practices. The Infection Control Committee Minutes need to contain more substantial information. The need to provide the Infection Control Nurses with additional technical assistance was discussed with the CNE and State Office Nursing Coordinator and both agreed this was needed. The State Office Nursing Coordinator was receptive to locating and providing the Facility Infection Control Nurses with technical assistance in an effort to improve the quality and effectiveness of the Infection Control Program. <u>Medical Emergency Response</u> The Facility did not meet substantial compliance with this sub-section of Provision M.1 for the Settlement Agreement's emergency care requirements and compliance with the Facility's Medical Emergency Response Policy. This issue has been identified in each of the previous reviews/reports. As was recommended at the last review, the Facility had established a CPR Committee on 2/10/11 along with guidelines and procedures developed for critiquing Mock Medical Emergency Drills for the past quarter and to convene "Special" CPR Committee meetings within three days after the occurrence of an actual Code Blue to review the event and to make recommendations for corrective action when indicated. The Committee is chaired	

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		by the Chief Nurse Executive. The standing membership includes a physician, Quality Assurance Nurse, Nurse Educator, Shift Nurse Managers, a representative from Residential Services and a CTD Trainer. Other members will be included as needed for emergent situations as they pertain to that particular event. According to the CPR Committee Guidelines: Monthly Mock Medical Emergency Drills will be performed. The QA Nurse or designee will assign drills quarterly to be performed on a monthly basis. Follow-up will be completed by the Nurse Shift Managers and/or Nursing Administration. All completed Mock Medical Emergency Drill sheets will be turned into the QA Nurse no later than the 25th of each month to ensure adequate tracking and trending can be performed. Failure to complete the required number of drills will be referred to their immediate supervisor for appropriate corrective action. Since the initiation of the CPR Committee, three scheduled meetings and one "Special" CPR Committee meeting have been held. The Monitoring Team's review of the CPR Committee Meeting Minutes (2/2011, 4/19/11, 7/11/11) and "Special" CPR Committee Meeting Minutes (6/3/11) demonstrated that the Committee was reviewing and evaluating the performance of the Mock Medical Emergency Drills and Code Blue events, and making recommendations for system improvements and/or corrective actions for identified deficiencies. Some of the improvements and/or corrective actions included: • The addition of a Nurse Educator, Residential Services Representative, and CTD Trainer to the Committee's standing membership. • Identified the need to perform monthly Mock Medical Emergency Drills in Brenham Production Services and Program Services areas. Drills in these areas were to start on monthly bases in June, 2011. • Identified the need to notify the staff responsible for failing to conduct Mock Medical Emergency Drills according to assigned schedule, and their immediate supervisor, to ensure that drills were completed accordingly. • Identified the fact that many CPR instructors had gone through the CPR course but had never completed the testing, consequently, they were not qualified to conduct Mock Medical Emergency Drills according to the CTD Department. The QA Nurse was to follow-up on these issues but no resolution was noted in the Committee Minutes. • Identified that some nurses who were conducting the Mock Medical Emergency Drills were signing the drill sheet as the responding nurse or having another nurse from their unit sign as the responding nurse. This was not acceptable practice. This issue was being handled through Nursing Administration. There was no disposition noted in the Committee Minutes as to the outcome of this issue. • Identified problems regarding the accuracy and quality of the drills performed.	

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		CPR Committee members began monitoring a sample of drills performed to ensure that the drills were carried out correctly and efficiently. • Identified the need to add information to the drill form on response time and time taken to complete the drill. The Mock Medical Emergency Drill form is a State form but according to the Medical Emergency Response Policy additional information can be added to the drill template at the discretion of the State Center. • As a result of the "Special" CPR Committee Meeting, the Committee identified the need to review the Security film by a core group of members when Code Blue events occur prior to a specially called meeting and to increase the number of drills on the units where the events occur. A corrective action plan was developed in relation to the 5/31/11 Code Blue event at Driscoll B that identified issues regarding the unit's emergency response performance. Refer to Provision L.3 for further information regarding this Code Blue event. The formulation and implementation of the CPR Committee to critique Mock Medical Emergency Drill performance and the "Special" CPR Committee to critique Code Blue events in order to make system improvements and/or corrective action on identified deficiencies represented a positive step forward in meeting compliance with the Facility's Emergency Response System. Review of the Committee Minutes failed to document the Committee consistently carried forth to resolution issues identified in the minutes that required follow-up actions. The CPR Committee and "Special" CPR Committee Minutes should have the status of the follow-up actions documented in the next Committee Minutes as to how recommendations were followed through to resolution. Although the completed Mock Medical Emergency Drill sheets were critiqued by the CPR Committee there were no analysis and trending reports available for review. It was the Facility's responsibility to analyze and trend data according to the Medical Emergency Response Policy, e.g., "Data must be reviewed at least monthly and trends must be analyzed quarterly." The Facility needs to identify individual staff, specific units/areas, as well as systemic deficiencies in order to take appropriate corrective actions. The drill and Code Blue data need to be analyzed and trended, including tracking recommendations and corrective actions. The Monitoring Team reviewed 133 of the completed drill sheets and identified the following concerns: • In 61 of the 133 (46%) drill sheets reviewed, the item "Ambu bag or one-way mask utilized" was marked as no or not applicable. All emergency equipment must be used to simulate a real time event to ensure staff can demonstrate competency in their use and check the working order of the emergency equipment. • The Mock Medical Emergency Drill sheet used, dated 7/21/2011, did not have a	

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		place to indicate if the drill was a "Pass" or "Fail." This needs to be added to the sheet. • According to the Medical Emergency Response Policy for the drills to "pass" all applicable items on the drill sheet must be marked "yes." If there is a 'no" marked for any item on the drill sheet there must be an explanation written in the comment section. However, as noted below, there were examples in which some items did not occur but the drill was not marked as "failed." • According to the Medical Emergency Response Policy the Mock Medical Emergency Drill sheets were to contain the Medical Services phone number. This number was not included on the sheet. • As was identified in the last review nurses in some areas did not participate in the Mock Medical Emergency Drills; this was evident particularly in the Cottages. Example: Nurses did not participate in the drills in Cottage B and D on 1/28/2011 at 10:33 p.m., in Cottage B on 4/6/2011 at 7:30 p.m., and Cottage C on 4/20/11 at 1:20 p.m. On 4/6/2011 at 7:30 p.m. the comment section stated, "A nurse could not be found, several calls were made and staff from Cottage C attempted to look for one." Apparently a nurse was not located as there was no indication on the drill sheet that one attended the drill. On 4/20/2011 at 1:20 p.m. the comment section stated, "No nurse came, phone was busy during the drill." These drills should not have been considered successful without the nurses' participation. These drills were not marked as failed as they should have been. • The Mock Medical Emergency Drill performed on 2/20/2011 at 10 a.m. in 505B reported in the comment section that the Physical and Nutritional Management Team Monitor did not assist with the drill. Neither did the physicians participate in any of the 133 drills. According to the Medical Emergency Response Policy all staff who have direct care responsibilities for individuals must participate in the drills. • The Facility did not have a public address system or other means to announce that a Mock Medical Emergency Drill or Code Blue was in progress. This was most concerning particularly when there is an actual Code Blue in progress because with out a system for rapid notification of all staff, particularly the clinical staff, the delay in response to the scene could have life threatening ramifications. This issue was identified as a serious problem in previous reviews/reports. • Frequently the Mock Medical Emergency Drill comment sections contained documentation of equipment malfunction, broken and/or missing equipment, but there were no Plans of Action for correcting the identified problems. Example: In Cottages A and B it was noted in the drill comment section on 4/13/2011 that there were no back boards in the lower cottages and the red flashing light on the AED box was not working. These are vital pieces of emergency equipment that need to be in place and in good working order. In Driscoll C the drill comment section reported that staff were unable to locate the "plastic bag" (one-way mask) used for airway on	

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		the mannequin. Therefore, the drill instructor allowed the staff to verbalized breathing two times between the 30 compressions. This practice was inadequate because the nursing staff should have a supply of masks and the staff should keep a mask with them for emergencies. • Frequently the use of the AED, backboard, Ambu bag, oxygen, and suction machine were demonstrated by allowing staff to verbalize their use and/or verbalize where the equipment was located. This practice is inadequate to allow the staff to gain competency in performing emergency response. The sole purpose of conducting routine drills is to ensure the staff develop and maintain competency in the event of an actual Code Blue. An impromptu Mock Medical Emergency Drill was conducted by the Nurse Educator and Nurse Manager on Driscoll B on 7/28/11 at approximately 3:45 p.m. The drill was observed by the Monitoring Team accompanied by the QA Nurse. The staff responded within seconds to the "man down" and began CPR, the Nurse Educator assisted the direct care staff with prompting, the required notifications were simulated, and the unit nurse promptly brought the Emergency Kit to the scene but the suction machine that was sitting across the room was not brought to the scene. The Emergency Medication box was not brought to the scene. The Emergency Kit containing the oxygen and AED was not opened. The only emergency equipment used was the Ambu bag the, other equipment was not used to simulate resuscitation efforts, nor was the equipment checked for working order. The Monitoring Team determined this to be a "failed" drill. There is no space on the form to rate a drill as passed or failed, which may make it more difficult to ensure corrective actions are taken and success or failure in drills is trended to identify need for systemic action. The issue of failure to simulate the use of emergency equipment was discussed with the nursing staff. The Mock Medical Emergency Drills need to simulate resuscitation efforts as close to real time as possible. All emergency equipment needs to be brought to the scene, e.g., Ambu bag, one-way mask, back boards, AED, oxygen, and suction machines, and Emergency Medication box. The equipment should be assembled for ready use so that the staff knows how to use and operate the equipment and ensure that it is in good working order. This includes opening and turning on the AED, applying the pads and operating the AED to ensure the nurses know to operate and where to place the AED pads as well as checking the expiration dates of the AED pads. The Monitoring Team reviewed the completed Monthly Emergency Checklists for all residential units and the Health Services Center. The Monitoring Team determined marginal improvements in the daily checking of Emergency Equipment in some of the residential units. Bowie and the Health Services Center (on the days the Center was open) consistently completed the Emergency Equipment Checklist. Driscoll rarely missed checking daily. Childress and Fannin frequently failed to check the entire	

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		Emergency Equipment item on the checklist. The Cottages were most delinquent in daily checking all items listed on the checklist. It was positive to find that all Monthly Emergency Equipment Checklists were reviewed monthly and Emergency Equipment Checklist Re-Training was conducted by the Nurse Managers. There was evidence found through review of the Emergency Checklist Re-Training material and signed Training Rosters that nursing staff were re-trained in the Cottages on 2/6/2011 and 7/11/2011, Childress on 3/17/11, and Fannin on 3/16/2011. Based on the Monitoring Team's review of the Monthly Emergency Equipment Checklists for the residential units with continued deficiencies in completing the daily checklists, the Nurse Managers need to identify and take assertive and effective actions to ensure that the Monthly Emergency Equipment Checklists are consistently and accurately completed. In addition, the Nurse Managers should put a process in place to observe nurses checking the emergency equipment at least quarterly to ensure they are familiar with the use of the equipment and that all emergency equipment, including back-up equipment, is checked for good working order. As found in previous reviews, numerous direct care staff were found delinquent in CPR: Basic Training. The CTD's Due/Delinquent Report, printed 7/25/2011; identified 36 direct care staff that were delinquent on CPR: Basic Training. It was positive to find that the CTD's report indicated that all clinical staff were up to date in Healthcare Providers CPR Training; this was a significant improvement since the last review. Based on the Monitoring Team's review, in order to meet substantial compliance with this sub-section of Provision M.1 of the Settlement Agreement for emergency care and the Facility's Medical Emergency Response Policy, the Facility needs to ensure that the following issues are addressed, but are not limited to: • The Facility staff responsible for the emergency response system should be re-trained in the Medical Emergency Response Policy and adhere to all components of the Policy. • The Facility needs to analyze and trend drill and Code Blue data, to identify individual staff, specific units/areas, as well as systemic deficiencies in order to take appropriate corrective actions and use tracking logs to track recommendations and corrective actions. • The CPR Committee and "Special" CPR Committee Minutes for identified follow-up actions should have the status of the follow-up actions documented in the next Committee Minutes and followed through to resolution. • All CPR Drill Instructors should be tested for competence before they conduct Mock Medical Emergency Drills. • The QA Nurse should conduct "Spot-Check" observations of the Mock Medical Emergency Drills to evaluate staff performance.	

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		• The Mock Medical Emergency Drill template needs to add a space to indicate if the drill was a "Pass" or "Fail" and add the Medical Services phone number. • All staff responsible for direct care to individuals must participate in Mock Medical Emergency Drills, including physicians. • The Facility should have a public address system or some other means of rapid communication to notify responsible staff when Mock Medical Emergency Drills and Code Blue are in progress. • When emergency equipment is missing or malfunctioning and documented in the Mock Medical Emergency Drill sheet's comment section there needs to be a Plan of Action written to correct the problem and validation that the problem was resolved. • The Mock Medical Emergency Drills need to simulate resuscitation efforts as close to real time as possible. All emergency equipment needs to be brought to the scene. The equipment should be assembled for ready use so that the staff knows how to use and operate the equipment and ensure that it is in good working order. • The Nurse Managers need to provide on going Emergency Checklist Re-training for nurses responsible for daily checking the emergency equipment to ensure that the Monthly Emergency Equipment Checklists are consistently and accurately completed. In addition, the Nurse Managers should put a process in place to observe nurses checking the emergency equipment at least quarterly to ensure they are familiar with the use of the equipment and that all emergency equipment, including back-up equipment, is checked for good working order. • The Facility needs to ensure that all staff identified as delinquent in CPR: Basic Training are retrained as soon as possible. <u>Quality Enhancement Efforts</u> For the Nursing Department to ensure the provision of health services needed to meet and maintain the requirements of the provision and current generally accepted practice are met, it needs a system of quality enhancement that will enable it to identify how well it meets requirements and to initiate corrective actions as needed. . The Nursing Department had continued to conduct audits using the 12 Nursing Monitoring Tools and other related nursing practices; however; they had not yet met substantial compliance with this sub-section of the provision. Since the last monitoring review a fulltime LVNIII position was transferred to the QA Department to assist with monitoring the Nursing Department. Through the Monitoring Team's interviews with the CNE, Nursing Operation Officer (NOO), and Quality Assurance (QA) Nurses, and the review of the monitoring data documentation, it was apparent that a cohesive and collaborative relationship continued to exist between them in their efforts to carry out and manage the monitoring procedures and processes. It was apparent they were making a concerted effort to analyze and trend the data extrapolated from the	

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		monitoring results, and to develop and implement plans of corrective action when indicated. However, the compilation, aggregation, analysis and trending of data, plans of correction continued to be refined. The CNE explained that the Nursing Department was continuing to refine their monitoring processes with databases and plans of correction. A formalized written plan for managing the Nursing Department's and QA Nurses' monitoring system was not available for review. As the Nursing Department refines and finalizes their monitoring management system plan, all procedures and processes need to be formalized into a written plan that addresses all aspects of the monitoring system. The Monitoring Team reviewed the monitoring data supplied by the Nursing Department and QA Nurses'. The review validated that the tabulated data derived from the monitoring tools were submitted to the NOO who reviewed for compliance and developed plans of correction for identified deficiencies on each item on each monitoring tool falling at or below 80% compliance. Then, the Nursing Operation Officer gave this information to respective unit Nurse Managers, Nurse Shift Managers, and/or RN Case Managers to review deficiencies and implement the plans of correction on their respective units. When items that required immediate corrective action were identified on individual monitoring tools, by the nurse auditor, "on the spot" corrective action was taken. The nurse auditors notified the NOO and/or responsible Nurse Manager of the corrective action taken and made recommendations for follow-up when indicated. It was positive the find that the Nursing Department had continued to make progress with regard to this sub-section of the provision, although they had not yet met substantial compliance with the Settlement Agreement. Some issues of concern that were identified by the Monitoring Team included: • The monitoring data was tabulated on spreadsheets that represented the percentage of compliance with each item on each monitoring tool for each unit, as well as for the entire campus. The monitored items tabulated on the spreadsheets falling at or below 80% compliance were highlighted for both the units and the campus. This method of flagging made deficiencies readily identifiable for use in decision making for areas of nursing practice that required plans of correction. While there was evidence that corrective actions were taken for the individual identified deficiencies, it was taken on a unit by unit bases, but did not translate into analyzing and trending the data systemically or implementing plans of correction systemically. For example, if the same item(s) repeatedly occurred in multiple units it represented systemic problem(s) that should necessitate corrective action for the entire nursing staff. Unless a systemic approach is used to analyze and trend areas of deficiencies and implement consistent plans of correction for the entire nursing staff it will be impossible for the Nursing Department to evaluate the status of compliance with	

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		each of the Nursing Monitoring Tools, which is necessary for internal management, as well as to demonstrate compliance with the requirements of the Settlement Agreement. • The tabulations on the spreadsheets did not calculate the overall percentage of compliance for each monitoring tool. This is necessary to evaluate the overall compliance with each tool, which would provide further information to demonstrate the status of progress made toward accomplishing the projected goal of at least 80% for each tool audited. After review of the calculations on the monitoring data spreadsheets there appeared to be some misunderstanding as how to calculate the percentages of the "Yes", "No", "N/A", and total number of items monitored in each category of the respective tool audited. The "N/As" were calculated in the total number of items monitored, which skewed the actual percentage of the "Yes" and "No" responses. Only the "Yes" and "No" responses should be entered into the calculations. Because of the two concerns identified above, the Monitoring Team was unable to determine the degree of compliance met with the monitoring data. The Facility had not implemented a formalized and consistent process for establishing inter-rater reliability for the monitoring tools. From the questions regarding inter-rater reliability asked while the Monitoring Team was onsite, it was apparent the Nursing Administration and QA Nurses were unsure how to execute this process. The QA Nurses had begun completing inter-rater reliability checks but were struggling with the process as to how to represent their findings for comparison. The Monitoring Team explained the concept of inter-rater reliability checks; and how to compare the data derived from the initial audits to the ones completed by the QA Nurses. Once the explanation was provided the QA Nurse, she said she had a much better understanding of the inter-rater reliability concept and how to evaluate and compare the data sets. The Facility should develop a procedure for establishing inter-rater reliability to ensure that all disciplines are trained and execute the process consistently. This is essential to ensure that the Facility's data consistently and accurately reflects the quality of care provided, and to quickly identify problematic trends and implement timely plans of correction. The Facility as a whole had not yet developed and implemented a consistent system to present monitoring data for interpretation. The Facility should develop a unified system to present the data generated from the monitoring tools. A unified system for the presentation of data would allow all disciplines to easily review and interpret monitoring data from different disciplines and departments. The Nursing Department needs to continue to refine and finalize their monitoring	

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		management system. All aspects of the monitoring management plan need to be formalized into a written plan. It is essential that the nurse auditors completing the Nursing Monitoring Tools follow the tool's guidelines to ensure consistency among the auditors. When completing the audits the nurses must evaluate nursing practices using sound clinical judgment that reflects high quality nursing care. If an item listed on the monitoring tool was present but failed to reflect quality care it should be marked "no". Monitoring data needs to be analyzed and trended to represent a systemic approach to identifying deficiencies, so that systemic plans of correction action can be developed, implemented, followed through to resolution, and evaluated.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In response to the Monitoring Team's consistent past findings indicating significant problems regarding nursing's competency related to overall nursing assessment, the State developed and implemented a Physical Assessment Class, 3/2011, which also included additional instruction on documentation. This class was designed for all RN levels of nursing staff. The training program consisted of a day of classroom instruction, followed by a day of competency-based demonstrations of assessment skills, which the RN participants performed on each other. Additional competency-based demonstrations of assessment skills were to be conducted for quarterly assessments, a chronic condition follow-up, and an acute illness review and/or clinic follow-up. These demonstrated competencies would be completed with an individual assigned to the RN Case Manager's caseload, and would be supervised by the Nurse Practitioner trainers. Based on past review of the Physical Assessment Competency Guidelines for Evaluation (draft), the curriculum and training being provided was thorough and reflective of appropriate competency-based training for nursing assessment skills. From a discussion with the State Office Nursing Coordinator, once all RNs at State Supportive Living Centers had completed the training, LVNs also would be provided competency-based training on assessments in alignment with their licensure. Since the last review, it was positive to find that 36 RNs had completed the mandated Physical Assessment Class. The Monitoring Team reviewed a sample of Annual and Quarterly Comprehensive Nursing Assessments completed by the RNs since they had completed the Physical Assessment Class. The sample included Annual and Quarterly Comprehensive Nursing Assessments for Individuals #411, #361, #408, #81, and #149. A review of the completed Annual and Quarterly Comprehensive Nursing Assessments revealed the following findings; o Five of five (100%) were completed according to their respective PSP Schedule. o Four of five (80%) indicated that the assessment had been sent to the Qualified Mental Retardation Professional (QMRP). o Five of five (100%) had accurate BRADEN Scale assessments completed. o Four of five (80%) included the date on the back of the assessment for the	Noncompliance

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		date completed. o Four of five (80%) demonstrated some in improvement the quality and content of the completed Sections I through IX, with the most notable improvement made in the physical assessment of systems and the accompanying summary describing findings of the physical examination. o Three of five (60%) identified nursing problems in Section X related to active medical problems and/or risk factors. o None (0%) of the Section XI nursing summaries were adequately completed to effectively demonstrated individuals' heath status related to their identified nursing problems/diagnoses in terms of progress made toward the problems' established goals and objectives. Neither the effectiveness of Health Maintenance Plans (HMPs) nor any changes needed or made to the HMPs were summarized in a meaningful or useful way for the PST to use in measuring individuals health status progress annually and/or quarterly. The purpose of completing the Comprehensive Nursing Assessment is to identify health problems, establish goals and objectives to be attained through effective plans of care, and to complete meaningful and useful summaries stating individuals' health status for each identified problem at the time of their annual and quarterly PST meetings. o Two of five (40%) of Section IX's nursing summaries were not written in a coherent manner; the content of narrative was not organized and written for each identified problem. The other three nursing summaries were fragmented with the specific problems scattered throughout the narrative, making it difficult for the reader to tie the information together to evaluate individuals' health status progress in relation to identified problems. As had been identified in all previous reviews, the summaries continued to contain raw clinical data related to: Past and present listings of surgeries, illnesses and injuries, treatment modalities, testing and diagnostic results, consults, hospitalizations, emergency room, and sick call visits. Occasionally the effectiveness of the treatment modalities was mentioned and the outcome of the testing and/or diagnostic results reported. However, the overall impact of these issues on individuals' heath status for their identified problems was not summarized. The summaries described interventions and activities related to the plans of care for the identified problems but failed to summarize the effectiveness of the plans and individuals' response to the plans. • Individual specific problems identified in the review included: o Individual #361's most recent nursing assessment, 6/27/2011, had hyponatremia listed as an active medical problem. This problem was not listed on the nursing problem/diagnosis list nor was a HMP established for this problem. The cause of hyponatremia was not indicated in the nursing	

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		assessment. Regardless of the cause, hyponatremia is an active problem and requires monitoring by nursing. o The effectiveness of medications was not included on the assessment. Individual #361 received two anticonvulsant medications and their effectiveness and therapeutic response needed to be monitored. The nursing observation assessment related to meal monitoring stated, "fed self." This was an inadequate assessment for describing Individual #361's dining habits and amount of food intake. o Individual #411's most recent nursing assessment, 7/7/2011, reported a blood pressure of 86/59. This is far below a normal reading and the summary should have indicated whether this was Individual #411's usual baseline or if this was an abnormal measurement. In the Musculoskeletal assessment section, Individual #411's check box was marked that she had "no abnormal findings" in the upper and lower extremities; this was misleading. Individual #411 had bilateral contracture of the hands with tightening of the arms and legs; such that she could no longer stand to transfer and required the use of a wheelchair for ambulation. The Female-Gynecological Section noted that Individual #411 was menopausal. There were no dates listed for current and past Pap smear screenings. Because she was menopausal does not negate the need for routine Pap smear screenings. Neither was the status of her mammograms included. o Individual #411's Section X, nursing problems/diagnoses included relevant active medical problem/risk factors. However, the nursing problems were all listed together for: aging, seizure disorder, chronic renal disease, urinary tract infection, GERD, respiratory compromised, choking, aspiration, skin integrity, and psychoactive medication side effects were entered into a Homeostasis HMP, revised 6/20/2011. The use of a Homeostasis HMP to address these complex and high risk problems is grossly inadequate. Each of these problems requires an individual and comprehensive HMP if Individual #411 is to receive adequate nursing care. o Individual #408's recently completed Quarterly Nursing Assessment, 7/22/2011, Section X did not contain a list of nursing problems/diagnoses although there were numerous active medical problems/risk factors.. According to Section XI, nursing summary she had HMPs for PICA and Hypercholesterolemia. Although there was general narrative regarding the other problems listed above indicating they were being monitored, no other HMPs were in place. The summary stated, "Individual #408 *has had a very healthy quarter."* Such statements are meaningless without describing individuals' health status progress for each identified problem. The Section XI, nursing summary also stated, "*The main concern for*	

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		Individual #408 *for the coming year is weight control."* However there was no HMP for addressing Individual #408's over weight problem. This demonstrated a lack of attention to Individual #408's weight problem and the inherent risk factors associated with obesity. Individual #408's immunization status for the Hepatitis B Series was not documented on the assessment. Neither were the dates for current or past Pap smear screenings documented. Nor were baseline measurements for temperature, pulse and blood pressure documented. o Individual#81's most recently completed Annual Comprehensive Nursing Assessment, 7/22/2011, found all active medical problems/risk factors were identified in Section IX nursing problems/diagnoses list and had corresponding HMPs; with the exception of the problem Individual #81 was having with weight. Individual #81's weight falls just below the lower limit of his desired weigh range. However, Individual #81's problem with weight was not included in the nursing problems/diagnosis list and in the nursing summary. This demonstrated a lack of attention to Individual #81's weight problem and the inherent risk factors associated with being under weight. Individual #81's Section XI, nursing summary was organized by nursing problems/diagnoses and a narrative summary was written for each. This was an improvement in organization of the summary. However, the summary contained raw clinical data and care plan interventions and activities to address the identified problems but failed to summarize Individual #81's health status progress in relation to the identified problems. From a review of the summary it was not possible to determine Individual #81's health status related to any one of the identified problems. The overall assessments reviewed had not demonstrated significant improvement, particularly in the area of analyzing clinical data derived from assessments and writing useful and meaningful nursing summaries. There was no consistent format used for writing the summaries and the format varied from RN Case Manager to RN Case Manager. The Nursing Department should pick one consistent format to use for writing the Comprehensive Nursing Assessment, Section XI nursing summaries to ensure continuity for the nurse to write and for the readers to understand. It was apparent the RN Case Managers were struggling with this issue. The RN Case Managers who completed the above assessments had just completed the Physical Assessment Class and had not had time to fully integrate and put into practice their newly acquired skills and knowledge. The competency-based training is essential to the forward movement towards compliance with the Settlement Agreement previsions related to nursing clinical practices.	

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		Since the last review, there were four new admissions of individuals under 18 years of age: Admission/Initial Comprehensive Nursing Assessments were reviewed for Individuals #381, #479, #511 and #590. The review revealed the following findings: • Four of four (100%) had Admission/Initial Comprehensive Nursing Assessments completed within 30 days of admission. • Four of four (100%) had At Risks assessments completed. • Individual #381 was admitted on 5/2/2011; and the Admission/Initial Comprehensive Nursing Assessment was completed on 5/23/2011. At the time of admission she was receiving multiple psychoactive medications, which were continued with some adjustments. She was assessed at medium risk for polypharmacy and challenging behaviors. However, a HMP for psychoactive medications was not implemented until 7/12/2011. There was no home leader signature on the HMP to validate that the direct care professionals had been trained on the plan. • Individual #590, a female adolescent with a diagnosis of Vitamin D Deficiency was identified as low risk for osteoporosis and fracture. The risk level should have been at least medium. Vitamin D deficiencies place adolescent girls at great risk, because their bones are still developing; the individual had a HMP for Vitamin D Deficiency. Although the At Risk Guidelines may have indicated that Individual #590 was at low risk for osteoporosis and factures, the PST should have exercised critical thinking in determining her risk levels for these problems; and taken in to consideration the potential long term impact the Vitamin D Deficiency could have on a developing adolescent female. • Individual #511 had active medical problems for constipation, PICA and was determined at medium risk for choking, weight (under), constipation, and fracture. The nursing staff did not have HMPs for constipation and choking. Individual #511 was receiving psychoactive medications, while he was assessed for low risk related to psychotropic medications, the fact that this was a new admission, a HMP for monitoring psychoactive medications should have been implemented, particularly to train the direct care professionals on side effects of psychoactive medication. The Annual and Quarterly Comprehensive Nursing Assessments were reviewed for the past year for 19 individuals: Individuals #191, #24, #83, #66, #576, #303, #163, #38, #392, #270, #165, #412, #422, #69, #96, #557, #59, #291, and #554. The review revealed the following information: • Nineteen of 19 (100%) had an Annual and Quarterly Comprehensive Assessment completed according to their PSP schedule. • Nineteen of 19 (100%) Annual and Quarterly Comprehensive Assessments were completed by the RN Case Manager.	

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		• Thirteen of 19 (63%) were identified for high risk for one or more risk factors. Refer to M.3 for HMPs related to high risk factors. There continued to be a significant lack of clinical assessments from the critical clinical health indicators, a lack of timely and appropriate follow-up on unresolved issues, a lack of an analysis of health and/mental issues, and a lack of critical thinking found in all nursing assessments review. The nursing summaries continued to contain raw clinical data as described above, with no associated analysis of clinical data indicating whether the individuals' health status was improving or regressing. Since only a limited number of RNs had completed the Physical Assessment Class, RNs who had not yet taken this class, would not be expected to show significant improvement in the quality and adequacy of the Annual and Quarterly Comprehensive Assessments reviewed above. This is a mandated class for which all RNs will take the class according to the Facility's schedule. The State's efforts in implementing the competency-based training program for nursing assessment and documentation skills should result in improvements in the documentation of nursing assessments and summaries. By the time of the next Monitoring Team review, most if not all, of the RNs should have completed the Physical Assessment Class, with additional instruction on documentation; and should have had enough time to fully integrate their newly acquired knowledge and skills into clinical practice. At the next review the Monitoring Team should find significant improvements in the assessments and analysis of clinical data in the nursing summaries. The State Comprehensive Nursing Assessment Form, in the Genitourinary Section for Female-Gynecological assessment, does not include an item for documenting mammography screenings. This is an important preventive screening that is not being assessed. The State and/or Facility should consider revising the Comprehensive Nursing Assessment form to include Genitourinary Section for Female-Gynecological mammography screenings. A review of the Community Living Discharge Plan (CLDP) for Individual #102 found the plan was inadequate regarding nursing and medical involvement. There was essentially no or little information contained in the CLDP that would guide the community staff in providing the needed nursing or medical care. The review identified two significant health concerns that were not adequately addressed in the CLDP related to frequent falls, often resulting in injuries, and weight fluctuations. Individual #102's issues related to frequent falls and weight fluctuations should be thoroughly evaluated for underlying causes before he is discharged to the community; and the CLDP revised to reflect any changes resulting from the evaluations. The lack of quality documentation regarding the nursing discharge summary developed for CLDP indicated the Facility did not have an adequate and consistent procedure	

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		regarding the requirements for nursing assessment and documentation. The Facility should review and revise its current CLDP nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is adequate to maintain continuity of care in the community. Refer to T.1b for additional information. , The Facility's POI indicated that it was not in substantial compliance with this provision. The Monitoring Teams concurs.	
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.	A sample of HMPs and Acute Care Plans (ACP) for individuals' whose Annual and Quarterly Comprehensive Nursing Assessments were reviewed in Section M.2., including Individuals #191, #24, #83, #66, #576, #303, #163, #38, #392, #270, #165, #421, #422, #68, #96, #557, #59, #291, and #554. The 19 individuals' At Risk Assessments were reviewed to identify those with high risk ratings, and then the high risk levels were cross-checked to determine if HMPs had been implemented for the corresponding high risk ratings. The review revealed the following findings: • Six of 19 (32%) were assessed for risk and were not identified as having any high risk factors. • Thirteen of 19 (68%) had one or more high risk ratings. • Eleven of 19(58%) had a HMP for one or more high risk ratings. Consistent with past reviews, the HMPs reviewed continue to lack any individual specific interventions based on the individuals' needs, and did not provide adequate direction for caring for the individuals who where identified as being at risk related to heath/mental health issues. In addition, the nursing interventions contained in the HMPS failed to include proactive interventions directed at preventing or minimizing the specific health risk. For each risk factor that was designated at high risk for the Individuals listed above, such as, seizures, osteoporosis, weight issues, aspiration, falls, fractures, cardiac issues, and GI problems, HMPs were essentially the identical protocol for each individual, with only difference being the individuals' baseline data. In order for the Facility's HMPs to be appropriate and clinically adequate, the Health Care Protocols/Nursing Care Plans have to be individualized to meet the individuals' needs, with measurable goals, specific nursing interventions that include proactive interventions, and identification of who will be implementing the action, how often it will be implemented, where it will be documented, and frequency of effectiveness when the interventions will be reviewed, and by whom. In addition, as required by Sections F and G of the Settlement Agreement, collaboration with other disciplines regarding care plans	Noncompliance

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		should occur so that an integrated team approach is used consistently, and interventions from other disciplines are integrated into all health management plans. It was positive to find, since the past reviews, that the HMPs and ACPs consistently contained the signatures of the Home Leaders on the plans validating that the direct care professionals had been trained on the plans, as were the Training Rosters signed by the direct care professionals. Occasionally the Training Rosters did not include the name of the specific plan. Direct care professionals were interviewed regarding individuals' #270, #191, and #163 health care plans. All three direct care professionals were able to verbalize their responsibilities for these individuals' care. Two of the three direct care professionals showed the Monitoring Team the Pink Care Plan Book. One direct care staff could not locate the book but was able to verbalize the required care. When asked how she would know what care was needed, she explained that the nurse had provided her with training on the plans. The RN Case Manager located the missing Pink Care Plan Book, which had been moved from its usual location. In addition, the RN Case Managers had begun developing and implementing a training sheet specific to the individuals' plans for the direct care professionals.	
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.	The BSSLC POI reported they had met substantial compliance with this provision. The Monitoring Team concurs. Since the last review, all of the State core nursing policies, procedures, processes, and protocols were finalized and issued to the State Supported Living Centers (SSLC). The Nursing Department's had also finalized core nursing policies, procedures, processes, and protocols specific to the Facility. Through interview with Nursing Administration and review of State and Facility nursing policies, procedures, processes, and protocols the Monitoring Team was able to validate that they were completed. Interview with the Nurse Educator and review of the comprehensive Nursing Training Log and supporting documentation, e.g., training and competency-based testing material used to for training the nursing staff on the core nursing policies, procedures, processes, and training rosters, the Monitoring Team was able to validate that 100% of the nursing staff had been trained at the time of the review and all of the policies, procedures, and processes had been fully implemented. This was a positive finding; it was apparent that the Nurse Educator was dedicated and competent in ensuring that the nursing staff received all required training. She had established an exemplary system for recording, tracking, and maintaining documentation on all required nursing training. Because of the meticulous recordkeeping and tracking system the Nurse Educator maintained, she was consistently able to determine the status of the required training for all nurses; and could identify at any point the percentage of nurses trained, as well as nurses delinquent on a particular topic. In addition, through review of the tracking system the Monitoring Team was able	Substantial Compliance

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		to validate that 100% of the nursing staff had received Annual Nursing Competency Training. The State-wide Nurse Educator Workgroup's Nursing Education Handbook Manual was finalized, 5/2011, and issued to the Facility for implementation in 9/2011. The Nurse Educator had begun using the training manual with each new Nursing Orientation Class. The Monitoring Team found the training manual impressive and comprehensive with established course objectives, lesson plans, and competency-base tests for all topics. This should significantly improve the quality of the nursing orientation training and continuing education. Since the training curriculum was developed by a State-wide group of Nurse Educators the training should bring about continuity in nursing practices throughout the State Supported Living Centers (SSLC). The implementation of a state-wide standardized training curriculum for training SSLC nursing staff was a positive finding. It was also positive to find that 36 of the Facility RNs had successfully completed the State mandated Physical Assessment Class, taught by Advance Practice Nurses. When all RNs have completed this required class, it should further improve the quality of nursing assessment and care plan practices at the Facility, as well as state-wide. Discussions with the CNE, Nurse Educator and State Office Nursing Coordinator indicated that plans are under way to develop a training curriculum for the direct care professionals on how to recognized, respond and report changes in individuals health status related to signs and symptoms of common acute illnesses and injuries. This training is much needed by the direct care professionals because they are the support staff who are most likely to be the first to recognize changes in individuals' health status and need to know how to recognize, respond, and report. The Monitoring Team will follow-up on the development of this training curriculum at the next review. The State Office Nursing Coordinator explained that a Medication Variance Policy was in draft. The policy will be an integrated approach and will include all disciplines responsible for medication administration and management. When this policy is finalized it should enhance all aspects of the Facility's medication management practices. The Monitoring Team will monitor the nursing policies, procedures processes, and protocols for compliance, e.g., how well they are implemented, followed, and their effectiveness, through review of the other Section M provisions; as well as through review of the other Sections of the Settlement Agreement that have a nursing component relative to these nursing policies, procedures, and processes.	
M5	Commencing within six months of	The BSSLC POI reported they had not met substantial compliance with this provision.	Noncompliance

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	the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Monitoring Team concurs. Since the last review, the Facility continued to report in the POI that all required staff had been trained on the At Risk Individual Policy. Individuals' level of risk were continuing to be assessed using the Risk Guidelines, which contained criteria to serve as a guide to assist the Personal Support Teams (PSTs) in determining appropriate risk levels for designated risk categories. The review of risk and the assignment of risk levels were occurring during the PST meeting. The RN Case Managers, in conjunction with the physicians, continued to be responsible for assessing risk factors in the following categories: • Aspiration • Respiratory Compromise • Cardiac Disease • Circulatory • Constipation/Bowel Obstruction • Diabetes • Gastrointestinal (GI) Problems • Osteoporosis • Seizures • Infections • Fractures • Fluid Imbalance • Hypothermia • Urinary Tract Infections To assess the Facility's risk screening process member of the Monitoring Team observed two individuals' (Individuals #26 and #181) special risk meetings to review their risk level while on site. Overall, the Team Members observed improvement since the last review. There was more clinical discussion, some degree of critical thinking exercised, and more use of supporting clinical data than had been observed at past risk meetings. It was positive that the individuals' entire teams were present and participated in the meetings. Having the entire team present and actively participating is essential a to accurately identifying individuals' risk factors and assigning risk levels, and in developing an appropriate and integrated Risk Action Plan for each identified risk factor with a score of high or medium. Refer to Provision I.1 for more information regarding the Monitoring Team's observations. The Monitoring Team reviewed the most recent Personal Support Plans and Personal Support Plan Addendums (PSPAs), Risk Levels, and Risk Actions Plans of Individuals	

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		#86, #52, #42, #303, #545, and #470. The review found that none (0%) of the records reviewed met compliance with the At Risk and/or PSP Policies' criteria. Review findings included: • Six of six (100%) contained risk conditions identified. • Four of six (67%) identified a change of status since the last visit. • Two of six (33%) contained assessment process started within five days of the change in status. Two of six (33%) did not have the assessment process started within five days of the change in status. For two of six (33%) there were no changes in status. • One of six (17%) contained a comprehensive interdisciplinary assessments. • Three of six (50%) assessments were adequate to support the risk level determinations. • Three of six (50%) assessments helped the Risk Action Plans to address risks. • Three of six (50%) contained the dates that Risk Action Plans were approved. • Three of the six (50%) verified Risk Action Plans were implemented within 14 days of approval. • Four of the six (67%) Risk Action Plans met the needs identified by the interdisciplinary assessments. • Three of six (50%) Risk Action Plans included preventative interventions to minimize the conditions of risk. • One of six (17%) contained the Risk Action Plans integrated into the PSPs. • Two of six (33%) contained documentation in the PSPAs or new PSP. • Three of six (50%) of the Risk Action Plans showed integration among all appropriate disciplines. • Two of six (33%) contained changes made in all relevant supports and services related to the risks. • One of six (17%) contained appropriate functional and measurable objectives incorporated into the PSPs to measure the efficacy of the plans. • Two of six (33%) identified appropriate clinical indicators to be monitored and the frequency of monitoring. It is essential that each discipline responsible for their respective risk categories thoroughly complete an assessment of individuals' mental and medical health as well as behavior status though collaboration with other relevant disciplines, including interviews with the individuals' direct care professionals, and a thoroughly review clinical records prior to completing their portion of the risk assessment to bring to the PST meetings so that risk factors are accurately identified. Since the RN Case Managers typically take the lead on completing the medical/health related risk categories, it is essential that they corroborate their risk assessment findings with individuals' physicians prior to the PST meetings to ensure that all medical/health related risk	

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		factors are identified; and that the risk levels are accurately scored. Refer to Provisions O.2 and O.6 regarding nursing's response to monitoring Aspiration Trigger Sheets and inadequate response when "triggers" were documented on the sheets and/or when nursing observed triggers. The issue regarding the nursing's responsibilities for monitoring Aspiration Triggers Sheets was discussed with the CNE who agreed to investigate the situation and to follow-up with corrective action as appropriate. The Nursing Department should conduct "spot checks" on the Aspiration Trigger Sheets to evaluate the nursing staff competency in complying with their required monitoring activities and follow-up on identified triggers. Nursing staff failing to meet compliance should be retrained and monitored until competency is achieved. Establishing a competent and reliable At-Risk system is essential in ensuring that those individuals who warrant the most clinical intensity are appropriately identified and provided appropriate care related to identified risk factor levels. Refer to Provisions M.2 and M.3 for additional information related to nursing assessments of risks and health care plans. In order for the Nursing Department to meet compliance with this provision, the Nurse Managers, RN Case Managers, and other relevant nursing staff must consistently meet all criteria contained in the At Individual Risk Policy and associated documents, including monitoring Aspiration Trigger Sheets daily on every shift and responding appropriately when "triggers" are identified.	
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	Since the last review, it was apparent that the Nursing Department had put forth significant effort to achieve substantial compliance with this provision. Although the Facility assessed this provision as in compliance, the Monitoring Team does not concur but does commend the Facility and Nursing Department for significant progress on the requirements of this provision and on approaching substantial compliance. The Monitoring Team conducted its review for substantial compliance with this provision through interviews with nursing staff, observations, document review, and attendance at the Medication Error Committee and Pharmacy and Therapeutic Committee meeting while on site. A review of the Nursing Training Tracking Log and related training documents found evidence that 100% of the nursing staff had received competency-based training on the Medication Administration Guidelines. Since the last review, the Nursing Department had continued to strengthen and to improve their quarterly Medication Administration Observations Guidelines. A revised	Substantial Compliance

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	care with regard to this provision in a separate monitoring plan.	procedure was to be implemented in August 2011. Significant changes from the Facility's previous procedure included: Observations will be completed on the State adopted Medication Observation form, revised 7/25/2011. The revised form combined the previous Medication Administration (for oral medications) Observation form and the Enteral Feeding/Administration Observation form. The observers must watch 16-20 doses of medication administered to individual or observe 100% samples of the individual receiving medication at the time of the observation, whichever number is smaller. The Nursing Managers and/or RN Case Managers continued to consistently complete quarterly Medication Administration Observations for both oral and enteral routes of medication administration. The QA Nurses completed up to 10 monthly inter-rater reliability Medication Administration Observations for both oral and enteral routes of medication administration. The QA Nurses also conducted quarterly performance observations on Nurse Managers as they completed Medication Administration Observations. The NOO or designee performed performance observations on the Shift Managers as they completed Medication Administration Observations. From the Monitoring Team's review of the Medication Administration Observation data completed over the past six months, by the nursing administrative and nursing management staff and the QA Nurses, there was evidence that when the nurses' failed to follow correct medication administration practices, the observer took "on the spot" corrective action. If the "on the spot" corrective action was not effective, the observers referred those nurses for Medication Administration retraining. All completed Medication Administration Observations sheets were submitted to the NOO for review and analysis. The results of the NOO's findings from the observation sheets were presented at the Medication Error Committee and Pharmacy and Therapeutic Committee meeting for further review and corrective action when warranted. A review of the submitted raw quarterly Medication Administration Observation Sheets for oral and enteral medication administration, completed by nursing administration/management staff on nurses for each residential living unit, and the cottages identified no deficiencies. A review of the MAR, Medication Room Checklist and Medication, Quarter Report: April, May, and June reported the following findings: • A total of 63 Medication Administration Observations (no distinction was made between oral and enteral administration) were completed by Nurse Manager/Designees and some randomly completed by Shift Nurse Managers. Of the 63 observations, all were reported to be 100% compliant with no retraining or prompting required.	

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		• A total of 11 Medication Administration Observations were made for oral administration by the QA Nurses. The following observations were made: o One of 11 (9%) required prompting in the area of removing medication from the packages without cross contamination. o One of 11 (9%) had problems with hand washing. o One of 11 (9%) prepared medication before it was ready to be administered. o Two of 11 (18%) did not identify by individual by name, what drug and purpose. o One of 11 (9%) did not identify the individual by name. o Two of 11 (18%) did not initial the MAR before going to the next individual. "On the spot" retraining was provided by QA Nurses to the nurses who failed to meet the criteria identified above. Overall there was an 88% compliance with the 11 observations completed. In order for the inter-rater reliability data to have confidence there must be at least an 80% or greater agreement between the two set of raters. In comparing the of the nursing staffs' medication administration observation data to the QA Nurses data this condition was met. The Nursing Department's overall goal of meeting at least 80% on the Medication Administration Observation audit tool was met through the validation of inter-rater reliability checks. • A total of 35 Enteral Feeding/Enteral Medication Administration Observation were completed by the QA Nurses. The following observations were made: o Three of 35 (9%) did not assess bowel sound. o One of 35 (3%) did not check placement by auscultation. o Three of 35 (9%) required prompting to check for tube placement. o Two of 35 (6%) required prompting to flush before and after medication administration. "On the spot" retraining was provided by QA Nurses to the nurses who failed to meet the criteria identified above. Overall there was a 94% compliance with the 35 observations completed by the Quality Assurance Nurses. In this situation the Nursing Department's goal of meeting at least 80% compliance with the Enteral/Feeding Medication Administration Observation audit tool was met through the validation of inter-rater reliability checks. MAR Audit: A total of 19 MAR audits were completed for the quarter of April, May, and June by the QA Nurses. The Nurse Managers no longer audit this item. The following issues were identified: • Fourteen of 15 (93%) MARs did not the have follow-up on documentation on the back of the MARs explaining the reason and the effectiveness of per necessary	

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		medications (PRNs) and/or an explanation for omitted medications. (This item had a different sample size from the total number identified by the QA Nurses.) • Fourteen of 19 (74%) MARs did not have initialed documentation on the back of the MAR. • For eight of 19 (42%) MARs did not match the Physician's Order for new or changed medications. • 19 of 19 (100%) MARs had missing nursing signatures identifying the nurses who were administering medications. • 10 of 19 (53%) MARs did not have verification that the Nurse Manager had checked the MARs for signatures. Some of the mathematical computations were found incorrect. The percentages represented in the report were corrected by the Monitoring Team. As a result of the corrections the MARs' an overall compliance was met by only 29%, falling far short of the Facility's desired goal of attaining at least 80% compliance. Medication Room Audits: A total of 15 Medication Room audits were completed for the quarter of April, May, and June by the QA Nurse. The Nurse Managers no longer audit this item. The following issues were identified: • Seven of 15 (47%) of the food items used for individuals were not labeled with the date, time, and initial of the nurses when opened. • Six of 19 (32%) opened containers were not labeled with the date, time, and initial of the nurses when opened. (This item had a different sample size from the total number identified by the QA Nurses.) <u>Medication Cart</u>: 1. Thirteen of 15 (87%) opened containers were not labeled with the date, time, and initial of the nurses when opened. 2. 15 of 15 (100%) of the control substance counts were not signed or cosigned. <u>Refrigerator /Freezer:</u> 1. Seven of eight (88%) did not have temperatures recorded daily and temperature was not maintained at 36 – 46 degrees. <u>Equipment Checks:</u> 2. Eleven of the 15 (73%) of the glucometers were not checked according to Facility policy. Overall 32% compliance was met with the Medication Room audits, falling far short of the desired goal of reaching at least 80% compliance. The Monitoring Team corrected the mathematical errors found in the MAR and Medication Rooms Audits for computing the percentages of noncompliance. The staff calculating the percentage for noncompliance should ensure that they use the correct	

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		mathematical formula for the computations. Otherwise, erroneous conclusions may be drawn regarding the data leading to faulty decision making; resulting in poor outcomes or incorrect plans of correction. A review of the Medication Error Committee's Minutes for June and July indicated that the deficiencies identified in the MAR and Medication Room Audits, for the quarter of March, April, and May, were discussed at the committee meetings and the plans of correction were put in place and implemented for the items found deficient. This process appears to have potential to reduce deficiencies and bring the Facility into compliance with this provision in the near future. The Monitoring Team completed Medication Administration Observations on Driscoll D at the 4:00 p.m. medication pass for Individuals: #437, #91, and #53. The purpose of the observations was twofold, to observe the Shift Nurse Manager while she observed the medication pass, as well as to observe the nurse administering the medications. Prior to observing the medication pass, the Monitoring Team interviewed the nurse administering medications who was asked to explain medication administration procedures. The nurse was able to successfully verbalize each step of the medication administration procedure, including the procedure for administering enteral medications. The three individuals observed were administered medications enterally. All individuals were provided privacy in an empty room and received medication while sitting upright in their wheelchairs. PNMPs were present and contained instructions for medication administration in each individual's Medication Administration Record. The nurse administering the medication demonstrated competency in all medication administration practices except two questions on the observation form: stoma sites were not assessed and care provide to the stoma prior to administering medications. The nurse explained that stoma assessments and care was performed after individuals' bath on the 2-10 shift. The Shift Nurse Manager accepted this explanation. The Shift Nurse Manager should have retrained the nurse to assess the stoma sites and provide care at each medication pass according to standard practices for enteral medication administration. The Shift Nurse Manager did score these two questions "no" on the observation sheets. The overall percentage of compliance for the three Medication Administration Observations was 95%. The two questions related to stoma assessment and care on the State Medication Administration Observation Form, revised, 7/25/11, appeared to be misleading. Example: The G-tube Section, question #7 stated, "Was stoma care assessed?" Question #8, stated, "Was stoma care provided?" Question #7 might be more accurately interpreted by the observers if it was rephrased to read, "Did the nurse assess the stoma site prior to administering medication?" The same is true for #8, which could be	

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		rephrased to read, "Did the nurse provide stoma care after assessment and prior to administering medications?" Nursing Administration and/or Management staff, and QA Nurses should review the State Medication Administration Observation Form regarding the G-tube Section's questions #7 and #8, related to stoma assessments and care prior the medication administration; to ensure that the questions are correctly interpreted by the observers. The Nursing Department had an exemplary Medication Error Database for tracking, analyzing, trending, and reporting medication error data. The database uses a root cause analysis approach. Reporting medication error data included: Severity Index, contributing/causative factors; type of medication errors; number of medication errors committed for each type of error; identification of staff committing the medication errors; dates and time; medication errors were committed and discovered; name of medications for which errors were committed, individuals on which the medication errors were committed, location where the medication errors occurred; and the rate of the total number of doses of medications administered in each living unit and the cottages. Medication error data were tracked, analyzed, and trended monthly for each living unit and the cottages as well as campus-wide. Medication error data were represented in tabular and graphic forms. The findings of the medication error trend data and plans of correction were presented and discussed at the monthly Medication Error Committee and quarterly Pharmacy and Therapeutic Committee Meetings. The disposition of Medication Administration data and plans of correction were reflected in committee meeting minutes. This was validated through the Monitoring Team's review of the Monthly Medication Error Committee Minutes and Quarterly Pharmacy and Therapeutic Committee Minutes. Attendance at these meetings while on site, found that the medication errors data and plans of correction were consistently reviewed and discussed, and when indicated additional recommendations were made for improvement. At the Pharmacy and Therapeutic Committee Meeting the Monitoring Team attended during the last review, physicians' expressed concern over medication errors related to psychoactive medications. At the meeting it was decided that the QA Nurses would identify individuals who missed doses of psychoactive medications, including seizure medicine, and follow-up to see if there was an increase in break through maladaptive behaviors or seizure activity. The QA Nurse had researched this issue over the past two quarters. Individuals' were identified for whom three or more psychoactive medication errors had been committed during the quarter. A retrospective record audit was performed on the identified individual to evaluate if there was a correlation with the medication error and the increase of maladaptive behaviors, increase of seizure activity,	

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		or other adverse changes. The QA Nurse reported there was no identifiable correlation found with psychoactive medication errors and increased incidents of maladaptive behaviors, seizures, or other adverse changes. The QA Nurse also reported this information at the Medication Error Committee, 7/27/2011. The fact that the QA Nurse researched this issue was a positive finding, demonstrating how clinical data can be used to prove or disprove heath care issues of concerns, as well as demonstrate integrated collaboration with other disciplines. The medication error data consisted primarily of nursing's reporting of errors related to medication administration, as required by the State adopted Medication Administration Guidelines. Although there were some medications errors attributed to pharmacy and physicians reported, these disciplines did not have a formalized system in place to collect, track, analyze, and trend medication error/variance data. Neither the State nor the Facility had an integrated Medication Variance policy that included all disciplines' medication errors/variances. A medication variance program is more comprehensive than just the reporting of medication errors. A functional, meaningful medication variance program involves an organized structure that consists of all relevant professionals, including nursing, pharmacy and physician services. Because of their central role and ability to closely monitor medications, the Pharmacy Department generally is responsible for a medication variance program. A medication variance program must include the following areas: • Storage and handling variance – such as security, temperature, humidity, expiration dates. • Dispensing variances. • Prescribing variances – including non-legible/non-complete scripts. • Administration variance. • Some medication variance programs also include failure to appropriately monitor for side effects and other adverse reactions. This was discussed with the State Office Nursing Coordinator who explained that the State Office had drafted a Medication Variance Policy that was under review by other disciplines and the Policy Management Office. There was not indication as to when this policy might be finalized and implemented. The Pharmacy continued to send medications that required nurses to split the tablet in order to give the correct dosage. Split tablets are often unequal and a substantial amount of the tablet can be lost during splitting, which can lead to inaccurate dosing and ineffective medical management. There can be a narrow margin between therapeutic and toxic doses in some medications. The ability to precisely split the pill can be difficult when the nurse attempts to split the pill in the bubble package, and if the pill is removed and a pill cutter used, there is the risk of cross-contamination. If pills must be split	

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		because the prescribed dose formulation was not manufactured or the State's formulary restricts the lower-dose, pills should be split the in the Pharmacy, then repackaged and labeled before dispensing them to the unit. The practice of nursing staff splitting pills was discussed with the State Office Nursing Coordination who will follow-up with the State Office Pharmacy Coordinator. A review of the Facility's Medication Error Reports for the past six months reported the following medication errors: • January – 74 total errors; of which 65 or 88% were omissions, 3% wrong drug; 5% wrong dose; and 4% extra dose. • February – 56 total errors; of which 43 or 76% were omissions; 4% wrong drug; 13% wrong dose; and 7% extra dose. • March – 55 total errors; of which 40 or 80% were omissions; 2% wrong drug; 10% wrong dose; 4% wrong time; and 4% extra dose. • April – 55 total errors; of which 46 or 83% were omissions; 13% wrong dose; 2% wrong time; 2% extra dose. • May – 50 total errors; of which 41 or 82% were omission; 6% wrong drug; 8% wrong dose; and 4% extra dose. • June – 45 total errors; of which 39 or 87% were omissions; 2% wrong drug; 9% wrong dose; and 2% wrong individual. A review of the of Medication Error Committee's past quarter's (April, May, and June) analysis of medication error contributing factors reported that performance deficits attributed to 56% of the errors, agency staff were responsible for 31% of the errors, and distractions were responsible for 13% of the errors. Based on these findings the Nursing Department had implemented plans of correction to further reduce the occurrence of medication errors. The Plans of correction included: • Providing the agency nurses with the total competency-based New Nurse Orientation Training. • Assignment of a dedicated Shift Nurse Manager to oversee the agency nurses, to ensure that agency nurses received a competent orientation and follow-up on performance issues, to maintain personnel files on agency nurses on site; and to coordinate nursing services and scheduling with the agency management. • The Medication Administration Observation Guidelines were revised to strengthen and improve the competency of the nurses conducting quarterly Medication Administration Observations. • The QA Nurses were assigned to conduct monthly inter-rater reliability checks. There there had been measurable improvements in all aspects of the Nursing Department's medication administration and management practices. It was positive to	

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		find that over the past six months the Nursing Department had progressively decreased the total number of monthly medication errors from 74 to 45 or by 61%. The reduction in the occurrence can be attributed to the concerted effort put forth by the Nursing Department to improve medication administration practices. The Monitoring Team was, however, concerned as to whether adequate progress had been made to justify a rating of substantial compliance due to the findings from the most recent quarterly report, e.g., MAR Audit, Medication Room Checklist, and Medication Administration Observation – Quarter Report April, May, and June. The audits for the MAR and Medication Room Checklist indicated that the Facility fell significantly short of compliance in these two critical areas of medication administration practices; however, the Facility had a process in place that identified this and took effective action. The Facility's POI self-assessment found Section M.6 in substantial compliance and the Monitoring Team concurs.	

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

1. As the Nursing Department refines and finalizes their monitoring management system plan, all procedures and processes need to be formalized into a written plan that addresses all aspects of the monitoring system. (Provision M.1)
2. The Facility should provide the Infection Control Nurses additional technical assistance in order to achieve and maintain an efficient and effective Infection Control Program in alignment with standard Infection Control practices. (Provision M.1)
3. The Facility needs to analyze and trend drill and Code Blue data, to identify individual staff, specific units/areas, as well as systemic deficiencies in order to take appropriate corrective actions and use tracking logs to track recommendations and corrective actions.
4. The Mock Medical Emergency Drill template needs to add a space to indicate if the drill was a "Pass" or "Fail" and add the Medical Services phone number.
5. The Mock Medical Emergency Drills need to simulate resuscitation efforts as close to real time as possible. All emergency equipment needs to be brought to the scene. The equipment should be assembled for ready use so that the staff knows how to use and operate the equipment and ensure that it is in good working order.
6. The Facility needs to ensure that all staff identified as delinquent in CPR: Basic Training are retrained as soon as possible.
7. The Nursing Department should pick one consistent format to use for writing the Comprehensive Nursing Assessment, Section XI nursing summaries to ensure continuity for the nurse to write and for the readers to understand. (Provision M.2)
8. The Facility should review and revise its current CLDP nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is adequate to maintain continuity of care in the community. (Provision M.2)
9. The RN Case Managers typically take the lead on completing the medical/health related risk categories, and it is essential that they corroborate their risk assessment findings with individuals' physicians prior to the PST meetings to ensure the all medical/health related risk factors are identified; and that the risk levels are accurately scored. (Provision M.5)
10. The Nursing Department should conduct "spot checks" on the Aspiration Trigger Sheets to evaluate the nursing staff competency in complying with their required monitoring activities and follow-up on identified triggers. Nursing staff failing to meet compliance should be retrained and monitored until competency is achieved. (Provision M.5)

11. Nursing Administration and/or Management staff, and QA Nurses should review the State Medication Administration Observation Form regarding the G-tube Section's questions #7 and #8, related to stoma assessments and care prior the medication administration; to ensure that the questions are correctly interpreted by the observers. (Provision M.6)

The following are offered as additional suggestions to the Facility:

1. The Facility should weight the cost benefits of utilizing a clerical level staff for entering infection control data against the use of RN level Infection Control Nurses. (Provision M.1)
2. The State and/or Facility should consider revising the Comprehensive Nursing Assessment form to include Genitourinary Section for Female-Gynecological mammography screenings. (Provision M.2)

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 (POI) 7/12/11 2. Adverse Drug Reaction Identification & Reporting Process (Local Process), Draft dated June 9, 2011 3. DADS Policy (011) Pharmacy Services and Safe Medication Practices, dated 08/31/09 4. Completed Medication Adverse Drug Reaction Reporting Forms for Individuals #154, #255, #97, #253, #440, #591, and #253 5. Severity Index of Medication errors 6. Copy of medication variance log since the last compliance visit 7. Nursing medication error scale 8. Medication Administration Variance data base (reviewed at Facility) 9. Single Patient Intervention Reports for Individuals #89 (7/15/11), #332 (7/14/11), and #332 (7/12/11) 10. Facility's Plan of Improvement, dated July 12, 2011 11. Medication Error Committee Meeting Minutes from June 29, 2011 12. Psychotropic Medication Oversight Committee Meeting Minutes from January through June of 2011 **People Interviewed:** 1. Joseph Williams, R. Ph, Pharmacy Director **2.** Tray Knittel, PharmD, R.Ph **3. Meeting Attended/Observations:** None
	Facility Self-Assessment: In the POI (which served as the Facility's self-assessment), the Facility described not only its rating of compliance but also the actions taken to make progress toward compliance. N.1. The Facility reported that it was in substantial compliance with Provision N.1, of the Settlement Agreement. The Facility reported that they began to complete Intervention Reports via WORx software, and that they printout monographs of potential drug interactions of all severity levels, to aid pharmacists in their review and making recommendations. Physicians are now to document their clinical plans on

	completed Intervention reports. The Monitoring Team did not concur with the Facility's assessment. N.2. The Facility reported substantial compliance with Provision N.2, of the Settlement Agreement. The Clinical Pharmacist reported that they review all labs, nursing assessments, annual medical review, active problem list, psychiatric reviews, and occupational and physical therapy assessments, for each Quarterly Drug Regimen Review (QDRR). The Monitoring Team did not concur with the Facility's assessment. N.3. The Facility Reported that they remain non-compliant with Provision N.3, of the Settlement Agreement. They reported further progress with their Psychoactive Medication Oversight Committee process and are developing a database to monitor the use of STAT medications, benzodiazapines, and anticholigergics. The Facility has made significant improvement of the monitoring for metabolic syndrome through the QDRR process. N.4. The Facility reported substantial compliance for Provision N.4, of the Settlement Agreement. No additional enhancements were reported for this review. N.5. The Facility reported substantial compliance with Provision N.5, of the Settlement Agreement. They reported that since the previous review, all MOSES and/or DISCUS assessments were reviewed during the QDRR process, to ensure that they are up-to-date. The Monitoring Team did not concur with the Facility's assessment. N.6. The Facility developed a workgroup on March 1, 2011 to discuss staff training on adverse drug reactions (ADRs) and full implementation of the committee occurred by May 18, 2011. The committee developed a draft policy for ADR identification and reporting of ADRs. Staff training on identifying and reporting ADRs remains in progress. The Facility reports that they continue to be out of compliance with Provision N.6, of the Settlement Agreement. N.7. The Facility reports that Drug Utilization Reviews (DUEs) were now more outcome based and that DUEs have been scheduled for 2011, and report that they are in substantial compliance with Provision N.7, of the Settlement Agreement. The Monitoring Team did not concur with the Facility's assessment. N.8. The Facility reports that they are in substantial compliance with Provision N.8, of the Settlements Agreement. Much work has been accomplished by the Facility in working towards compliance. The Facility developed a severity index of medication error and error scale was developed by nursing services. The Pharmacy developed a medication variance log to identify actual, and potential medication variances involving transcriptions, prescribing, dispensing and storage, while administration errors are to be tracked and reported by nursing services. Nursing services has also developed a database to track administration variances. Additional nurses have been added to the medication error committee. Nursing has also approved of medication administration guidelines. Nursing services was also tracking and conducting trends analysis, that includes "contributing factors" to medication errors. The Monitoring Team did not concur with the Facility's assessment.
	Summary of Monitor's Assessment:

	N.1. The Facility did not have a policy and/or procedure in place that comprehensively addressed the Facility's review process of medication orders. The Facility did not have a formal mechanism that ensured that pharmacy recommendations were followed up by the Clinician. There was no formal mechanism in place that ensured pharmacists were appropriately trained on conducting reviews of medication orders. Review of Single Patient Intervention Reports indicated the need for enhanced follow-up on physician recommendations. Pharmacy did not monitor for the use of non-FDA approved uses of medications at the Facility. Examples of Single Patient Intervention Reports provided to the Monitoring Team did not have physician documentation of their clinical plans, as indicated per the Facility's self-assessment. For these reasons, the Monitoring Team disagreed with the Facility's self-assessment and determined that the Facility remained out of compliance with Provision N.1, of the Settlement Agreement. N.2. The Monitoring Team noted significant improvement with the quality of the QDRR process. QDRRs are more comprehensive and take into account important clinical issues through the review of the nursing assessments, annual medical review, problems list, laboratory results, psychiatric assessments and OT/PT evaluations. Because of staffing issues, the Facility is between four and six weeks delayed in completing QDRRs. The pharmacist should also be more comprehensive when reviewing MOSES and DISCUS assessments. Because of these deficiencies, the Monitoring Team concluded that the Facility remained out of compliance with Provision N.2, of the Settlement Agreement. N.3. At the time of this review, there was no organized process, other than the PMOC meetings, in place for the pharmacist to provide on-going analysis of the use of all benzodiazapines, anticholinergics, polypharmacy and STAT medication use. The Facility continues to rely on selective professional staff to "select" samples for review. Subsequently, the Monitoring Team concurred with the Facility and determined that the Facility remains out of compliance with Provision N.3, of the Settlement Agreement. N.4. The Monitoring Team determined that pharmacists are ensuring that physicians address their recommendations from the QDRRs. The Monitoring Team concurred with the Facility's self-assessment and determined that the Facility remains in substantial compliance with Provision N.4, of the Settlement Agreement. N.5. The Monitoring Team identified several issues of concern with monitoring of tardive dyskinesia (TD). There is no evidence to support that more frequent monitoring of TD is routinely provided to Individuals, when appropriate. More frequent monitoring should be conducting whenever there is a dosage increase or decrease of an antipsychotic medication, when a medication that has the potential to interact with a prescribed antipsychotic medication in a way that might result in unmasking TD, and when there are observed changes in behavior and functional abilities of the individual. Also, the Monitoring Team noted that nursing staff were completing the prescriber's component of the drug monitoring assessment tools. Review of completed QDRRs noted that scheduling for the MOSES and DISCUS was assessed by the pharmacist; however, the pharmacist did not review the forms for completeness or appropriateness. For these reasons, the Monitoring Team disagrees with the Facility's self-assessment and determined that the Facility is out of compliance with Provision N.5, of the Settlement Agreement.

	N.6. The Facility continues to progress towards compliance with Provision N.6, of the Settlement Agreement. A workgroup was established on March 1, 2011 to discuss staff training on adverse drug reactions (ADRs) and full implementation of the committee occurred by May 18, 2011. The committee developed a draft policy for ADR identification and reporting of ADRs. Following its review, the Monitoring Team noted that the Facility had not implemented a comprehensive, local policy to address ADRs. The Facility did not collect, archive, nor conduct trend analysis on ADR, which is necessary to accurately report on ADRs, and for these reasons the Monitoring Team had determined that the Facility remained out of compliance with Provision N.6, of the Settlement Agreement. N.7. The Monitoring Team noted improvements with the quality of the DUE process. DUEs are now more outcome based. Following review of the Pharmacy Services and Safe Medication Practices, State Policy (011) dated 08/31/09, specific to DUEs, review of recent DUEs and minutes from the last four Pharmacy Therapeutic Committee Meetings, which addressed DUE's, the Monitoring Team disagreed with the Facility and determined that the Facility remains out of compliance with Provision N.7, of the Settlement Agreement. N.8. The Monitoring Team compliments nursing services on its stellar performance in enhancing the medication variance process at the Facility. Unfortunately, the process remains fragmented among nursing, physician and pharmacy services; there is no unified method to initiate remediation of professionals; pharmacy does not have a meaningful mechanism to conduct longitudinal analysis of medication errors; and there is no unified local policy that clearly and comprehensively outlines the Facility's medication variance process. Subsequently, the Monitoring Team disagreed with the Facility's self-assessment, and determined the Facility to be out of compliance with Provision N.8, of the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results,	To assess compliance for Provision N.1, of the Settlement Agreement, the Monitoring Team reviewed completed Single Patient Intervention reports for Individuals #89 (7/15/11), #332 (7/14/11), and #332 (7/12/11), and conducted a meeting with the Director of Pharmacy and the Facility's Clinical Pharmacist. The Facility did not have a policy and/or procedure in place that comprehensively address the Facility's review process of medication orders. The Facility did not have a formal mechanism that ensured that pharmacy recommendations were followed up by the clinician. There was no formal mechanism in place that ensured pharmacists were appropriately trained on conducting reviews of medication orders. Of the three examples of Single Patient Intervention Reports provided to the Monitoring Team for review, the report of July 14, 2011, on Individual #332, was of particular concern to the Monitoring Team. The Single Patient Intervention Report for this Individual indicated that the Individual had a blood pressure of 160 to 170 systolic over	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	110 diastolic and the physician ordered Clonidine to help lower the blood pressure. The pharmacist appropriately alerted the physician that there is a reported risk of severe hypertension if Clonidine is abruptly discontinued while on Atenolol (Individual #332 was on Atenolol 50mg bid) and that if Clonidine was administered that close monitoring of blood pressure was needed, especially if Clonidine was to be discontinued in the future. The Pharmacist also recommended rescheduling Atenolol from 50mg bid to 100mg daily in the AM. The Pharmacist documented that the Physician continued Clonidine because "the benefit outweighed the risk" and that close monitoring of the blood pressure and rescheduling of Atenolol to 100 mg per morning would be accomplished. Review of the physician orders for this issue indicated that the Clonidine was prescribed as a STAT medication for severe hypertension. In fact, the physician order stated "Emergency", at 11:25 a.m. At 2:25, pm, after the Pharmacist issued her recommendations, the Physician wrote orders to: 1. Discontinue Atenolol 50 mg BID 2. Start Atenolol 100 mg PO Am, beginning 7/15/11 3. Check BP every morning for one week and report findings to the physician The issue of concern was that the individual had experienced a medical emergency, with a blood pressure of 170/110. Blood pressure values of this level could result in significant and potentially life threatening consequences if not appropriately managed. The combined prescribing of clonidine and atenolol continued but with reduced frequency of blood pressure monitoring, so the Pharmacist (who had appropriately acted initially to notify the physician) had the responsibility to continue to ensure notice of the need for more frequent monitoring of blood pressure. The Monitoring Team was also concerned because this particular issue should have been identified as one that required a DUE in order to determine whether actions, including staff training, should be taken; if an individual was to miss a dose, either because it was not administered, discontinued or if the individual did not ingest the medication, the potential for a serious adverse effect, including myocardial infarct, stroke or even death, is a real possibility. Unfortunately, a DUE was not triggered for this issue. While conducting reviews for medication orders, the Pharmacy did not specifically address non-FDA approved uses for medications. The Monitoring Team recognized that there are many occasions when non-FDA approved uses for medications should be used; however, such uses must always, unless for an emergency, be reviewed through the team process and legally responsible representatives made aware of such use. Pharmacy is a logical stop-gap, to ensure that such uses are acceptable. All Single Patient Intervention Reports provided to the Monitoring Team for review lacked the Physician's documentation of clinical plans on the Intervention Report, as indicated per the Facility's	

#	Provision	Assessment of Status	Compliance
		self-assessment. The Monitoring Team compliments the Pharmacist for issuing the warning for abrupt discontinuation of Clonidine and to reschedule the Atenolol order; however, the Monitoring Team strongly recommends that a more robust system be in place to ensure that appropriate treatment is provided individuals subsequent to recommendations. The Monitoring Team also compliments the Facility for significantly enhancing medication order reviews by pharmacists; still, further improvements to the process are needed.	
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.	Following review of Quarterly Drug Regimen Reviews (QDRRs) for Individuals #465, #363, #440, #90, #126, #79, #249, #34, #5, #513, #130, #381, #184, the Monitoring Team noted significant improvement with the quality of the QDRR process. QDRRs are more comprehensive and taking into account important clinical issues by review of the nursing assessments, annual medical review, problems list, laboratory results, psychiatric assessments and OT/PT evaluations. Because of staffing issues, the Facility is between four and six weeks delayed in completing QDRRs. The Monitoring Team noted that 46 individuals were lacking QDRR review at the time of this review. The clinical pharmacist informed the Monitoring Team that the pharmacy is between four and six weeks behind schedule, because of staffing issues. The Monitoring Team acknowledges that a comprehensive QDRR review, inclusive of documentation and discussion with treating clinicians, each review would require, on average, two hours to complete. Because of this deficiency, the Monitoring Team concluded that the Facility remained out of compliance with Provision N.2, of the Settlement Agreement.	Noncompliance
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	The Facility established a Psychoactive Medication Oversight Committee (PMOC) which monitors the use of anticholinergic medications and intraclass psychotropic medication and polypharmacy. The Facility reports that psychiatric services reviews all psychotropic medications, including benzodiazepines, as part of their monthly reviews and Pharmacy reviews psychiatric medication treatment as part of the QDRR process. Pharmacy reported that they are reviewing the use of STAT medications. The Monitoring Team asked for specific policies and/or procedures that specifically outline their process for monitoring the use of STAT medications, benzodiazepines, anticholinergics, polypharmacy and metabolic syndrome. The Facility provided the Monitoring Team with a copy of the Services and Safe Medication Practices, State Policy (011) dated 08/31/09, which contains a brief generalized statement (page 444) indicating that the Facility must monitor such issues. The Facility did not have a comprehensive policy and/or procedure that outlines how the Facility is to monitor and assess the use of benzodiazepines, anticholinergics, STAT medications, polypharmacy and metabolic syndrome. The Monitoring Team reviewed the past six PMOC Minutes for January through June, of 2011. The Minutes demonstrated that the Facility is assessing some individuals who are	Noncompliance

#	Provision	Assessment of Status	Compliance
	monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	prescribed polypharmacy, anticholinergics and anxiolytics. The minutes also reflect that the Facility is attempting to develop a "database" to assist with their process. Through review of QDRRs, the Monitoring Team noted that metabolic syndrome is being assessed and appropriate recommendations are being made; however, there was no formal policy or procedure in place to ensure that this process will continue in the event of staff turnover. At the time of this review, there was no organized process in place, other than the PMOC meetings, for the pharmacist to provide ongoing analysis of the use of all benzodiazapines, anticholinergics, polypharmacy and STAT medication use. The Facility continued to rely on selective professional staff to "select" samples for review. The process for review needs to continue to evolve to increase collaboration on a regular and ongoing basis. Subsequently, the Monitoring Team concurred with the Facility and determined that the Facility remains out of compliance with Provision N.3, of the Settlement Agreement.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	Review of completed QDRRs for Individuals #465, #363, #440, #90, #126, #79, #249, #34, #5, #513, #130, #381, #184, indicate that physicians are reviewing the QDRRs and concurring with recommendations. During this review, there were no examples of physicians not agreeing with pharmacy recommendations. The Monitoring Team agreed with the Facilities self-assessment and determined that the Facility remains in substantial compliance with Provision N.4, of the Settlement Agreement.	Substantial Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	The Monitoring Team identified eight examples of the nurse completing the prescriber's assessment component of the screening tools. This issue was brought to the attention of Facility leadership who discussed the issue with nurse managers, who concurred that this practice had occurred. Subsequently, nurse managers have been advised not to perform this action and ensure that the prescribing physician actually completes this component of the assessment tools. Furthermore, even when DISCUS and MOSES screenings were performed more frequently than scheduled due to changes in medication, they were not always completed or signed by the physician on a timely basis. The Monitoring Team requested examples of ten individuals who experienced a dose change of their neuroleptic medication and ten individuals who were on a neuroleptic and had an additional psychotropic medication added. The Monitoring Team was only provided a total of five examples of individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
		who experienced changes of their neuroleptic medication (#109, #118, #61, #259, #493). • Individual #118 was assessed by DISCUS for dose changes on 6/2/11, 3/9/11, and 12/7/10. The physician reviewed the assessments more then two weeks following the assessment date, and on all three of the assessments, the physician did not complete the physician component of the assessment. The frequency of the DISCUS assessment was quarterly. The MOSES was performed on 3/9/11, and 9/3/10. The frequency of the Moses was every six months and, on both assessments, the physician did not complete the physician component of the assessment. • Individual #61 had a DISCUS performed on 6/7/11, 5/10/11, 4/13/11, and 2/22/11. The individual had more frequent DISCUS performed for dose change; however, one assessment was not signed until ten days after the assessment, and in three of the four assessments, the physician did not complete the physician's assessment. The MOSES was performed on 6/7/11, 4/13/11, and 2/22/11. In this case, the physician signed all assessments; however, the physician component of the assessment was completed electronically by the nurse, and not the physician. • Individual #259 had a DISCUS performed on 7/20/11, 6/7/11, 5/10/11, 3/11/11, and 1/19/11. The individual was provided more frequent DISCUS assessments; however, all five assessments were not completed by the physician and one was signed nine days following the assessment. The MOSES was obtained on 3/11/11, 9/22/10, and 3/8/10. One assessment was signed 13 days after the assessment was performed and physician component was not completed on one of the assessments. • Individual #493 had a DISCUS performed for medication dose change on 7/7/11, and 6/7/11. Neither of the two assessments had the physician component section completed and both were signed greater the two weeks after the assessment was completed. The MOSES was completed on 7/18/11, 6/7/11, and 3/3/11. Two of the three assessments were signed by the physician more then two weeks following performance of the assessment. None of the three had the physician assessment component completed. • Individual #109 had a DISCUS performed on 5/31/11, 4/7/11, 3/4/11 and 12/1/10. Two of the four assessments were completed by the physician more then thirty days after the assessment was performed, and two assessments were signed by the physician more then 20 days following completion of the assessment. The MOSES was obtained on 5/31/11, 4/1/11 and 12/23/10. Two of the three assessments were signed, but not completed by the physician, and one	

#	Provision	Assessment of Status	Compliance
		assessment was not signed or completed by the physician. Review of QDRR assessments, and attached MOSES and DISCUS assessment tools for Individuals #465, #126, #79, and #249, demonstrated that the Clinical Pharmacist did not review the MOSES and DISCUS forms for completeness or appropriateness (the forms reviewed by the pharmacist were not completed or signed by the physician). Review of active records of Individuals #102, #478, #56, #557, #84, #291, #381, #83, #129, 334, #325, #24, #48, and #312, did not support that the Facility conducts more frequent monitoring of side effects when a medication dose had been changed, a medication was discontinued, a new medication had been added, to the medication regimen or a change occurs in behavior, functional abilities, or health status of individuals who were prescribed antipsychotic medications. There was no process at the Facility to regularly assess interrarater reliability of the MOSES and DISCUS. The QDRR process ensures that MOSES and DISCUS have been completed as routinely scheduled.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	The Facility continued to progress towards compliance with Provision N.6, of the Settlement Agreement. A workgroup was established on March 1, 2011 to discuss staff training on adverse drug reactions (ADRs) and full implementation of the committee occurred by May 18, 2011. The committee developed a draft policy for ADR identification and reporting of ADRs. The Monitoring Team reviewed completed ADR forms on Individuals#154, #255, #97, #253, #440, #591, #253 and found them to be complete and comprehensive. The Monitoring reviewed Pharmacy and Therapeutic Meeting Minutes dated July 29, 2011, and April 28, 2011, which reported on ADRs. The Monitoring Team also reviewed the State Policy on ADRs (DADS Policy 011, dated 8/31/09), which calls on the Facility to develop its own local policy. The Facility had yet to develop and implement a comprehensive policy for its ADR process. Although ADRs were discussed during the P&T Meetings, the Facility did not collect, archive, nor perform trend analysis, which is necessary to accurately report on ADR's. Such trending should be done for two reasons. First, the information may help the Facility determine whether ADRs are being reported consistently across residences. Second, the information may help the Facility to identify areas for planning of systemic initiatives to improve health care. For these reasons, the Monitoring Team concluded that the Facility remains out of compliance with Provision N.6, of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team reviewed a draft copy of the State Policy for ADRs, which was attached to the Pharmacy Services and Safe Medication Practices, State Policy (011), dated 08/31/09, No local policy or procedures was provided to the Monitoring Team at the time of this review. The Facility reported substantial compliance with Provision N.7, of the Settlement Agreement. They reported to the Monitoring Team that a schedule for Drug Utilization Evaluations (DUEs) had been developed for 2011. Pharmacy Staff reported that DUEs are now more outcome based. No other progress had been reported for this monitoring period. It was reported to the Monitoring Team that DUE selection occurs at the time of Pharmacy and Therapeutic Committee Meetings by the Clinical Pharmacist, and are offered once per quarter. It was also reported that in the event of an FDA or manufacturer's warning, additional DUEs could be provided. There is no specific process in place, per policy and/or procedure that outlines how DUEs are conducted at the Facility. The Monitoring Team reviewed the past DUEs, which were conducted at the Facility (July 2011 on benztropine and April 2011, on clozapine). The DUEs appear more outcome based and appropriate recommendations were made; however, besides sending emails to physicians specific to recommendations, the Monitoring Team did not identify an organized method to follow-up and ensure that recommendations were actually followed, nor was there a method to longitudinally ensure that recommendations become incorporated into the Facility's practice standards.	Noncompliance
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	Nursing Services had made significant strides in the area of medication variances; however, their efforts were specific to medication administration variances. Nursing services had developed a database to track administration variances. Two additional nurses had been added to the medication error committee. Nursing services had also approved of medication administration guidelines. Nursing services tracked and conducted trends analysis, that includes "contributing factors" for all medication errors. In addition, nursing services developed a severity index of medication errors and an error scale. Pharmacy was monitoring and reporting on storage, prescribing, transcriptions and dispensing variances. Pharmacy did not have a mechanism to collect, archive, and analyze data related to medication variances. Importantly, remediation action for medication variances was not well defined, and remediation was conducted	Noncompliance

#	Provision	Assessment of Status	Compliance
		independently by nursing, physician and pharmacy services, respectively. The Monitoring Team had concerns over the continued fragmentation of the Facility's Medication Variance process and strongly recommends that the process be unified among nursing, pharmacy and physician services. The Monitoring Team was also concerned that there was no unified policy to address medication variances at the Facility. The Monitoring Team compliments nursing services on its stellar performance in enhancing the medication variance process at the Facility. Unfortunately, the process remained fragmented among nursing, physician and pharmacy services; there was no unified method to initiate remediation of professional staff. Pharmacy did not have a meaningful mechanism to conduct longitudinal analysis of medication errors. Furthermore, there was no unified local policy that clearly and comprehensively outlines the Facility's medication variance process. Subsequently, the Monitoring Team disagreed with the Facility's self-assessment, and determined the Facility to be out of compliance with Provision N.8, of the Settlement Agreement.	

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

1. Complete and implement a local and comprehensive policy for the Facility's ADR process, and ensure that all relevant staff, including pharmacists, direct care staff, nurses and physicians are regularly trained on the ADR process.
2. Develop and implement a mechanism to collect, store and conduct regular trends analysis on ADRs.
3. Drug Utilization Evaluations must be conducted for all alerts and warnings issued by the FDA and Manufacturers. A local policy and/or procedure should be developed to ensure that Individuals receiving medications with recent alerts be assessed for adverse drug effects and that the medication is being prescribed and administered according to new warnings
4. Continue to enhance the DUE process by establishing robust policy and/or procedure at the Facility that comprehensively outlines this important practice. This must include a mechanism that ensures that recommendations made for DUEs are actually completed by the physician.
5. Develop a unified system to address all medication variances and ensure that the Facility's policy and/or procedure fully outlines the process.
6. Develop a mechanism to conduct longitudinal trends analysis for all medication variances.
7. Ensure that there is a unified mechanism, that fairly, appropriately and effectively provides remediation, when necessary, to staff that are responsible for medication variances. The process should be non-punitive when possible.
8. Prescribing clinicians must complete the prescribers review component of side effect assessment tools.

9. The Facility must ensure that all individuals are more frequently monitored for tardive dyskinesia and other side effects, such as adverse drug reactions,

10. Regular assessments for intra-rater reliability should be provided to those responsible for completing the MOSES and DISCUS and those responsible for reviewing these assessments.

11. When conducting QDRRs, the Clinical Pharmacist should review MOSES and DISCUS assessments for completeness and appropriateness, not just ensure that they are present.

12. It is imperative that the pharmacy immediately address the backlog of QDRRs and maintain timeliness; this may require the Facility to address staffing issues.

13. A DUE should be conducted for the use of Clonidine.

14. Unless for an emergency, ensure that all non-FDA approved uses for medications have been reviewed by the team and that the legally responsible representative concurs with such use.

15. The Facility must develop specific or unified policy and/or procedure that clearly delineates its process for monitoring and assessing the use of all benzodiazpeinze (and other sedatives), anticholinergics, polypharmacy and STAT medications. The policy and/or procedure must outline the role and responsibility of the POMC.

16. The Facility must develop a policy and/or procedure that outlines ifs process of monitoring for metabolic syndrome.

17. The Facility must better ensure that important and potentially serious pharmacological issues are addressed by the Team. Issues such as medication variances, realized adverse reactions, metabolic syndrome, and prescribed or considered medications that are known to be high risk, should be well incorporated into the team process.

The following are offered as additional suggestions to the Facility:
1. Consider incorporating recommendations established through the DUE and ADR process into medical quality assurance process, as benchmarks.
2. It would be advantageous for the Facility to ensure that high risk pharmacological issues, such as movement disorders, sedation and metabolic syndrome be incorporated into the Risk Assessment Tool.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI), dated 7-12-2011 2. Local Polices for the Physical and Nutritional Management Team (PNMT), and Physical and Nutritional Management Plan (PNMP) 3. Record reviews: • Sample 1: Individuals #33, #59, #79, #163, #189, #291, #342, #411, #413, #496, #504, #508, and #591 • Sample 2: Individuals #33, #60, #79, #163, #291, #342, #413, #496, and #591 • Sample 3: Individuals #43, #305, #331, #392, #395, #474, #505, #567 4. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 5. A list of continuing education sessions or activities participated in by PNMT members since last review (1/2011) 6. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 7. Individual PNMT reports as available for individuals reviewed above 8. Tools used to screen and identify individuals' PNM health risk level 9. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 10. Tools used to assess PNM status and needs 11. A list of PNM assessments and updates completed in the last two (2) quarters 12. PSPs for the sample individuals 13. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 14. Tools used to monitor implementation of PNM procedures and plans 15. A list of individuals for whom PNM monitoring tools were completed in the last quarter 16. Tools utilized for validation of PNM monitoring 17. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans 18. Nutritional management plan template and any instructions for use of template 19. Dining Plan template 20. PNM spreadsheets generated by the Facility 21. Lists of individuals: (a) On modified diets/thickened liquids; (b) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (c) With BMI equal to greater than 30; (d) With BMI equal to less than 20;

	(e) Since January 1, 2010, who have had unplanned weight loss of 10% or greater over six (6) months; (f) During the past 12 months, have had a choking incident; (g) During the past 12 months, have had a pneumonia incident; (h) During the past 12 months, have had skin breakdown; (i) During the past 12 months, have had a fall; (j) During the past 12 months, have had a fecal impaction; (k) Are considered to be at risk of choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, with their corresponding risk severity (high, med, low etc.); (l) With poor oral hygiene; and (m) Who receive nutrition through non-oral methods 22. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 23. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 24. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans 25. Since the last review, a list of competency-based training sessions addressing foundational skills in PNM **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Erin Pepper Speech Language Pathologist (SLP) 3. Donna Baron SLP 4. Tracy Searles Physical Therapy Assistant (PTA) 5. Direct Care Professionals on (2) Childress, (3) Driscoll, (2) Bowie, and (3) Program Services **Meeting Attended/Observations:** 1. Daily activities on Bowie, Driscoll, Childress, and Program Services 2. Mealtimes on Bowie, Driscoll, Childress, Fannin, and Program Services 3. PNMT meeting 7/26/11 Risk Meetings-Individuals #181 and #26
	Facility Self-Assessment: BSSLC Plan of Improvement, updated 7/12/2011, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with provisions O.2, O.3, O.4, O.5 and O.6 and in compliance with provisions O.1, O.7, and O.8. This was inconsistent with the Monitoring Team's findings as all provisions were found to be noncompliant. BSSLC stated that O.1 was in compliance due to the presence of a PNMT which the monitoring team agrees with, however, O.1 also includes review of the PNMP, and development of the PNMP which were found to be not in compliance therefore O.1 was noncompliant with the settlement agreement. O.7 which covers monitoring was found to be in compliance by BSSLC but was found to be not in compliance due to the lack of a thorough review process of individuals who were at the highest level of risk as well as the review of individuals who returned from the hospital

	with a significant PNS event. O.8 was found by BSSLC to be in compliance but was found by the monitoring team to be not in compliance due to the lack of investigation into potential pathways to oral intake (i.e., oral musculature exercises and stimulation to improve oral and pharyngeal phase functioning). Other areas of noncompliance will be discussed generally in the Monitors' Assessment and in more detail under each provision. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight provisions, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self assessment process, it will be important to ensure that data are used in meaningful ways to assist in identifying areas in which improvements are needed.
	Summary of Monitor's Assessment: **Provision O.1:** This provision was determined to be not in compliance. Although great strides had been made which included consistent membership and participation of all relevant disciplines, and a localized policy outlining the roles and responsibilities of the PNMT. There was still no evidence that data were collected and the PST or PNM team were reviewing this data to better identify system issues or respond to recurrent issues on a regular basis. Additionally, this provision is an over arching provision that covers multiple other issues outside of the PNMT. These areas include review of the PNMP, and development of the PNMP. These areas will be discussed in detail in provision O.3. **Provision O.2:** This provision was determined to be not in compliance. While the new risk process had improved in its ability to identify those individuals who are at increased risk, it remained inconsistent. Individuals were not provided with a comprehensive assessment by the PNM team or PST that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day and during nutritional intake. The OT components regarding oral care and medication administration were missing or lacking in detail. **Provision O.3:** This provision was determined to be not in compliance. PNMPs were not comprehensive due to the plans lacking detailed information regarding oral care and medication administration as well as staff positioning for these activities. **Provision O.4:** This provision was determined to be not in compliance. PNMPs were readily available to staff. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Nevertheless, staff were observed not implementing PNMPs and displaying safe practices that minimize the risk of PNM decline. Individuals were observed poorly positioned and with safe dining strategies not implemented. Per interview, staff were 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. While a new process was reported to be in place that ensured no staff outside the home was utilized as pull staff, home leaders were not aware of this process. Additionally, foundational trainings were still not provided as part of an annual refresher course. **Provision O.6:** This provision was determined to be not in compliance. BSSLC had ample frequency of 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. **Provision O.7:** This provision was determined to be not in compliance. Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem. The clinicians did not conduct routine, proactive review of the plans with frequency based on health risk level. **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. Significant improvements were noted with the PNMT. Membership in and participation by all relevant members were consistent. Additionally, the PNMT was in the process of revising their roles and responsibility in an effort to become more involved with individuals who experienced PNM events. Another positive was that the PNMPs included detailed information regarding adaptive equipment, bathing/showering positioning, transfer information, mealtime strategies as well as communication strategies.:

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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	BSSLC had developed a Physical and Nutritional Management Team (PNMT). The team consisted 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. Members of the PNM team included: • Kori Kelm PT • Erin Pepper SLP	Noncompliance

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	Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, 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.	• Coye Hoth RD • Marissa Rudloff OT • Kristi Wanner RN PNM (NMT) Team attendance records and meeting minutes from 03/01/2011 to 07/12/2011 documented 100 % of attendance level by PNM Team standing members. The makeup of the PNMT is in compliance with standards set forth by the Settlement Agreement. Review of documentation of PNM clinical instruction submitted revealed that three of five (60%) PNM Team members had completed training and professional development provided by central office related to physical and nutritional supports within the last 12 months. Due to the importance of PNM, continuing education in the field of PNM should be mandatory for all members of the team. This training should extend beyond the trainings provided by central office. Experience documented per the CVs submitted in the past indicated that each of the currently identified clinicians had a varied clinical background that included previous experience with individuals who had developmental disabilities. The PNMT held meetings weekly with the focus of the meetings ranging from development or review of policy and procedures to comprehensive assessment if an individual was referred to the team by the PST. Beginning the week of July 18, 2011, the PNMT's focus changed to include review of all individuals who were hospitalized with a PNM issue. Per interview, this change was implemented due to the lack of PST follow up upon discharge. Due to this change being recent, the Monitoring Team was not able to review a sufficient sample to determine the effectiveness of this policy change. Regardless of the change in policy or its effectiveness, it is the responsibility of the PST to review individuals who had experienced a change in health status. In addition to the state policy, BSSLC developed a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was intended to occur with the Personal Support Team (PST). There was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. 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	

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		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, as well as identify other improvements and corrective actions that should be addressed. PNMPs were not in alignment with current best practice standards. For issues related to this component, please refer to provision O.3. PNMPs were not clearly developed with input from all members of the PST or reviewed consistently by the PST. For examples, please refer to provision O.3.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	To select individuals for sample 1, PNMT meeting minutes were reviewed, and Monitoring Team observations of mealtime, positioning transfers, medication administration, toothbrushing, personal care, and functional communication provided a list of people with relevant issues. In addition, individuals meeting the following criteria were reviewed, with a focus on individuals who experienced these issues within the prior six months. From the list of names, the Monitoring Team selected 13 individuals. o Emergency Room visits o Hospitalizations o Individuals with severe dysphagia o Individuals who experienced a choking incident which required abdominal thrust within the last 6 months o Individuals with a diagnosis of aspiration pneumonia o Individuals with chronic respiratory infections Based on a review of 13 records of Individuals who experienced an aspiration or choking event and/or were noted by the Facility to be at a high risk of aspiration and choking, 12 of 13 (92%) records reviewed (Individuals #33, #59, #79, #163, #189, #291, #342, #411, #413, #496, #504, #508, and #591) accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of individuals not being appropriately identified include: • Individual #496 was identified as being at a "low risk" of aspiration but per guidelines should have been listed as a "medium risk." The PST has the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. Lack of critical clinical thinking and discussion was noted when the PSTs had to move beyond the guidelines.. This lack of clinical judgment impacted the risk scores and increased the likelihood of inadequate supports being provided to the individual. An example was Individual #181 who experienced multiple seizures per month and had poor posture during dining but was listed as "low risk" of choking. More information	Noncompliance

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		regarding the identification of risk may be found under section I. Based on a review of 13 individuals' OT/PT assessments (sample 1), zero of 13 (0%) Individuals were provided with a comprehensive assessment by the PNM team or PST that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. OT components regarding oral care and medication administration were missing or lacking in detail. The oral motor section of the assessments showed some improvement from the previous review but still did not provide clear objective information regarding swallow status and cannot be considered an assessment. For example: • Individual #33's OT/PT assessment stated the person had poor oral motor skills but did not state or provide information regarding the different components of the oral motor status (i.e., lingual or labial range of motion, and anterior-posterior propulsion) and how it impacted his overall swallowing ability. • Individual #508's OT/PT assessment stated the person had poor lateral tongue functionality but did not provide information on how this impacted the swallow. • Individual #496's OT/PT assessment stated that tongue laterality was good as was swallow function but did not provide information as to the functional impact or provide objective measurable information regarding swallow function. Two out of nine (22%) individuals who were diagnosed with a PNM issue (Individuals #33, #60, #79, #163, #291, #342, #413, #496, and #591--sample 2) were not assessed by the PNMT or PST. For example: • Individual #413 was diagnosed with aspiration pneumonia on 4/14/11 and 5/12/11 with no evidence of discussion or assessment by the PNMT. The PST conducted a risk screening on 4/16/11 but there was no evidence of discussion regarding etiology of the event. • Individual #291 had aspiration pneumonia on 5/30/11 with no evidence of discussion or assessment by the PNMT or PST. • Individual #342 had aspiration pneumonia on 3/10/11 with no evidence of discussion or assessment by the PNMT or PST. • Individual #413 was noted in the progress notes to have increased residual and emesis but there was no review or referral provided to the dietitian. Of particular concern was Individual #60. Based upon review of the trigger data sheet, the individual experienced 77 episodes of coughing with struggle during the month of April 2011, 94 episodes of coughing with struggle during May 2011, and 181 episodes of coughing with struggle as well as 28 episodes of wet vocal quality during the month of	

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		June 2011. Documentation as well as communication surrounding this event were vague and at times nonexistent. For example: • DCPs were noting on the trigger sheet all the aspiration triggers but were not consistently documenting in the observation notes • Nursing was signing off demonstrating that review of the trigger sheet was completed but did not follow up consistently with a note in the IPN or an assessment. Although the triggers were occurring throughout April, May and June 2011, the first note acknowledging this issue was not until July 3, 2011. A total of three nursing notes were noted in the IPNs related to this issue. There was no evidence that the information was shared with the physician. • Nursing note on 7/15/11 stated that although there was coughing, lung sounds were good, and that coughing was not an appropriate trigger. This determination was made without PST input or assessment by Speech Therapy. • Physicians' note on 6/17/11 stated that DCP reported to him that Individual #60 had been coughing on Ensure for a while but he did not know how long this had been occurring, although it had been identified on the trigger data sheet for months. Physician requested modified barium swallow study (MBSS) "As Soon As Possible." • 6/28/11 Physician's order written for MBSS if SLP thought individual could tolerate. No SLP evaluation was provided until 7/17/11, therefore no MBSS was completed. • 7/17/11: SLP/OT evaluate individual and state that individual is in distress and "drowning" on liquids and needs to be admitted to hospital. Individual was admitted and returned to BSSLC with a g tube. The above demonstrates a severe lack of communication between team members and an alarming lack of awareness regarding aspiration indicators. This is evident not only by what is stated above but also by the lack of PST intervention throughout the last three months. Additionally, during the PNMT meeting, the physician stated that there was an order for abdominal girth measurements to be conducted daily; however, this order could not be located in the chart and members of the team were not aware of this order. Refer to Provision O.6 for more issues regarding lack of aspiration trigger notification. Findings were submitted to the Director of the Facility who contacted protective services regarding the concern. Per interview with Kori Kelm (Director of Habilitation Therapies) due to the lack of PST review of individuals returning from the hospital, the PNMT began on July 18, 2011 seeing all individuals who were diagnosed with a PNM related event (i.e., choking,	

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		aspiration) upon return from the hospital. Due to this just being implemented, the Monitoring Team was not able to review this change in process. Another issue that was noted by the Monitoring Team was lack of oral hygiene. Failure to provide appropriate oral care increases the risk of pneumonia for those individuals who are at an increased risk of aspiration or have known swallowing difficulties. Please refer to Provision Q for additional information.	
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 were not comprehensive as information regarding oral care and medication administration was lacking the detail needed to ensure safe consistent delivery of service. This included lack of staff positioning, and information regarding texture or consistency of liquids or medications. Based on a review of an identified sample of 13 individual records (Sample 1), individuals were not provided with a comprehensive PNMP as evidenced by: • In six of 13 records reviewed (46%) comprehensive strategies for medication administration were included. • In zero of 13 records reviewed (0%) positioning of staff during medication administration and oral care were included. • In six of 13 records reviewed (46%) comprehensive strategies for oral hygiene were included. • In zero of 13 records reviewed (0%) personal care instructions were included. Examples of individuals who were not provided with a comprehensive PNMP included: • Individual #508's oral care section of the PNMP simply stated the position for oral care but not other information relevant to safe oral care. (i.e., how water should be provided and staff positioning). • Individual #508's medication administration section of the PNMP stated that liquid medications may be given through a straw but did not mention the need for liquids to be thickened to nectar consistency. • Individual #591's PNMP did not contain information regarding oral care and was not comprehensive as it relates to medication administration, as information regarding liquid intake was absent. • Individual #163 and #342's PNMP did not have an oral care section. Positives noted through review of the same 13 PNMPs included: • In 13 of 13 records reviewed (100%) individual adaptive equipment was included.	Noncompliance

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		• In 13 of 13 records reviewed (100%) bathing/showering positioning and instructions were included. • In 13 of 13 records reviewed (100%) positioning instructions for wheelchair and/or alternate positions instructions were included. • In 13 of 13 records reviewed (100%) transfer instructions were included. • In 13 of 13 records reviewed (100%) the mealtime/dining plan included intake strategies for mealtime and snacks • In 13 of 13 records reviewed (100%) the mealtime/dining plan included diet consistency. • In 13 of 13 records reviewed (100%) positioning of individual during medication administration and oral care were included. • In 13 of 13 records reviewed (100%) communication strategies to enhance PNM services were included. Based on a review of an identified sample of 13 individual records (SAMPLE #1) PNMPs were not formally developed with input from the team. In zero of 13 records reviewed (0%), PNMPs were clearly developed with input from the PST with an emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the PSPs that the PNMPs were included, but there was no evidence of discussion or input from other team members. Examples of where there was no evidence individual PNMPs were developed with input and participation from the IDT included Individuals #33, #163, #342, and #591. In 13 of 13 records reviewed (100%), there was documentation in the PSP that PNMPs were reviewed annually but as mentioned above, there was no evidence of active discussion of the plan. PNMPS were not reviewed by the PST but were updated by Habilitation Therapies as indicated by a change in the person's status or as dictated by monitoring results. In two of nine records reviewed (22%) (Sample #2), PNMPs were reviewed by the PST as indicated by a change in the individual's status. Examples of when PNMPs were not reviewed by the PST as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #413 was diagnosed with aspiration pneumonia on 4/14/11 and 5/12/11 with no evidence of discussion or assessment by the PNMT. The PST conducted a risk screening on 4/16/11 but there was no evidence of discussion regarding etiology of the event or review of the PNMP. • Individual #291 had aspiration pneumonia on 5/30/11 with no evidence of discussion, assessment or review of the PNMP by the PNMT or PST.	

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		• Individual #342 had aspiration pneumonia on 3/10/11 with no evidence of discussion, assessment or review of the PNMP by the PNMT or PST. On a positive note, nine of nine PNMPs (100%) from the same sample reviewed demonstrated that PNMPs were updated as indicated by a change in status. The problem was that as stated above, there was no evidence that members outside of Habilitation Services participated in the development or revision of said PNMPs.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	PNMPs and Dining Plans were generally developed by the therapy clinicians with limited input by other PST members as described above. Generally, the PNMP was located in the individual notebook or was otherwise readily available nearby. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Fourteen 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 four of 14 (28%) observations, staff were following mealtime plans. • In nine of 14 (64%) observations, staff were following wheelchair positioning instructions. • In eight of 14 (57%) observations staff were following positioning instructions. • In three of three (100%)observations staff were following transfer instructions, • In five of nine observations (55%)staff were following toothbrushing instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: o Individual #299 was observed eating with a posterior pelvic tilt resulting in increased fatigue during the meal. o Individuals #436, #523 and #543 were observed taking large bites when the plans called for small bites. Staff did not understand rationale of recommendations and interventions as evidenced by not verbalizing reasons for strategies outlined in the PNMP. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Staff were observed to read the plan when asked a question, though	Noncompliance

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		reference to the plan before beginning the meal was inconsistent. In four of nine (44%) cases where an error was noted by the Monitoring Team, the staff was asked to read the plan and still were unable to recognize the error in implementation. Based on interviews with direct support professionals: o In five of nine (55%) interviews with staff, they were able to identify the location of PNMP and/or mealtime plan. o In three of nine (33&) interviews with staff, they could describe individual-specific PNMP strategies. o In four of nine (44%)interviews with staff, they could describe the schedule for implementation of PNMP strategies. o In three of nine (33%) interviews with staff, they stated they had received individual-specific training for PNMP strategies. o In four of nine (44%) interviews with staff, they could describe the intent of the aspiration trigger process and the DCP's role in its implementation.	
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.	Per interview with the Director of Habilitation Services, 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 that are found to be noncompliant multiple times will be required to attend the full version of the class. Review of the Facility's training curricula revealed that training included adequate PNM foundational 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 Mealtime positioning o Food and fluid consistency o Safe presentation techniques for food and fluid o PNMPs. There were skills-based checklists and or written or verbal tests to establish competence related to adaptive equipment, mealtime and functional eating skills, thickened liquids, positioning, wheelchair positioning and transfers. Skills-based performance was monitored by the PNMP coordinators (PNMPCs) after the new staff were assigned to a home. Per interview with the Director of Habilitation Therapies, an I-learning course was recently completed but was being revised by State Office. This I-learning course will	Noncompliance

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		cover foundations of PNM and will be provided annually. This course was originally scheduled to be implemented by this review but now is not scheduled until Fall 2011. Per interview with the Director Habilitation Therapies, all staff had been provided with competency based PNM training and all staff received annual refreshers regarding Lifting/Transfers and will receive foundational training annually as soon as the mentioned I-learning course is completed. Staff were provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for PNMP coordinators. PNMPCs are then responsible to train their assigned homes. Documentation of the training was maintained by the therapy departments as well as sign-in sheets for in-services provided to direct care staff. A major concern of the Monitoring Team was that although there was evidence of staff training, it did not translate into implementation of the plans designed to mitigate risk. BSSLC had adopted the practice of not utilizing pulled staff from other homes and only using those staff that were familiar with the medical needs of the individuals. Per report by the Director of Habilitation Therapies, pulled staff are not allowed to work with individuals with specialized training needs. Upon interview with home leaders, this practice was not widely known by the home leaders and therefore was not determined to be a functional process. As mentioned previously, training sheets were maintained and housed at the therapy department. The location of these training sheets was not ideal as they were not available for review when pulled staff were needed, making it more difficult for home managers to determine what staff should be assigned to what individuals. As with many other processes, there was not a formal process in place that clearly defined the method of implementation.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in 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. The PNM policy stated that monitoring will be performed as scheduled but there was no schedule provided. Based on review of the Facility's monitoring practices, a comprehensive PNM monitoring form was in place that was designed to address mealtime as well as areas outside of mealtime.	Noncompliance

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		While the forms were designed to address mealtime and other PNM areas and had multiple professionals involved, a policy or process was not fully developed that included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, • Identification of monitors and their roles and responsibilities, • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor, and • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician. While deficiencies noted through the monitoring process were shared with the appropriate Habilitation Therapy staff through a bi-monthly report, there was a lack of data acquisition and analysis regarding the completion of the monitoring forms. Per monitoring database, 595 monitors were completed for 28 high risk individuals utilizing the comprehensive monitoring form during the months of April, May, and June 2011. A review of Facility monitoring reports from 4/2011 to 12/2011 documented that staff were not being monitored in all aspects in which the individual was determined to be at increased risk. Per review: o 464 of 595 (70%) monitoring forms focused on oral intake (meals and snacks) o 66 of 595 (11%) monitoring forms focused on bathing o 2 of 595 (0.3%) monitoring forms focused on medication administration o 70 of 595 (10%) monitoring forms focused on Oral Care. Approximately 198 monitors per month were conducted and an average of 7 monitors per month per person. There was not a formal process in place that ensured individuals with increased PNM issues were provided with increased monitoring. At the time of the review, this process was informal and directed by the attending clinician. The 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 previously did not contain clear directives on what areas would be monitored.	

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		Due to this informality, it was unclear as to who was responsible for what monitoring area (i.e., meal, bathing, snack, oral care). Additionally, risk action plans with the request to increase monitoring were not consistently provided to Habilitation Therapies in a timely manner or at all. The frequency of monitors appear to be more than sufficient but the ratio of the monitors did not cover all the areas needed as evidenced by the large number of meal monitors in comparison to the oral care, medication administration, and bathing. Lack of monitoring in areas outside of mealtime is essential to reducing the risk of pneumonia and aspiration. More time should be spent providing monitoring to areas such as oral care to ensure proper technique and consistency of care. While the PNM status was scheduled to be regularly reviewed during the PST quarterly meetings, there was no clear indicator that status was reviewed by the team in the event of a change in status. Please refer to Provision O.2. An Aspiration Trigger Sheet was implemented for all individuals with PNM needs. The issues noted upon review were that the trigger sheet and process were not consistently implemented or reviewed. For example: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when observed by staff were not consistently brought to the attention of nursing. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing review of the trigger sheet was inconsistent and even when present lacked evidence of review and response to triggers Examples of the trigger issues were: • Individual #413 had triggers occurring on 6/4/11 (coughing), 6/16/11 (vomiting), 6/24/11 (increased residual), and 6/25/11 (emesis). The trigger sheet was lacking documentation of the coughing, vomiting, and residual trigger and only contained the emesis on 6/25/11. • Individual #291 had an emesis on 5/28/11 but no triggers were documented on the data sheet • Individual #342 had a trigger documented on 3/24/11 (wheezing) and 3/25/11 (emesis) but the nurse was only notified of the emesis event. • Refer to provision O.2 for information regarding individual #60 All of these issues could have been identified if the nurse would have routinely reviewed the trigger data sheet. Nursing review of the sheet must occur to ensure accurate completion and timely identification of potential PNM issues. Without such oversight, the tool does little to mitigate the risk of aspiration.	

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O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Based on the review of nine individual records (sample #2), the PNM Team or PST did not document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. While PNMPs are reviewed at the PSP, there was not a system fully in place that clearly monitored the effectiveness of the plan by tracking clinical indicators for all individuals who are determined to be at a high risk such as the occurrence or absence of triggers (signs and symptoms associated with physical and nutritional decline that require staff response). Issues with the current trigger process were described in Provision O.6. Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem. Routine, proactive review of the plans was not conducted by the clinicians with frequency based on health risk level. All members of the PNM team did not conduct monitoring. There was no system of routine review established to be conducted by the clinicians relative to the health status of those individuals at high risk who were followed by the PNMT. There was no formal and consistent review of the PNMPs relative to how well the plan addressed or minimized these concerns. Even during the annual assessments, the plans were reviewed in a more rote manner to continue a strategy with no clear review to measure or evaluate the actual efficacy of the plan. For example, there was no review to determine if strategies to address falls for an individual effectively resulted in a reduction from the previous period. There was no detailed comparative analysis of data or assessment findings. There was no system implemented to address monitoring by the PNMT. There was no mechanism to analyze the information obtained by the PNMPCs ,and it would be difficult to track individual-specific issues through to resolution or to track and trend concerns noted in homes or across the Facility. PNMP and Dining Plan monitoring were conducted by the PNMPCs and, as paraprofessionals, they would not be able to make judgments as to efficacy of the plans and to determine if there was a positive outcome related to PNM risks. Currently, there was no other system of monitoring of PNMP effectiveness for those at highest risk. As stated above, there was no routine documented review of the supports and services	Noncompliance

#	Provision	Assessment of Status	Compliance
		conducted by the licensed clinicians to address effectiveness for those at highest risk unless a problem had been identified and, as such, the process was reactive rather than proactive.	
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.	The following section was based on a sample gathered from individuals who received enteral nutrition (Sample 3). Eight of these individuals had been included in the sample reviewed by the Monitoring Team. One aspect of the At Risk Individuals policy, implemented as of 1/1/11, was an outline for an Aspiration Pneumonia/Enteral Nutrition Evaluation. This form was to be used for all individuals who were at high risk for aspiration pneumonia or who were hospitalized for aspiration pneumonia multiple times within the last year, as well as a means to conduct an annual assessment of individuals who received enteral nutrition. The assessment was to be compiled by the nurse case manager based on information provided by the PCP, nursing, Habilitation therapists, dietitian, pharmacist, and other members of the PST There were approximately 51 individuals listed as receiving enteral nutrition. Enteral evaluations for individuals in the sample were requested by the Monitoring Team. All individuals who received non-oral intake (NPO) in the selected sample had been provided a PNMP that included the same elements described above. Based on the sample of eight individuals (sample 3), no individuals had received the interdisciplinary enteral nutrition assessment provided by the State. All eight individuals had received a Habilitation Therapy assessment but content within these assessments were inconsistent and variable between therapists. While some assessments included why the tube was medically necessary, none of the assessments for those individuals who were NPO identified a clear pathway to oral intake. In other words, just because an individual fails a trial of oral intake does not mean that there are not other strategies to implement to work towards the end goal of resumed oral status. Based upon review, individual trials of intake were the only method attempted by BSSLC to increase oral intake. While transitioning from NPO status to Oral status is possible and appropriate for some individuals, there are many steps in between that are available to focus on. Included in this is oral motor strengthening or skills acquisition training related to mealtime intake. All individuals were provided a PNMP and Dining Plan; these elements would likely also	Noncompliance

#	Provision	Assessment of Status	Compliance
		be provided to an individual who transitioned back to oral intake. A draft protocol outlining therapeutic pathways for resuming oral intake for an individual who was enterally nourished had been developed for statewide review, but as yet had not been implemented. An issue noted through document review was that potential pathways to oral intake were not consistently provided to individuals. For example: • OT received a consult regarding the potential return to oral intake for Individual #411. A trial of liquids was provided to the individual but when coughing was observed, the trial was stopped. There was no evidence of discussion of methods to increase tolerance or functioning prior to the trial. The need for continued enteral nutrition was not integrated into the PSP. Based on a review of eight individuals' PSPs, FOR zero of eight (0 %) (Sample #3) who received enteral nutrition, the individual's PSP clearly documented the rationale for the continued need for enteral nutrition. An example of an individual PSP that did not document the rationale for the continued need for enteral nutrition was that Individual # 305's PSP simply stated that nutrition is provided enterally.	

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. Integrate into the PNMT process a method for data analyses and review.
3. 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.
4. PNMPs should be expanded to include oral care and medication administration. Strategies should not only include positioning for these activities but also other strategies and adaptive equipment that will assist in minimizing the individuals' risk.
5. The Facility's PNM NEO training curriculum should be revised to include generic and individual-specific mealtime risk triggers that alert staff to problems, and what staff are to do if these triggers are observed.
6. Aspiration Pneumonia/Enteral Nutrition Evaluations should evaluate the potential for moving an individual to a less restrictive form of receiving enteral nutrition.
7. Consider an increase in nutritional staff. Two dietitians for the Facility were insufficient to adequately meet the needs of all individuals living at BSSLC (317 individuals).
8. As was recommended in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing,

toothbrushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);

b. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
d. Formal schedule for monitoring to occur;
e. Individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
f. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
g. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
h. Establishment of thresholds for staff re-training.

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI), dated 7/12/2011 2. Record Reviews: • Sample 1: Individuals #33, #59, #79, #163, #189, #291, #342, #411, #413, #496, #504, #508, and #591 • Sample #4: Individuals #26, #133, #163, #254, #255, #381, #453, #479, #511, #567, #576, and #590. • Sample #5: Individuals #185, and #575 3. OT/PT Policy 014 dated 10/7/2009) 4. Localized OT/PT policy 5. 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. 6. PNM maintenance Logs (June 2010-present) 7. OT/PT assessments template 8. Wheelchair seating, PNM clinic assessment templates and related documentation OT/PT-related spreadsheets. 9. 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. 10. List of individuals receiving direct OT and/or PT services and focus of intervention. **People Interviewed:** 1. Kori Kelm Physical Therapist(PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA) 3. Direct Care Professionals on (2)Childress, (3)Driscoll, (2)Bowie, and (2) Program Services **Meeting Attended/Observations:** 1. Daily activities on Bowie, Driscoll, Childress, and Program Services 2. Mealtimes on Bowie, Driscoll, Childress, and Program Services 3. PNMT meeting 7/26/11 re: individual #60 Risk Meeting-Individuals #181 and #265
	Facility Self-Assessment: BSSLC's self-assessment identified compliance with provisions P.1 and P.2 and noncompliance with

	provisions P.3 and P.4. The self-assessment was inconsistent with the Monitoring Team's assessment of noncompliance for each aspect of this provision. P.1 was found to be not in compliance secondary to lack of assessment post a significant change in status and P.2 was found not to be in compliance due to lack of integration into the PSP and not being consistently provided with interventions to enhance current abilities and skills. While assessments exist for all individuals, they were not comprehensive as the section covering oral motor lacked detail regarding health risks and clear objective information surrounding status. Areas of improvement noted by BSSLC include: • Openings for an additional OT and PT • Quarterly meetings by the PST to review plans Training of staff on local Habilitation Therapy policy
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. BSSLC has 1.5 open positions for PT and 2 positions for OT, which should assist in lowering the caseload but these positions had not been filled as of this review. Assessments were completed in accordance to the schedule set forth by BSSLC; however, assessments were not being consistently completed in response to a change in status and are not consistently comprehensive. **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. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written and staff was not knowledgeable of the OT/PT plans. **Provision P.4:** This provision was determined to be not in compliance. Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: o Definition of monitoring process o Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities o Formal schedule for monitoring to occur o Monitors are re-validated on an annual basis by therapists and/or assistants o Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor 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.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	The Facility did not provide an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience. There were three Occupational Therapists, one Certified Occupational Therapy Assistants, 3.5 Physical Therapists and one Physical Therapy Assistant (PTA). There are openings for two OTs, 1.5 openings for PTs, and one opening for a PTA. With the current staffing, ratios for Occupational Therapy were 1:105 and PTs 1:90. The staffing ratios were not adequate to address standard OT/PT practices in addition to the increased demand of physical and nutritional supports. Clinicians were responsible for the annual assessments or updates, providing supports and services as needed, reviewing and updating the PNMP, and responding to any additional needs as they came up for each individual on their caseload, with additional supports available from the therapy assistants. Annual assessments/updates were completed by OT and PT collaboratively. Some of those who did not have established PNM needs would likely require occasional supports to address acute injuries or to address more chronic conditions associated with aging. Many others would likely benefit from skill acquisition/enhancement programs related to movement and mobility, as well as fine motor skills and independence. This level of supports and services could not be adequately met with the current staffing levels for PT. Current utilization of the OTs did not appear to be appropriate to adequately address individual needs beyond those related to the PNMP. Based on this review, a very limited number of individuals were provided with OT or PT services beyond the PNMP (only six individuals were receiving direct therapy). All individuals had received an OT/PT assessment. If newly admitted, this occurred within 30 days of admission (Sample #4). The assessments submitted were completed by both OT and PT. Assessments indicated whether or not the individual required OT/PT supports and services for 12 of 12 (100%) records reviewed. The OT/PT assessment addressed movement, mobility, range of motion and independence but, as stated in Section O, the area lacking in the OT/PT assessment remained the oral motor section. There remained a lack of objective measurable data as well as explanation of how these deficits are functionally affecting the individual. Additional concerns noted in the assessment reports reviewed included:	Noncompliance

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		• There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, wheelchair propulsion, transfers, gait, and positioning. • In many cases, clinical information was merely reported, but was not utilized to guide decisions regarding intervention. • In the cases that therapy supports had been provided, there was no assessment as to the effectiveness of the interventions. • There was no comparative analysis of health and functional status from the previous year. • There was no analysis of findings that was based on the data reported and compared to a previous comprehensive assessment or update, or that provided a rationale for the recommendations for interventions and supports. • Specific health risk ratings established by the PST were not identified, and interventions, primarily the PNMP, were not specifically linked to these ratings. Medical issues and health risk indicators were not consistently included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. Twelve of the 12 (100%) assessments (Sample #4) reviewed contained medical issues and health risk indicators but did not provide information regarding how the risk or medical condition contributed to the overall plan of care. Examples of assessments that did not appropriate rationale included: o Individuals #5 and #133's OT/PT assessment contained a diagnosis list but did not provide information or links to how these diagnoses impacted the level of care. Evidence of communication and or collaboration was present in the OT/PT assessments. Based on review of 12 OT/PT assessments, 100% included signatures and date of both OT and PT. Based on review of 12 OT/PT assessments, 100% included evidence of active collaboration between OT and PT. Assessments/screenings completed for those individuals who were newly admitted were completed within 30 days of admission. Four of four individuals (new admissions) had received an OT/PT assessment. For individuals receiving services (sample #5), the individual was provided an OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a	

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		change in status. Based on record review of two individuals or 33% of those receiving services, two of two (100%) reviewed had received an OT/PT assessment within the last 3 years. Based on record review of two individuals, or 33% of those receiving direct services (sample 5) two of two (100%) reviewed had received interim update(s). Individuals determined via comprehensive assessment to not require OT and/or PT services did not receive subsequent comprehensive assessments when indicated by change in status or PST referral. Based on review of individuals with changes in status (sample #1), there was not an assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #413 was diagnosed with aspiration pneumonia on 4/14/11 and 5/12/11 with no evidence of discussion or assessment by the PNMT. The PST conducted a risk screening on 4/16/11 but there was no evidence of discussion regarding etiology of the event or review of the PNMP. • Individual #291 had aspiration pneumonia on 5/30/11 with no evidence of discussion, assessment or review of the PNMP by the PNMT or PST. • Individual #342 had aspiration pneumonia on 3/10/11 with no evidence of discussion, assessment or review of the PNMP by the PNMT or PST. • Individual #299 was observed sitting with a posterior pelvic tilt in the chair and per DCP report was a new occurrence but there was no evidence of assessment or review. Per report, OTs/PTs were not consistently notified of referrals in a timely manner to ensure completion within 30 days. Orders were sent via fax but follow up regarding receipt did not exist on a consistent basis.	
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	Based on review of comprehensive OT/PT assessments or updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans and clinician progress notes for nine individuals receiving OT/PT services, plans were developed within 30 days of the date of the assessment/update as indicated by the assessment. Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills. Please refer to Provisions O.2 and P.1 regarding assessments in response to a change in status. Intervention plans related to positioning were based on objective findings in the	Noncompliance

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	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.	comprehensive OT/PT assessment or update with analysis to justify specific strategies. Based on reviews of PNMPs and other positioning plans for 12 individuals (sample #4), equipment was specified for 12 of 12 (100%) plans reviewed. Within 30 days of the annual PSP, or sooner as required for health or safety, a plan was developed as part of the PSP but was not consistently reviewed by the PST. Plans were generally limited to the PNMP that was reviewed at the time of the annual PSP and were updated as needed due to a change in status. The main issue was that there was little to no evidence that the majority of plans were reviewed by the PST related to program changes or changes in status. For example: • Individuals #591 and #163 had their PNMPs updated in response to a change in status but there was no evidence of PST review or discussion of these changes. Interventions were generally present to enhance: movement; mobility, range of motion, independence, and as needed to minimize regression. Other than the limited evidence of direct intervention discussed above, the primary support provided was via the PNMPs. PNMPs and Special Service objectives (SSOs) addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; interventions did not focus on skills acquisition or independence. PT intervention was generally designed to address gait, ambulation, and transfers and range of motion. OT intervention was designed to promote range of motion or to provide splints. The few interventions in place were well documented and had established measurable and functional goals. Justification for continued therapy or discharge was well justified as a result. Programs and interventions for other skill acquisition were not identified as a need and, as such, were not provided. The PNMP addressed use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used but lacked the specificity needed to ensure safe oral care and medication administration. Please refer to section O for additional information. Based on reviews of PNMPs and other positioning plans for 12 individuals (sample 4), the rationale for the plans are clearly stated in the OT/PT assessment or update for 12 of 12 (100%) plans reviewed. Assessments clearly stated that the PNMPs should be followed as well as stating the function of the device. This has significantly improved since the previous review. Based on reviews of PNMPs and other positioning plans for 12 individuals, equipment is	

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		specified and identified in a photograph(s) for 12 of 12 (100%) plans as indicated, however, the rationale for the provided equipment was not consistently present on the PNMPS	
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.	Though equipment generally was available and improvements since the last review were noted, implementation by staff was not consistently performed as intended per the PNMP or per the generally accepted professional standards of care. For examples, please refer to provision O.4. Staff successfully completed general and person-specific competency-based training related to the implementation of OT/PT recommendations. Based on review of training rosters and in-service outlines, direct support staff, 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 12 of 12 (100%) individuals reviewed in the sample (sample 4). Staff was unable to verbalize rationale for interventions. Based on interviews of direct support staff, staff did not understand the rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the OT/PT plans and /or PNMPs. Lack of understanding regarding why an intervention was important contributes to a lack of urgency regarding implementation. Based on interviews with direct support professionals: o In five of seven (71%) interviews with staff, staff were able to identify the location of OT/PT plans. o In three of seven (42%) interviews with staff , staff could describe individual-specific OT/PT strategies. o In four of seven (57%) interviews with staff, staff could describe the schedule for implementation of OT/PT strategies. o In three of seven (42%) interviews with staff, staff stated they had received individual-specific training for OT/PT strategies.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and	The Facility had not yet developed a system to monitor and address all the requirements of this provision, although progress has been made. Per maintenance spreadsheet and OT/PT monitors, a system still existed that was designed to routinely evaluate fit, availability, function, and condition of all adaptive equipment/assistive technology. A formal system did not exist that ensures staff responsible for positioning and transferring high risk individuals receive training on positioning plans prior to working	Noncompliance

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	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.	with the individuals. This includes pulled and relief staff (Refer to Section O-5). A policy/protocol addressing the monitoring process did not exist and did not provide a clear direction regarding its implementation and action steps did not exist at this time at BSSLC. Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions which included: o Definition of monitoring process o Identifies monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities o Formal schedule for monitoring to occur o Re-evaluation of monitors on an annual basis by therapists and/or assistants o Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor Responses to monitoring findings were not clearly documented from identification to resolution of any issues identified. There was documentation noted directly on the monitoring form as well as a bimonthly report sent to the house therapist but the issue with the process was that there was no data system to collect and aggregate data obtained from the completion of the monitoring forms. On a regular basis, all staff were monitored for their continued competence in implementing the OT/PT programs. This was accomplished through the use of annual refresher trainings that focused on lifting and transfers as well as the monitoring of the PNMPs. A stated in provision O.5, an I-learning course was still in the process of being developed. Another way staff were monitored was through the use of the comprehensive PNMP monitoring form.	

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

1. 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.
2. 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.
3. 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.
4. 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.

5. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines as outlined in the OT/PT evaluation template.
6. More oversight and directions were indicated for the PNMPCS in order to ensure that there is consistency in the schedule and frequency of monitoring. This should be reviewed for compliance on a routine basis. There were a number of observations noted by the Monitoring Team that should have been picked up through the monitoring procedures.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI) 7/12/11 2. Dental Records for Individuals #449, #406, #536, #595, #512, #138, #139, #126 and #12 3. BSSLC Client Services/Medical Services: Dental Policy III.2.a, undated 4. Dental Report Form 5. Active clinical records for Individuals: #102, #478, #56, #557, #84, #291, #381, #83, #129, 334, #325, #24, #48, and #312 **People Interviewed:** 1. Jennifer Nguyen, DDS 2. James Ligon, DDS 3. Vicky Kenjura, Dental Hygienist 4. Jennifer Pampell, Dental Assistant **Meeting Attended/Observations:** 1. Observation of Individuals #478, #56, #102 and #56 at Day Program 2. Observation of Individual #56 at the annual Personal Support Plan Meeting
	Facility Self-Assessment: The Facility reported to the Monitoring Team that because of inadequate staffing, they were unable to effectively progress toward Settlement Agreement compliance. They reported that the Dental Policy was revised on June 28, 2011 and that they are currently attempting to hire a dentist and dental hygienist. In addition, the dental office was able to develop a new "dental report" form, which reflects the individuals' current dental issues and needs; have developed a database to track dental appointments; and generate a daily dental report that is emailed to residential staff for communication and follow up. The Facility reported that they remain out of compliance with both provisions of section Q, of the Settlement Agreement.
	Summary of Monitor's Assessment: The Monitoring Team clearly recognized the serious staffing issues experienced by the Dental Office. The lack of appropriate number of Dentists, and Hygienists and limited dental assistance, is preventing progression towards compliance with the Settlement Agreement and is adversely impacting the lives of Individuals served at the Facility. At present there is only one dental assistant who is also responsible for all clerical activities; one dental hygienist, who is also responsible for the sution tooth brush program;, and one dentist. The Facility is recruiting one full time dentist and hygienist; however, no dental assistants are being hired.

	The Monitoring Team determined that dental policies and procedures were inadequate; oral health and dental services were not adequately provided to Individuals served; desensitization programs were not implemented; and total intravenous anesthesia (TIVA) was ineffectively utilized. Dental Services must address these concerns, and implement corrective actions immediately. Given its findings, as outlined above, the Monitoring Team had determined that the Facility remains out of compliance with Provisions Q.1, and Q.2, of the Settlement Agreement.

#	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 Monitoring Team met with the out-going Director of Dental Services, Dr. Ligon, the newly hired Director of Dental Services, Dr. Nguyen, the Facilities Dental Hygienist, Ms. Conjure, and Ms. Pampell, who also serves as the Dental Office clerk and dental assistant. At the time of this review, the Facility had one Dental Director who also served as the Facility's only Dentist, one hygienist, and one dental assistant, and no office support staff. The Facility had recently posted an opening for an additional Dentist and Hygienist. There are no positions for additional assistants or office support staff. Because many of the individuals served at the Facility cannot participate independently in dental care or may be uncooperative, Dentists and Hygienists cannot work independently, and must have adequate support by at least one dental assistant, whenever performing direct care. Primarily because of limiting staffing, the Facility has made little progress towards compliance of Section Q, of the Settlement Agreement. It was reported to the Monitoring Team, by Dental Office Staff, that oral hygiene remained deficient at the living area. When individuals are seen at the dental office, there is evidence of "undisturbed plaque," which is indicative of lack of tooth brushing. Inadequate oral hygiene was reported to be pervasive, including people that do not have significant behavior challenges. This issue is of serious concern to the Monitoring Team, as it not only causes poor dentition but also can lead to serious and potentially lethal medical consequences, secondary to aspiration pneumonia, cardiac issues and other serious infections. Evidence to support this issue is supported by reviewing the dental records of Individuals #449, #406, #536, #595, and #512. In addition, the Monitoring Team observed exceptionally poor oral hygiene while observing the following Individuals at Day Program: #478, #56, #102 and #56. The Monitoring Team had attempted to get an accurate, up to date schedule of all persons who had "completed" their annual exam and treatments. However, because the Facility did not have an adequate mechanism to track dental services, other then a very basic access database and calendar, it was not possible to obtain an actual accounting of individuals who had "completed" their annual exam. The Monitoring Team was informed	Noncompliance

#	Provision	Assessment of Status	Compliance
		that since April 2011, 204 individuals had been seen. Per interview, many times, individuals were scheduled and seen for their annual assessment and care; however, because of behavior challenges they did not have their exam completed (exact numbers or accurate estimates were not provided). The Facility does not use any form or oral sedation or oral anxiolysis to support people who experience mild behavior challenges, and the use of TIVA for individuals with moderate to severe behavior challenges was limited to a total of six individuals per month. Since April 2011, there were four reported dental emergencies (Individuals #138, #139, #126 and #12). Review of the Dental Records indicated that appropriate treatment was realized, and completed timely. The policy for dental emergencies was reviewed by the Monitoring Team and was determined to lack specificity and did not indicate adequate back-up services, in the event that the Facility Dentist and Hygienist was not available. The Facility must have necessary back-up professional staff to address dental emergencies after hours. The Facility's Policy for all Dental Services is incorporated into one six page document, entitled "Client Services/Medical Services; Dental." The copy provided to the Monitoring Team was undated. Following review of the Dental Policy, the Monitoring Team determined it was vague, lacked specificity and did not provide adequate guidance to staff. For example, in the event of a dental emergency, the policy simply states that the Facility on-call Physician will be notified and "if he/she decides that treatment is needed, then he/she will consult with the dental hygienist, whose phone number is located on the on-call sheet. The dental hygienist will then notify the dentist to determine if:" The policy does not provide latitude for contacting other professional staff in the event that the Facility's one hygienist is unavailable – the Hygienist can not take 24/7 call, nor can a Dentist take 24/7 call, hence there must be additional resources available to the Facility in the event of a dental emergency. The Policy also provides exceptionally vague procedure, in the event of an avulsed tooth. In this situation, the policy gives staff direction on attempts to place the tooth back into the individual's socket and how to preserve an avulsed tooth in the event it cannot be replaced into the individual's jaw. The policy does not indicate what staff is involved in this process and uses terms such as "as soon as possible." The Facility's Dental Policy must be reviewed and revised. The Monitoring Team attending a Personal Support Meeting (PSP) for Individual #56. During the Meeting, the PSP members did not address dental issues, until the relative of the individual commented on the Individual's poor dentition. The Team members had to go through the clinical record and attempt to formulate a dental history and plan. The Monitoring Team observed the Individual's oral hygiene to be extremely poor. The gums	

#	Provision	Assessment of Status	Compliance
		were hypertrophic, erythematous, and significant plaque build up was noted and large pieces of food material present. The individual also was noted to have severe bruxism. These issues were not noted in the Clinical Record, nor addressed by professional staff, or the PST. The Monitoring Team discussesd these concerns with dental office staff, who reported that the individual has significant behavior challenges that prevent essential exams and treatments. Of concern, the individual had not been evaluated for TIVA. The dental office developed a form to communicate dental issues that is referred to as "Dental Report". This report could enable adequate communication of dental issues, as well outlining services and supports needed to enable quality oral and dental care and could also inform the team of potential risks and benefits of treatments and lack of treatment. A dental report was not in the active clinical record, nor presented at the PSP meeting. The Facility's Dental Hygienist provides oral suction tooth brushing at the living area during the morning hours on Monday through Thursday; general dental hygiene is not available to individuals during that time. The Facility had yet to develop a comprehensive list of all individuals who require suction tooth brushing at the Facility. It was reported by dental staff that many times oral tooth brushes are dry, upon inspection by the dental hygienist, indicating that staff have not provided this necessary treatment. Following review for Provision Q.1, of the Settlement Agreement, the Monitoring Team concurs with the Facility's self assessment of non-compliance. This outcome was determined based on the above observational assessments of individuals served, attending a PSP meeting, review of clinical and dental records and discussion with dental office staff.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to	Regarding Dental Policies and Procedures, please refer to Provision Q.1. Dental Policies are not specific and do not enable adequate guidance for Facility staff. The Monitoring Team requested a complete list of all individuals who underwent TIVA for dental treatment, during the past six-month period. The list generated indicated that only 19 individuals received treatment under TIVA and there was no active "waiting list." Dental office staff reported that there are "many more" individuals at the Facility who could benefit by TIVA. It was reported that no more then three, and sometimes fewer, individuals are provided per TIVA treatment day (there are two TIVA days scheduled per month). The Monitoring Team had determined that the number of Individuals enabled treatment per TIVA was significantly inadequate, and that the TIVA process must be re-evaluated. No individuals are provided oral sedation or anxiolysis, to assist in the event of mild behavioral challenges; although provision of pre-treatment sedation or anxiolysis might reduce need for TIVA, monitoring would still be needed to ensure safety.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	As previously discussed in Provision Q.1, of the Settlement Agreement, the current scheduling system does not enable an adequate reflection of dental services of individuals served ; staff can not effectively or efficiently identify treatments and services that have been completed and that are pending completions, by the dental office. The dental office staff reports that the Individual's QMRPs are writing desensitization programs for Individuals who could benefit by a desensitization program. To date, the dental office had not seen one individual for treatment who has a desensitization program. The Monitoring Team has determined that the Facility had an ineffective desensitization program, at the time of its review. The dental office employed the use of a "Dental Report" that, if used appropriately, could provide the PST and PSP with adequate information to better understand oral and dental health care issues and required services and supports. By review of active clinical records for Individuals #102, #478, #56, #557, #84, #291, #381, #83, #129, 334, #325, #24, #48, and #312, and attending a PSP meeting for Individual #56, the Monitoring Team determined that there was significant and serious lack of integration of oral and dental needs throughout the team process, and that legally responsible representatives were not provided adequate information regarding oral and dental health care needs.	

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

1. Immediately determine adequate staffing needs. Ensure that Dentists and Hygienists have appropriate staff support while performing dental treatments
2. Immediately develop a scheduling mechanism that will enable staff to accurately and efficiently identify current, past and scheduled dental treatments and other therapies.
3. Immediately determine individuals who could safely benefit from anesthesia and anxiolysis.
4. Enhance integration of oral and dental health care issues in the PST process and ensure that oral and dental health care issues are communicated to the legally responsible representative
5. Conduct a comprehensive review of all Individuals at the Facility and establish appropriate treatment plans to ensure that oral and dental health care issues are appropriately addressed
6. Ensure that living area staff have necessary training to safely provide suction tooth brushing to persons who require such treatment, and general oral hygiene to all individuals at the Facility. Regular supervision and monitoring of direct care providers should be established specific to their providing of oral hygiene. Oral hygiene must be improved immediately.

7. Immediately collaborate with psychological services to ensure that a meaningful desensitization program is in place at the Facility.

8. Review and revise the current dental policy.

The following are offered as additional suggestions to the Facility:
1. Consider sharing the "Dental Report" process with Medical Services, so that they may develop a similar process to communicate medical issues at PST and the annual PSP meetings.

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:** **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI), dated 7/12/11 2. Record Reviews of Individuals: • Individual Sample #6 (Individuals #1, #32, #61, #68, #87, #91, #165, #169, #230, #237, #246 #283, #337, #403, #470, #588) 3. Communication Services and Supports (Policy 016 dated 10/7/2009) 4. Localized Communication Services and Supports policy (not dated) 5. A list of people with Alternative and Augmentative Communication (ACC) devices 6. AAC screening forms 7. AAC evaluation and Speech Language assessment template 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 **People Interviewed:** 1. Kori Kelm Director of Habilitation Services 2. Erin Pepper SLP 3. Donna Baron SLP 4. Direct Care Professionals on (2) Childress, (3) Driscoll, (2) Bowie, and (3) Program Services **Meeting Attended/Observations:** 1. Daily activities on Bowie, Driscoll, Childress, and Program Services
	Facility Self-Assessment: BSSLC Plan of Improvement, updated 7/12/2011, provided comments/status for Section R. BSSLC stated that compliance had been achieved with provision R.1 and all other provisions were noncompliant. This was inconsistent with the Monitoring Team's findings. The Monitoring Team found R.1 to be noncompliant secondary to lack of staff needed to participate in all phases of care in which communication is either needed or integrated. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive Assessment of compliance with each of the indicators. The POI did not include data from its self assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self assessment process, it will be important to ensure that data is used in meaningful ways to assist in Identifying areas in which improvements are needed.
	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. Per report and observation, SLPs were not able to adequately track or write goals or provide the level of monitoring and modeling needed to implement communication strategies and policies at the home level. **Provision R.2:** This provision was determined to be in not in compliance. Individuals identified as having decreased communication had not consistently been provided with the needed assessments; however, the assessments being provided by BSSLC since November 2010 were noted to be comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning. Additionally, BSSLC presented a plan that would ensure all individuals would receive the new comprehensive assessments by the end of 2013. Due to the significant improvement and the plan identified by BSSLC to assess all needed individuals, continuation of the current practice should result in substantial compliance by the next review as a larger sample will be available that includes the revised assessments.. **Provision R.3:** This provision was determined to be not in compliance. DCPs interviewed were not knowledgeable of the communication programs and communication plans and how the individual communicates was not consistently included in the PSP. **Provision R.4:** This provision was determined to be not in compliance. BSSLC had 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. It should be noted that significant progress had occurred with the communication assessment and that many of the assessments reviewed were some of the best that this Monitoring Team had seen from any of the state centers.

#	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	The Facility did not provide an adequate number of Speech-Language Pathologists or other professionals (i.e. Assistive technology (AT) specialists) with specialized training or experience. As of this review, BSSLC had five full-time Speech-Language Pathologists in addition to the augmentative communication specialist. This represented 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 continuing education in the last 12 months. Although the number of therapists filled all the available positions, therapists continued	Noncompliance

#	Provision	Assessment of Status	Compliance
	assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	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 improve the likelihood 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. Twelve of 16 (75%) individuals reviewed (sample #6) did not have appropriate communication goals. Examples of goals not being written appropriately or not written at all included: • Individual #68's communication goal stated to assist with communication book as needed but did not provide any additional information • Individual #403's Communication assessment states that the individual never responds to pictures but the goal written by the QMRP focused on the use of pictures. • Individual #165's communication assessment identified multiple strategies to utilize and areas to focus on communication but there was no evidence of these strategies being developed into a meaningful goal. Per interview with SLPs, therapists' time was focused on the development and completion of improved assessments, and they did not have the time needed to track down devices, follow up on training, write goals, monitor goals and ensure staff involvement with implementation of the plans.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	Through interview with the Speech Therapists and based on review of individuals observed to be nonverbal and/or with a limited form of expressive language, it was noted that there were numerous individuals in need of AAC who were not consistently identified as being in need of AAC or were not provided with base communication goals to improve expressive language. In 10 of the 16 records (62%) 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. In 10 of the 16 (62%) records reviewed, the Communication Assessment addressed: • In 10 of 16 (62%) records reviewed the assessment addressed verbal and nonverbal Skills.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• In 10 of 16(62%) records reviewed the assessment addressed expansion of current abilities. • In 10 of 16(62%) records reviewed the assessment addressed development of new skills. • In 16 of 16 (62%) records reviewed the assessment addressed whether the individual requires direct or indirect Speech Language services. • In 10 of 16 (62%) records reviewed the assessment addressed the need for further assessment in Augmentative Communication. An important issue to note was the substantial improvement of the communication assessments completed post November 2010 (when a new format was implemented). Assessments were noted to be much more detailed and included all the components needed to not only identify and explain any deficits in communication but provide detailed strategies to help improve interaction and involvement with one's environment. The assessments that did not contain all the needed elements were assessments that were completed prior to the new assessment format and process. While noncompliance remains (due to small sample), continuation of this practice should lead to substantial compliance during the next review. BSSLC should be commended for the improvement of their assessments skills as it relates to speech and language. Per interview and provided documentation of the plan to address individuals with severe impairments, BSSLC's process was as follows: Goal: Every individual with severe speech language impairments will receive a comprehensive speech language assessment with AAC screening and/or evaluation in the next 2 years (Projected Completion: December 2013) • Each month the SLP will determine which assessments are due and must be completed based on the SLP policy, Personal Support Plan calendar, master plan and last assessment recommendations • The SLP will complete a comprehensive assessment to include AAC screening and/or evaluation that focuses on the needs of the individual • The SLP will focus on providing quality assessments, producing quality reports and providing appropriate and effective implementation and monitoring of AAC in order to focus on the needs of the individual • The process will continue monthly until all individuals have a received a comprehensive assessment.	

#	Provision	Assessment of Status	Compliance
		Since the new assessment process was developed in November 2010, approximately 84 individuals (26%) of the census have received the new comprehensive assessment. For persons receiving behavioral supports or interventions, the Facility had a process designed to identify who would benefit from AAC or communication assistance. Per interview and review of PBSC minutes, an SLP regularly attended the meeting and served as a liaison to the other therapists. Additionally, the behavior support plans are distributed prior to the committee meeting thus allowing all members of the communication staff to review and determine potential correlations between the behaviors being addressed and the impact communication or lack of communication. A policy existed that outlines assessment schedule and staff responsibilities. BSSLC had developed a localized policy that addressed the frequency and depth/detail of assessments and services that would be provided. The issue lies in that the policy does not include clear guidelines regarding monitoring of the plans or goals related to speech and language. These issues will be discussed in more detail in provisions R.3 and R.4. All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission. Since the previous review, there were four individuals admitted to BSSLC. Records for four of these individuals were requested, including Individual #381, Individual 479, Individual #511 and Individual #590. Four of four individuals (100%) received a Speech Language evaluation within 30 days of admission. The admission evaluations were signed and dated by respective Speech Language Pathologist(s).	
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.	In zero of the 16 records reviewed (0%), goals and objectives were determined to be functional and meaningful as evidenced by the demonstration of progress and or improvement. Programs, goals and objectives related to the acquisition or improvement of speech or language were not written by the SLP. In zero of 16 records reviewed (0%), individuals with needs for language acquisition had goals/objectives/outcomes written and followed by the SLP on a monthly basis if service is direct and quarterly if indirect. Rationales and descriptions of interventions regarding use and benefit from AAC were not clearly integrated into the PSP. Three of the 16 records reviewed (18%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included: • Individual #91's PSP did not mention communication.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual #237's PSP simply stated that the individual was not interested in AAC. PSPs contained reference or a brief statement of an individual's communication skills but does 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 PSPs offered very limited descriptions of how an individual communicated with others**.** In most cases only recommendations from the communication assessment were identified rather than descriptions of the individual's abilities or potentials. Strategies that staff could use to communicate were also very limited or non-existent. Some examples included: • Three of the 16 records reviewed (18%) clearly identified how the individual communicates with others and interacts with his surroundings. For example: o Individual #403's communication assessment stated that he never responds to pictures but the SSO has him working with pictures. This demonstrates lack of review prior to the development of goals. • Communication information was not integrated into the daily schedule. o Zero of the 16 records (0%) reviewed had communication interventions and methods to improve communication integrated into the daily schedule. Communication interventions were referenced in the assessment section of the PSP but there was limited evidence of integration of the individual's methods for expressive or receptive communication as well as strategies for use by staff throughout the document as well as in other programs such as day program, skills training on the home, or in leisure activity program plans. • Individual #68's assessment stated that verbal prompts and gestures to help improve cooperation and comprehension but there was no evidence of these strategies integrated into his service objectives. SLP's 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: • Individual #68 was provided with a Dynavox trial but there were no notes indicating status of trial and/or progress. • Individual #337 was provided with a trial of a device but there was no evidence of therapy or discharge from therapy. Staff were not trained in the use of the AAC. Although AAC is trained during new	

#	Provision	Assessment of Status	Compliance
		employee orientation, the information contained within the training did not filter down and present itself at the home level. Zero of the nine direct support professionals interviewed (0%) were knowledgeable of the communication programs as evidenced by: o In zero of nine (0%) interviews with staff, staff could describe individual-specific communication strategies. o In zero of nine (0%) interviews with staff, staff could describe the schedule for implementation of communication strategies. o In zero of nine (0%) interviews with staff, staff stated they had received individual-specific training for communication strategies. General AAC devices were readily available in all common areas. Four of the four (100%) homes had general AAC devices present in the Common areas. However, zero of the four (0%) common area AAC devices contained clear directives on how staff should utilize general AAC devices. Although the number of devices had increased, the use of the devices throughout the day did not increase unless a formal goal was being trained. During the observations on Fannin, Childress, Bowie, and Program Services, there was no utilization of the communication boards by staff although there were multiple opportunities (such as mealtime) in which the use would have been beneficial and appropriate. Communication strategies/devices were not implemented and used. Four observations demonstrated that staff did not implement interventions and recommendations outlined in the Communication Assessment. Examples of individuals where staff did not implement a communication program as written included: • Individual #68 was not observed using sign or communication book. • Individual #32 was not observed using Velcro communication book. • Individual #588 was not observed using communication book.	
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	A monitoring system was in place that tracked the presence of the ACC and working condition of the AAC but did not address the effectiveness of the device. A review of Facility monitoring reports from January 2011 to June 2011 documented that staff were not being monitored in all aspects of AAC utilizations: This included: • In six of six (100%) monthly reports reviewed, the presence of the ACC was documented. • In six of six (100%) monthly reports reviewed, the working condition of the AAC was addressed. • In zero of six (0%) monthly reports reviewed, the implementation of the device was addressed.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• In zero of six (0%) monthly reports reviewed, the effectiveness of the device was documented. Monitoring did not cover the use of the AAC during all aspects of the person's daily life in and out of the home. The individual record sample documented that equipment monitoring occurred in the Individual's residence only. There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author. Validation checks occur when two professionals observe the same individual and then compare findings to ensure consistency. Validation checks are essential in assuring accuracy of reports and consistency between staff conducting the monitors.	

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

1. 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 to provide 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.
2. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as their PBSPs to ensure the AAC device is meaningful to the individual and the individual has a voice in multiple environments.
3. Progress notes should be completed, and should justify the initiation, continuation or discontinuation of speech therapy supports, including an analysis to determine the efficacy of the direct therapy supports provided. If progress was not made, recommendations and/or objectives should be revised.
4. Communication Goals should be followed by the SLP on a monthly basis if service is direct and quarterly if indirect.
5. 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.
6. Staffing was not sufficient to meets all the needs of the individuals. This especially relates to the availability of staff to provide modeling and monitoring of goals and objectives, as well as the ordering of equipment.

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. BSSLC Plan of Improvement (POI) dated 7/12/11 2. Facility Policies and Procedures: Counseling Policy undated 3. Minutes for the Positive Behavior Support Committee (1/1/2011 – 07/01/2011) 4. Minutes for Behavior Services departmental meetings (1/1/2011 – 07/01/2011) 5. Curriculum materials for the Q Construction Training 6. Contracts for professionals providing external peer review, intellectual and adaptive assessment, and counseling. 7. 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: Individuals #1, #3, #5, #9, #11, #12, #15, #20, #27, #31, #51, #57, #60, #65, #84, #98, #120, #131, #151, #181, #181, #202, #247, #255, #259, #286, #299, #314, #342, #349, #381, #390, #399, #400, #412, #417, #425, #467, #478, #479, #484, #488, #490, #493, #538, and #595. **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. Vickie Morgan, MD – Psychiatrist 7. Andrea Miller – Program Services 8. Pam Boehnemann – QMRP Coordinator 9. Michael Doebler – Vocational Services 10. Cheryl Powell – HRC 11. Ric Savage –Training Consultant 12. Active Treatment Monitors 13. Direct Care Professionals **Meeting Attended/Observations:** 1. Risk Management Meeting – 7/26/2011 and 7/27/2011 2. PSP for Individual #390 – 7/26/2011 3. Restraint Reduction Committee – 7/26/2011 4. Positive Behavior Support Committee – 7/25/2011

	5. Psychology – Psychiatry Workgroup – 7/27/2011 6. Human Rights Committee – 7/28/2011
	Facility Self-Assessment: BSSLC reported in the self-assessment that no Provisions of the SA were in substantial compliance. The Monitoring Team agreed with the findings of the self-assessment. In addition, however, the Monitoring Team did find that considerable progress had been made in relation to skill acquisition assessment and training.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 7/25/2011 through 7/29/2011. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that no Provisions in section S of the SA were in substantial compliance. Despite the lack of substantial compliance with the Provisions, the review process did reflect that the Facility had achieved considerable progress in many areas. One area of progress involved the development of skill acquisition programs. During the documentation review, it was noted that 100% of sampled skill acquisition programs included the majority of necessary components, such as operational definitions, schedules for implementation, and specific consequences for successful trials. It was also noted that BSSLC was involved in the pilot of a new Functional Skill Assessment (FSA) protocol. It was positive to see that an attempt had been made to replace the previous assessment instrument. The new FSA included improvements in items, the assessment procedure, and the expansion of skill rating beyond "Strength" and "Weakness". Despite the improvement represented by the FSA, however, it was not clear that the protocol was sufficient for skills assessment that would assist in identification of goals for acquisition. The new FSA lacked the sensitivity to differentiate between subtle differences in skill use. In addition, the FSA lacked individualization. Despite improvements in the skill acquisition programs, the implementation of those programs was inadequate. Staff were seldom observed providing formal or informal training, and individuals were often observed in situations that lacked functional activity. Based upon the findings of the current site review, it was evident that considerable work remains before substantial compliance with the SA can be achieved.

#	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	Since the site visit completed in January 2011, the Facility reported that a substantial amount of staff training had been completed. One training target included the PSP process. The QMRPs and PST members were provided PSP training using the "Q Construction: Facilitating for Success curriculum." This curriculum focused upon terminology, leadership skills, organizing priorities, and team building. QMRP staff	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	reported that the training was very beneficial and displayed enthusiasm for the new approach. In order to assess the impact of the Q Construction training, a PSP meeting for Individual #390 was observed on July 26 2011. The following limitations were noted during the PSP meeting. • Minimal effort was demonstrated by the QMRP to include the individual's sister, who was on speakerphone, in the PST discussion. o Shortly after the PSP meeting begins, the sister states twice that she cannot hear the conversation. The QMRP does not ask PST members to speak louder or move the phone to capture the discussion better. o Three times during the PSP meeting, while the sister was conversing with the individual, the QMRP continued the PST discussion. This prevented both the sister and the individual from participating in the discussion. o At 3:00pm, 40 minutes had passed without the QMRP directing comments or questions to the sister. • Multiple instances reflected poor awareness of the individual's preferences or attempts to meet the individual's preferences. o The SLP indicated that the individual preferred to use speech to communicate, but is often difficult to understand. It was reported that the individual had "rejected" programming and communication devices, but the PST did not discuss ways to explore this "rejection" or to devise alternate strategies. o Although the individual indicated that he preferred to work, he had attended the Harmony retirement program for several months. o It was indicated that the individual enjoyed television and radio. Both his television and radio had been broken for several months. o During the discussion of attending church services, the individual indicated he would like a tie to wear. His comment was ignored. • The PST discussion did not offer full and completed discussion of programmatic needs. o Despite fine motor limitations, no discussion was offered concerning the need for adaptive dining equipment. The SLP indicated a PNMP was needed, but there was no discussion of why the plan was needed or what it would involve. o When undesired behavior was discussed, the psychologist indicated that indicated that behavior that had been labeled as pica, "was behavior and not true pica." No further discussion of pica or undesired behaviors was offered. • The PST failed to assess risk and the provision of adequate protections fully. o A medical assessment had revealed silent aspiration of thin liquids and	

#	Provision	Assessment of Status	Compliance

chopped meats. The nurse indicated that she "had no idea where the diagnosis of dysphagia came from." No further discussion of the condition was offered.

- In discussion of the circulatory risks, the nurse indicated that many things were close, "but technically in the safe range." No further discussion was offered.

Another area in which the Facility had provided staff training since the previous site visit involved the development of skill acquisition programs. Specifically, Facility staff were provided training on task analysis, the format for skill acquisition programs, skills assessment, and the use of the Murdoch Center Program Library materials.

In order to assess the progress achieved in regard to skill acquisition programs, a sample of 15 individuals was selected. The individuals selected were identified by the Facility as reflecting the best skill acquisition programs. The findings of the review of this sample ware presented below in comparison with findings from the baseline site visit.

	01/2010	07/2011	Change
Plan reflects development based upon a task analysis	0%	100%	100%
Behavioral objective(s)	0%	100%	100%
Operational definitions of target behavior	0%	100%	100%
Description of teaching conditions	0%	100%	100%
Schedule of implementation plans for sufficient trials for learning to occur	0%	100%	100%
Relevant discriminative stimuli	0%	100%	100%
Specific instructions	0%	100%	100%
Opportunity for the target behavior to occur	0%	100%	100%
Specific consequences for correct response	0%	100%	100%
Specific consequences for incorrect response	0%	0%	0%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	100%	100%
Documentation methodology	0%	100%	100%

The sample of skill acquisition programs reflected substantial progress over previous programs reviewed at previous site visits. One noted limitation was the lack of a specific consequence when the individual failed. The response to a failed trial is a critical component of the learning process. If reinforcement is available following a failed trial, the individual is reinforced for displaying a different behavior. Even when such

#	Provision	Assessment of Status	Compliance
		circumstances occur rarely, it is possible that the power of reinforcement for success is weakened. A second limitation was that documentation typically involved recording the level of prompting required for success. Recording the prompting level may be appropriate for some skills being learned during the initial learning process. Prompts, however, involve behavior displayed by the trainer rather than the individual who is to learn the skill. Data collection should focus upon the behavior displayed by the learner in relation to the goals of the training program. Such data collection could focus upon a variety of skill or behavior characteristics, such as the number of successful trials, the rate of responses, or the accuracy of the responses. In addition, information about prompting typically has the greatest relevance in the early stages of training. Once the individual has developed a degree of independence in relation to the skill or behavior, prompting is no longer an integral part of the learning process even though the learning process is continuing. Therefore, although data on level of prompt required for a correct response to occur may be one form of data to assess progress, it should not be the predominant or sole type of data as other types of data will be more appropriate in many cases. Adequate data collection should include such elements as the occurrence of reinforcement, incorrect responses, refusal, and displays of undesired behavior. Most importantly, data collection should capture the extent to which the individual is developing the target skill. For example, the data collection process should measure and document the frequency or rate of correct and incorrect responses, the percentage of correct responses, improvements in the speed of responses, etc. The current process of revising the skill acquisition programs was not completed for the entire Facility at the time of the current site visit. In addition, the issues of consequence for failed trials and the type of data collected remained to be addressed. Nevertheless, the efforts by the Facility in the area of skill acquisition programs reflected substantial progress toward compliance with the SA. Furthermore, skill acquisition training can occur in a number of different areas. The Facility, in some cases, developed interventions that had a focus on management of a condition but did not consider the role of skill acquisition. For example, physical therapy interventions were generally present to enhance: movement; mobility, range of motion, independence, and as needed to minimize regression. Except for limited evidence of direct intervention by a physical therapist, the primary support provided was via the PNMPs. PNMPs and Staff Service objectives (SSOs) that addressed areas related to positioning, transfers, handling, and mobility, but interventions were limited when related to promoting independence and skill acquisition; interventions did not focus on skills acquisition or independence. Similarly, the use of replacement behaviors within	

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		PBSPs to provide an alternative way to achieve functional reinforcement can include skill acquisition; however, it was not clear that the PST paid attention to skill acquisition, as data on replacement behaviors showed no progress in some cases for extended time without revision of the training programs. Habilitation and skill acquisition occur not only through provision of formal training but also through planned and informal activities to support maintenance of learned skills and to provide learning opportunities for a wide range of skills. Staff were seldom observed providing formal or informal training, and individuals were often observed in situations that lacked functional activity.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Since the previous site visit, BSSLC was selected by DADS to pilot a new Functional Skills Assessment (FSA) protocol. The FSA piloted at BSSLC reflected advancement from the previous PALS assessment. Rather than listing a variety of skills as either a strength or weakness, as was required by the PALS, the FSA was constructed more like a task analysis of a variety of skills. Each individual is rated by the level of prompting required for success on skill or task. This provided a more detailed representation of each individual's abilities. Despite the improvement represented by the FSA, it was not clear that the protocol was sufficient for skills assessment. One substantial limitation was the lack of granularity and individualization reflected in the FSA. For example, one item under "Household/General Safety" required the level of prompting necessary for the individual to cooperate with a fire drill. Cooperation during a fire drill is an important skill, but more information than just level of prompting is required to determine an individual's ability in this area. A second limitation was the apparent inability to assess those individuals with physical limitations upon the use of skills. For example, one item under "Meal Time Skills" was "Eats with a utensil". For some individuals, eating with a utensil would not be physically possible. For other individuals, extra time might be required to control fine motor coordination. These types of circumstances have no relation with the level of prompting required. The FSA included an area for comments on each item, but providing a comment about the inability of the FSA to measure the skills would not equate with assessing that skill. It would be unrealistic to expect that any instrument designed for the assessment of adaptive skills would possess the ability to capture all underlying circumstances for skill deficits. It is essential, however, that such an instrument include the means by which to measure the individual's abilities in the context of the individual's physical, developmental, cognitive, and environmental circumstances. Without the ability to capture the basic information about individual abilities within these contexts, any	Noncompliance

#	Provision	Assessment of Status	Compliance
		assessment results would be of unclear benefit in understanding the individual's needed supports and services, or in the development of skill acquisition plans. In many available instruments, this limitation is in part addressed by standardizing the instrument across variables such as physical ability, intellectual ability and living environment. The FSA reviewed at BSSLC was not a standardized instrument. Therefore, a greater burden is created to ensure that the findings of the FSA provide individualized and relevant insights into the needs of the person being assessed. Based upon the review at BSSLC, the FSA was unable to meet this burden. The FSA was a draft document, and was only being piloted at the Facility. Staff indicated that revisions to the document were likely. Therefore, further time will be needed before the FSA can be reviewed as a final product. The preliminary review at the site visit suggested, however, that substantial work remained to be completed. The Monitoring Team will need to review how all assessments, including the FSA, provide the information on preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities that can assist PSTs in making decisions about habilitation services to be provided.	
S3	Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As noted in Provisions K5, K6, K7, K9, and S1, BSSLC had invested considerable effort into improving assessment and the provision of teaching. Not all efforts had been completely successful or fully implemented, but progress had been made. Observations during the site visit, however, revealed substantial disparity between improvement in development of programs and the ability of the Facility to ensure that the programs were implemented. • Staff on Bowie – C were unable to describe the methods of a PBSP to be used with an individual demonstrating aggression. Staff were also unable to find the PBSP in the chart or identify in what section the PBSP should be located. • One individual in the Bowie – C living room declined a prompt to watch a movie. Staff made no attempt to locate or provide alternative activities.	Noncompliance

#	Provision	Assessment of Status	Compliance

- In the Bowie – D dining room, one individual was holding her spoon upside-down while eating. Staff did not intervene.
- On Driscoll – D, staff were not observed to offer choices, provide materials or encourage interaction

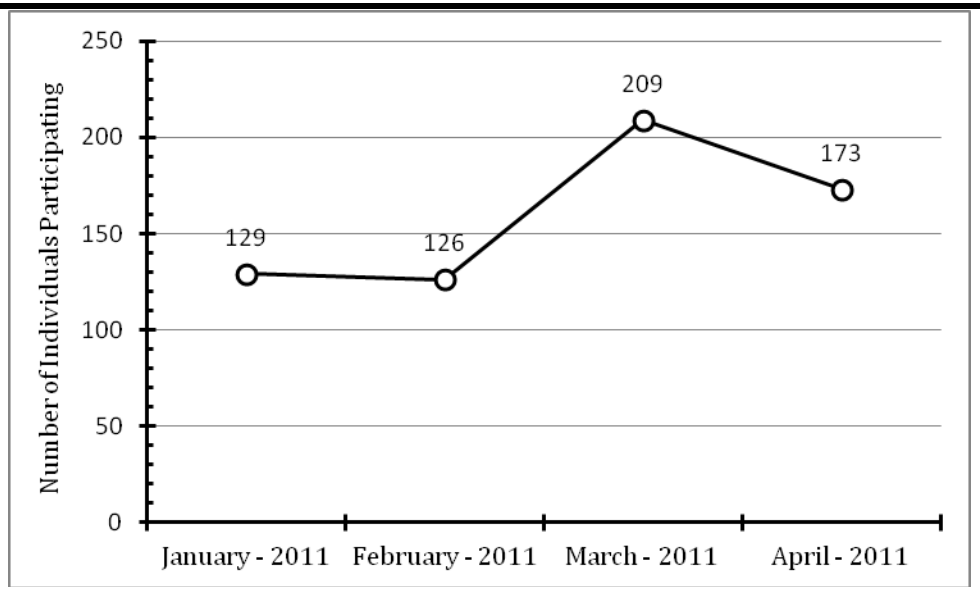
A sample of locations where individuals were expected to be involved in meaningful activities was selected for observational review of engagement and active treatment. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior.

	Staff	Individuals	Engaged	% Engaged	Ratio
Program Services A					
Dining Room	4	2	2	100%	2:1
TA2	2	7	2	29%	2:7
TA3	1	6	0	0%	1:6
Dining Room	1	3	0	0%	1:3
Program Services D					
Dining Room	1	5	5	100%	1:5
TA1	2	3	2	67%	2:3
TA2	1	5	4	80%	1:5
TA3	1	5	0	0%	1:5
TA4	2	2	2	100%	2:2
Program Services C					
TA1	1	6	2	33%	1:6
TA2	1	4	1	25%	1:4
TA3	1	6	2	33%	1:6
Dining Room	2	3	0	0%	2:3
Bowie					
A - Dining Room	2	8	4	50%	1:4
C - Dining Room	4	11	0	0%	4:11
C - Dining Room	4	7	4	57%	4:7
C - Dining Room	1	8	1	13%	1:8
D - Dining Room	5	9	4	44%	5:9
Childress					
C - Dining Room	2	4	0	0%	1:2
D - Dining Room	5	9	3	33%	5:9
	2.54	4.88	1.64	38%	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The observation reflected that, on average, only slightly more than one third of all individuals were engaged during observations. This supported that, despite improvements in skill acquisition programs, the application of those programs continued at an inadequate level.

The Facility had expanded the role and procedures of program monitors since the previous site visit. This was implemented to enhance program implementation and address concerns about low levels of active treatment. In interviews and observations, the program assessors displayed high levels of enthusiasm for their responsibilities and demonstrated a good grasp of the skills and activities they were expected to monitor and improve. The tools and procedures that they were to follow had not yet been finalized, which resulted in a lack of focus. Once the process has been finalized, the staff should possess the skills needed to provide effective monitoring and training.</td><td></td></tr>
<tr><td></td><td>(b) Include to the degree practicable training opportunities in community settings.</td><td>The site visit procedure included an observation of the vocational opportunities provided to the people living at BSSLC. As of May 2011 (the last month for which data were provided) the individuals living at the Facility were employed in the following jobs.

<table><tr><th colspan="2">May 2011</th></tr><tr><td>Workshops</td><td>99</td></tr><tr><td>Supported Employment</td><td>0</td></tr><tr><td>Client Worker Program (on campus)</td><td>2</td></tr><tr><td>Enclave Work (off campus)</td><td>20</td></tr><tr><td>Enterprise</td><td>0</td></tr><tr><td>Competitive Employment</td><td>0</td></tr><tr><td>Total</td><td>121</td></tr></table>
Since the previous site visit, the Facility had conducted numerous community outings. The number of individuals participating in community outings is presented below. The total number per month potentially included individuals who participated on multiple outings.</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		 The Facility also reported that, since the previous site visit, 10 community outings had been conducted in order to provide skill acquisition training. These trips included locations such as fast food restaurants, local retailers, and animal shelters. A total of 62 individuals participated in the skill acquisition outings, for an average of 6.2 people per outing. While it was positive that attempts were made to provide training in a community setting, 62 total participants over a six-month period falls short of full participation by individuals living at the Facility.	

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

1. Skill acquisition programs, where appropriate, should include outcome measures beyond the level of prompting required. In addition, such programs should include procedures to ensure that incorrect responses are not intentionally or inadvertently reinforced. (S1)
2. The FSA requires revisions to ensure that individual skills can be identified. (S2)
3. The Facility needs to ensure that skill acquisition programs are implemented as written, including the frequency and location of training. (S2)
4. The amount of skill acquisition training in the community needs to be substantially increased.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), dated July 12, 2011 2. BSSLC Policy on Admissions, Transfers and Reassignments 3. BSSLC Policy on Personal Support Plan Process, dated 12/10/10 4. Since January 1, 2011, a list of all individuals who have been referred for community placement by their PSTs, including name, date of recommendation, and current residential status 5. Since January 1, 2011, a list of all individuals who have requested community placement, but have not been referred for placement 6. Since January 1, 2011, 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 January 1, 2011, 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 June, 2010, a list of all individuals who have been assessed for placement since, date of assessment, and resulting recommendation(s) 10. Community Placement Report, dated June 07, 2011 11. Community Placement Obstacles, dated June 07, 2011 12. 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 13. Since January 1, 2011, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 14. Personal Support Plans (PSPs) for nine Individuals #12, #14, #68, #247, #312, #407, #471, #485, and #576 15. Personal Focus Assessments (PFA) for ten Individuals #12, #14, #68, #242, #247, #312, #407, #471, #485, #576 16. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for 32 individuals: Individuals #14, #31, #52, #56, #68, #91, #98, #131, #169, #188, #192, #195, #221, #226, #247, #299, #312, #332, #334, #371, #390, #407, #429, #446, #471, #484, #485, #493, #538, #567, #576, and #599 17. Revised Community Living Discharge Plan instructions and format, undated 18. Completed CLDPs for four individuals: Individuals #139, #386, #539, and #562 19. Partial CLDPs for two individuals: Individuals #2 and #102 20. CLDP Attendance Signature Sheets for 12 individuals: Individuals #64, #70, #99, #180, #209, #298, #311, #374, #378, #395, #438, and #559 21. Pre-Move Site Review document for eight Individuals #23, #70, #139, #196, #420, #539, #562, and

	#596 22. MRA Continuity of Care Pre-Move Site Review Instruments for eight individuals: Individuals #23, #70, #139, #196, #420, #539, #562, and #596 23. DADS Obstacles Report for the State Supported Living Centers, dated 10/10 24. Completed Post Move Monitoring (PMM) checklists for 12 individuals: Individuals #23, #70, #100, #139, #196, #229, ##298, #420, #539, #562, #569, and #596 25. Discharge Plan for Individual #3 **People Interviewed:** 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Sherri Gilliland, Post-Move Monitor (PMM) 3. Debbie Burgett, APC Specialist 4. Ric Savage, Consultant 5. Sally Schultz, Consultant 6. Bill Davis, DADS Operations Coordinator 7. Four QMRPs **Meetings Attended/Observations:** 1. PSP for Individual #390 2. Personal Focus Assessment (PFA) meeting for three Individuals: Individual #115, #242, and #390 3. Post Move-Monitoring Visits for Individual #374 4. CLDP Meeting for Individual #102
	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. The POI did not provide details as to the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit and, in some cases, provided a list of Action Steps and completion status. The Facility should consider how it may use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. For example, the Facility may want to track and report on the numbers of individuals who participate in CLOIP tours, reasons CLOIP tours are cancelled, how referrals are being made for CLOIP tours, etc, in order to continue to improve the overall efficacy of the tours. The current POI simply reports on actions taken, rather than evaluating whether the actions taken are producing the desired outcomes, and why or why not. **For Provision T1**, the Facility indicated that it believed it was in compliance in several sub-sections, including the provision of the Community Placement Report. The Monitoring Team concurred with this assessment. The Facility reported substantial compliance with the provision of adequate education about available community placements, but the Monitoring Team did not concur. Finally, BSSLC reported substantial compliance with certain aspects of CLDPs under T1c. The Monitoring Team concurred only with the assertion that they had specified in the CLDP the Facility staff responsible for ensuring implementation of the essential and nonessential supports. BSSLC noted a number of actions it had taken since the previous site visit, and provided a series of Action Steps related to education about community placement, the implementation of the pre-move site review for the CLDP and the development of policies

	and procedures for alternate discharges. **For Provision T2**, the Facility indicated it was in substantial compliance, but the Monitoring Team did not concur. The POI only addressed compliance with the timeliness requirements of this provision. It did not address the process of identification of deficiencies in the provision of any supports, nor of the required follow-up when such deficiencies are noted. No Action Steps were provided for this provision despite findings during the last monitoring visit that suggested improvements were needed. While there was progress noted in these processes during this visit, certain deficiencies still existed. **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 was not in compliance with most of the provisions of this Section, but did achieve substantial compliance in two areas, those being the issuance of a Community Placement Report under Provision T1 and involving the individual and LAR in the decision-making process of the CLDP . The summarized findings of the Monitoring Team for each provision are as follows: **Provision 1:** This provision was determined to be not in compliance overall. In most instances this was consistent with the Facility's self-assessment. Twelve individuals had transitioned to a community placement in the past six months, which was a relatively high pace. At the same time, the Monitoring Team remains very concerned about the continued admission of children, for whom more integrated and individualized settings would be preferable. 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 and development of individualized strategies for education about community living options to promote informed choice. There were a number of times staff seemed unfamiliar with key aspects of an individual's current status, needs and/or preferences. It was noted during PFA and PSP meetings held during the monitoring visit that staff appeared to be more open to the concept of community living and more interested in learning about the available options. This was a positive development. DADS had also developed and provided QMRP Facilitation training, and were providing follow-up evaluation and coaching. The Monitoring Team applauds this investment and was able to see not only some new skill sets, but also a new energy and attitude among the QMRPs observed and interviewed. In addition, DADS and BSSLC had recently initiated providing training and mentoring from a group of outside consultants that had made some immediate impact on the skills of the QMRPs and appeared to hold promise for much more. These initiatives should be continued. The Facility reported it believed it was in compliance with some key indicators related to the CLDP and the Monitoring Team found there were improvements in the CLDP processes, but these continued to be hampered by the deficiencies in assessment practices at the Facility. One death occurred shortly after transition and there were important omissions in this CLDP, including identification of essential supports,

	the documentation of provider inservice, and the thoroughness of the Pre-Move Site Review. Overall, the Facility was only in substantial compliance with involving the individual and LAR and seeking their input in the decision-making, but not with other components in the CLDP process. The Facility also reported it was in compliance with component T1h, the issuance of the Community Placement Report at required six month intervals. The Monitoring Team concurred. **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. A single PMM visit observed during the compliance visit continued to demonstrate improvement in thoroughness and attention to detail, but there were still some supports that were not methodically observed and documented. This finding was affirmed by a review of additional completed PMM Checklists in which supports were not always observed, documented and/or had deficiencies carefully followed-up. The Monitoring Team did find that the most recent PMM activities were significantly improved over those from the beginning of this six month period. It was also noted that a revised PMM Checklist was to be implemented in the near future that more explicitly calls for detailed documentation by the PMM, and that BSSLC staff had attended training on its use. This Checklist holds promise for ensuring the PMM process is comprehensive and thorough. **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 reported one such alternative discharge to another SSLC during this monitoring period, and this appeared to have been implemented consistent with CMS-required discharge planning procedures, but the Facility reported pending revisions to its current policy and procedure to address alternative discharges. This should be sufficient to achieve substantial compliance once complete.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take	Since January 2011, BSSLC reported that 12 individuals had transitioned to the community in the past six months. No individuals had returned from a placement, but one death occurred for an individual who had moved to community living within that time span. This was a relatively high number of community transitions. At the same time, the Facility reported five admissions, all of whom were 16 years of age or younger. The Monitoring Team remains very concerned about the continued admission of children, for whom more integrated and individualized settings would be preferable.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	It was reported by the Facility that the staff person assigned to the initiative to facilitate transitions to the community for children left shortly after the last monitoring visit and that position had been vacant since then. The Facility had plans to fill the position again in the near future. 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 (see Provisions F1c, F1d, F1e, F2a1 F2ab, T1b1); education for community awareness; (see Provision T1b2)and transition and discharge planning (see Provisions T1c1, T1d, T1e and T2) indicated the Facility could not be said to be effectively assisting and encouraging individuals to move to the most integrated setting yet. BSSLC had, however, undertaken some actions to further assist PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. • All of the QMRPs at BSSLC had completed Q-Facilitation training and were receiving ongoing coaching and follow-up training from the DADS-certified trainers, as described in Provision F1a. • BSSLC had also begun to receive consultation centered on the PSP process, as reported in Provision F1a. This process was in the early stages of implementation, but appeared to have had some immediate impact on team process and QMRP skills, and held promise for continued improvement. The Monitoring Team commends this initiative, but found that it had not yet focused to any significant extent on the needs of the QMRPs and PSTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. • A revised and expanded PMM process had been developed and was soon to be implemented. The APC and Post-Move Monitor had completed training in the use of this new process in July 2011. The presence of an effective transition monitoring process is an essential component in assisting an individual to successfully move to community living, and also serves to enhance the confidence of individuals, family members and LARs in the potential for that success.	
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,	This component was found to be not in compliance, as described below.	Noncompliance

#	Provision	Assessment of Status	Compliance
	procedures, and practices shall require that:		
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	The PSTs at BSSLC 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 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 F1e 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. As described in Provision F1c above, the PFA process was still not being 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 PFA did prompt the PST to consider specific assessments that might be appropriate in advance of the PSP meeting. In terms of community living options, related assessments listed included Community Leisure Assessment, Community Awareness Assessment, Community Participation Assessment and Community Traffic Safety Awareness. None of the 10 (0%) PFAs reviewed recommended any of these assessments be completed, even when community living was suggested as an alternative. The rote questioning process by which the PFA was implemented was also unlikely to support adequate participation by an individual overall. The Monitoring Team reiterates its recommendation that 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 recommends that the Facility implement a formal	Noncompliance

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		curriculum for "planning my future" that is incorporated into the overall active treatment program on an ongoing and regular basis. Information regarding person-centered training models that might assist QMRPs to better facilitate this process may be found at: http://www.ilr.cornell.edu/edi/pcp/courses.html. Additional details as to this recommendation may be found in Provision F1b. The Monitoring Team attended three PFA and two PSP annual planning meetings and reviewed nine PSPs completed using the new process and format for the purpose of evaluating this component. Consistent with the findings under Provision F1e, the PSTs did not exhibit proficiency in the assessment of the most integrated setting appropriate to an individual's needs, the identification of needed supports and services in that setting other than those things being provided at the Facility, or the obstacles and/or strategies to overcome those obstacles. Examples included: • For Individual #485, the PST found no barriers to community living, and during both the CLOIP and the PFA, the individual indicated a desire to live with the individual's mother. The LAR choice was for the individual to remain at BSSLC. The PST then determined the most integrated setting for the individual was BSSLC, based solely on LAR choice. It was noted this individual was not listed on the Community Placement Report as not referred due to LAR choice. • For Individual #408, the individual's sister participated in the PFA meeting. She stated several times that she wished to see the individual moved home or at least closer to the family, even though she knew the individual's mother was opposed. The PST did not take the opportunity to explore the sister's interest in community living options, despite several instances in which the sister expressed concern that distance prevented the family from spending time with the individual. The PST did not identify any obstacles to community placement, other than LAR choice, but neither did they identify any strategies or action steps toward exploring community living options or addressing the mother's objections, nor how the sister's interest might open up such options.	
	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.	BSSLC was taking some actions to increase education and awareness, but these do not appear to have been well thought-out with clear goals in mind. PSTs continued to need additional instruction as to how to develop an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. As described by the Monitoring Team in its previous report, 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 sample of CLOIP Worksheets for PSPs held during the monitoring site visit and during the	Noncompliance

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		month preceding the site visit. This review indicated that for 28 of 32 (87%) CLOIP Worksheets, the individual had no response and/or didn't seem to comprehend the materials or information being offered. This included three individuals who were not offered the materials due to visual impairments. 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. For zero of four (0%) CLOIP Worksheets in which the MRA documented some interest on the part of the individual, LAR or family member in learning more about community living options, was there any indication of any follow-up actions taken to provide this information. These were missed opportunities 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. For example: • For Individual #576, the MRA documented the individual was interested in the picture of "living by myself," but then went on to state the individual did not seem to have any expectations for moving into the community. No action was documented to follow-up on this apparent expression of interest, nor were any recommendations made as to possible follow-up. • For Individual #371, the MRA documented the LAR's preference for the individual to remain at BSSLC, but noted the LAR had thought about moving the individual closer given the LAR's age and the long driving distance required to make a visit. The MRA then went on to document the LAR had no expectations about the individual moving to the community. No exploration of the potential interest in facilitating a move to be closer to the LAR was documented. In the PSP process itself, little attention was devoted to careful assessment of the individual's specific need for education in this area. For zero of nine (0%) recently completed PSPs, were there individualized plans for increasing awareness of community living options that took into account the learning needs of the individual. Examples of the lack of an individualized plan included: • For Individual #407, the PST identified in the PSP Optimistic Living Vision that the vision would be for the individual to live in a "group home type setting" and agreed there were no obstacles. The team determined the most integrated setting would be BSSLC based on LAR choice. The section on education regarding living options was left blank, and no Action Plans were developed to provide education or awareness of current community living options for the individual or LAR. The team also suggested it did not feel the individual would benefit from training to increase his community awareness because the individual "knows what to do, just has to be reminded to do it." This statement provides little to no guidance to the PST and	

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		DCPs working with the individual as to what is expected they should remind him about, nor does it relate to any stated obstacle. • For Individual #312, the PST agreed there were no obstacles for the individual to live in the community, but also noted the individual's mother preferred BSSLC. In the PFA, the team documented the individual would like to live closer to family and that his dream for the future was to live in the community. The team indicated that education regarding living options was available upon request of the individual and/or the mother, but left the most integrated setting segment of the PSP blank. No Action Plans were developed to increase awareness of community living options to facilitate the individual's desire to live closer to family or dream to live in the community. It was noted this individual was not listed on the Community Placement Report as not referred due to LAR Choice. The Facility reported that it was scheduling CLOIP tours every second and fourth Tuesday and Thursday, but the documentation provided was insufficient to determine how many individuals and/or staff had participated. It was noted that, on occasion, CLOIP tours did not occur as scheduled. 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. In addition, BSSLC has continued to provide some other opportunities for staff to become more aware of community options. These included the Continuity of Services Community Living Options In-Service held on June 15, 2011 and the 5th Annual Providers Fair held on July 15, 2011. It was noted during PFA and PSP meetings held during the monitoring visit that staff appeared to be more open to the concept of community living and more interested in learning about the available options. This was a positive step.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each	The Facility continued to assert 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 303 individuals who had been assessed for placement since 6/8/2010 using this definition. 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 the case. A number of improvements should be made to how the process is implemented before	Noncompliance

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	Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	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 clarification from DADS of its expectations for each discipline-specific assessment to provide an assessment of each individual for the most integrated setting appropriate to their needs as called for by the ADA and the Olmstead decision, including recommendations for protections, services and supports the individual would require. • A focus on the ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning. This will require considerable investment in 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 June 07, 2011. Seven of the 12 community placements listed exceeded the 180 day timeframe. While several of these exceeded the timeframe by only a month, there were four that had been pending for more than one year. Three of the 16 current referrals- had also exceeded the 180 days. While it was noted that more recent referrals had moved toward placement much more quickly, 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.	Noncompliance
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	The CLDP process is a continuation of the Facility's responsibility to assess the needs of an individual who will be moving to a more integrated community setting, and to ensure that the community setting adequately meets those needs. The identification of essential and non-essential supports must begin by considering those things identified in the PSP. The PST did appear to rely heavily on the PSP and the assessments associated with the PSP to guide the identification of the essential and non-essential supports. The potential problem with this was that it was not clear the PSTs were proficient in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or finally, the identification of the supports and services needed and desired in a community setting during the PSP, as described in Section T1b, Section F1c and Section F2a. The Monitoring Team reviewed four completed CLDPs for individuals who had	Noncompliance

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		transitioned to a community setting. The listing of essential and non-essential supports did not always adequately capture basic requirements for a successful transition. Examples included: • For Individual #386, the Monitoring Team found the CLDP failed to adequately identify essential supports in the area of nutritional support needs and failed to provide documentation around training given to provider staff to prepare them to adequately meet the individual's needs. The individual had a PNMP that detailed certain needs, including, for example, a ground diet texture, ensuring all food had cleared the individual's mouth before offering another bite, and nectar thickened liquids. The CLDP required only that the provider staff be trained in the use of Thick-It. There was no documentation that the provider staff were trained in the individual's nutritional support needs, including even the one that had been identified in the CLDP listing of essential supports. The individual died from complications due to choking on a piece of meat that was not ground within days after moving. • For Individual #562, there was a handwritten identification of essential and nonessential supports which included a gait belt. This support was not transferred to the final typed version and was not then included on the PMM Checklist. The Monitoring Team attended the single CLDP meeting held during the site visit, for Individual #102. 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 #102 had not had a physical examination since before 2009, because the individual would not tolerate it. The PST initially suggested that a physical exam could be postponed until six months after transition. After some discussion with the Monitoring Team about potential health issues, the PST reconsidered the need to obtain a physical exam prior to transition. • Health issues that were not addressed included a significant unplanned weight loss since December 2009 of almost 20 lbs. In part, the team failed to recognize the weight loss because they did not look past 12 months. • Until prompted by the Monitoring Team, the PST did not identify the increasing propensity for falls, nor identify a need for a falls assessment and/or an environmental assessment in the new environments. • Until prompted by the Monitoring Team, the team did not identify the individual's frequent attempts to run from the home, nor develop a plan to support his safety in this regard in his new living environment.	

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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 four of four CLDPs reviewed, the Facility did not consistently assign specific Facility staff responsibility for each and every one of the essential and non-essential supports. In a number of instances, staff from the selected provider were identified rather than Facility staff. While it is appropriate to identify where the provider or MRA has responsibility, it is also necessary to clearly state which 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 should provide an avenue for designating the responsibility of Facility staff to follow-up to ensure that all others have completed their responsibilities. 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.	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 four completed CLDPs for evidence that the individual and, as appropriate, the LAR had participated in the CLDP. For four of four (100%) there was documentation that the individual and/or significant others had participated. In some instances, there was lengthy and substantial documentation. The Monitoring Team commends this development. 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. Specifically, the process requires that: • PSTs will meet at various stages of the community transition process. Deliberations from these meetings will be captured in the CLDP. • Direction from the individual and/or LAR (if applicable) should be solicited and documented at each stage of the process The Facility had 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. Four of four (100%) of the completed CLDPs included a summary of all actions the PST had taken to inform the individual and LAR and solicit their input and direction. The Monitoring Team also reviewed two partial CLDPs which were in progress. For one of two (50%), there was documentation of the deliberations of the PST and the participation and input of the individual and/or LAR. Overall, it appeared the Facility was in substantial compliance with involving the individual and LAR and seeking their input in the decision-making; however, the Facility should remain vigilant in maintaining consistency in this area. This is demonstrated by the one in-process CLDP that did not provide the necessary documentation. According to the CLDP policy, the CLDP was	Substantial Compliance

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		intended to be a living document that ensured and captured individual and family/LAR involvement and input as the process progressed from referral through trial visits to provider selection and final CLDP meeting. For Individual #2, the Monitoring Team reviewed the current CLDP and found that there was no documentation of the individual's participation in the process. The individual's QMRP indicated in interview that the individual's mother had not been involved in the provider selection and that the QMRP intended to call the mother after all the trial visits were complete.	
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. 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. For the CLDP held during the monitoring visit, a number of assessments were not available 24 hours prior to the meeting. These included: • Behavioral Services Review Summary • Annual Medical Assessment • Pharmacy Update • QMRP Report A review of the individual's record revealed no physical examination had been completed within at least the past two years and staff were unable to ascertain the last time such an examination had been completed. The PST indicated there was no plan to complete such an examination prior to the individual's leaving, until a discussion prompted by the Monitoring Team. It was also noted by the provider representative during the CLDP for #102 that there had been a number of issues related to another individual who had transitioned from BSSLC that had not been adequately identified during that other individual's CLDP. The provider stated this had created significant issues during the transition process, and she wanted to be sue this did not occur for Individual #102. This illustrated the critical nature of providing 45-day assessments that are comprehensive and accurate. In addition, as described in T1c1 above, the discipline-specific assessments 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.	Noncompliance
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	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 eight individuals who had transitioned to the community since January 2011. These	Noncompliance

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	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.	generally appeared to have been completed in a timely manner following the CLDP and prior to the actual transition date, per the completion date. 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-Move Site Visits to providers before an individual leaves the Facility. The Monitoring Team reviewed eight Pre-Move Site Visits and found significant discrepancies in the process and documentation of one such pre-move visit, as described below, that would call the overall thoroughness of the process and accuracy of the documentation into question. • For Individual #386, the individual who died shortly after transition, the Pre-Move Site visit failed to verify that a required provider inservice on the essential support for the use of Thick-It had been completed. While the CLDP also failed to adequately identify all of the essential support needs in the area of nutritional support, as described in F1c and T1c1 above, even this one support was not verified during the Pre-Move Site visit. The Pre-Move Site Visit indicated the training was to be completed by BSSLC staff on the day of the visit and would be evidenced by training rosters. No training rosters were obtained. The Comments section indicated that the provider staff "have been provided information regarding the individual (including a behavioral support plan and/or a Physical/Nutritional Support Plan (PNMP) if applicable)". This generic language did not speak to the needs of this individual.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	This component was found to be not in compliance. The Facility stated it 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. The APC was using a tracking sheet to track the completion of assessments for the CLDP meeting, but this was somewhat ineffective in that several assessments were not completed or available the day before Individual #102's CLDP meeting. 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	Noncompliance

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		activities are completed, even if a provider or MRA staff has primary responsibility for the activity; • Assessments for the CLDP are completed on a timely basis. Given the deficiencies found in the CLDP process of identifying the essential and nonessential supports for both Individuals #102 and #386, the Facility should also develop a quality assurance process for ensuring that these supports are adequately identified to facilitate a safe and successful transition.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	This component was found to be not in compliance. The Facility provided a one page document, entitled Community Placement Obstacles, dated June 07, 2011, covering the period from 1/1/2011-6/7/2011. It listed identified obstacles for 11 individuals who had a preference for community placement but were not recommended for placement by their PST. The identified obstacle for nine of the 11 (81%) individuals was LAR Choice. It is not clear that this data can be considered accurate or comprehensive, in light of the failure of PSTs to adequately identify the most integrated setting appropriate to an individual's needs, nor the lack of adequate community living options education that is individualized and appropriate to each individual's learning needs. It is also 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. The Facility should 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 • 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. In terms of methodology, this process relied 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	Noncompliance

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		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 continued to 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 purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community	BSSLC indicated that it was in substantial compliance with this component and the Monitoring Team concurred. The Facility issued a Community Placement Report on June 7, 2011, covering the period of 1/1/2011- 6/7/2011. The report was in the standardized format as prescribed by DADS State Office. It listed: • Twelve community placements • Sixteen current referrals • Two rescinded referrals • Six prefers community, but not referred, due to LAR choice • Two prefers community, but not referred due to other reasons • Zero LAR prefers community, but not referred The Facility may want to ensure its records regarding individuals not referred due to LAR Choice are consistent. Although the Community Placement Report listed six such individuals, another report issued the same day of Individuals Requesting Community Placement With No Recommended Movement contained only four names of such individuals. Similarly, a Community Placement Obstacles Report issued the same day listed nine individuals for whom the identified obstacle was LAR Choice. Only eight of these names were found on the Community Placement Report. Finally, the review and observation of PSPs during this monitoring visit (see T1b1 and T1b2) indicated there are a number of individuals who may have expressed interest in living elsewhere and for whom the PST determined BSSLC to be the most integrated setting based on LAR Choice, but who were not included in the Community Placement Report; the Facility needs to ensure that all people who should be included in each category of the Community Placement Report (including all who have requested movement but not been referred, and all not referred due to LAR choice) are listed.	Substantial Compliance

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	Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	This component was found to be not in compliance. The Facility had indicated it was achieving some level of compliance in the area of PMM. The Monitoring Team reviewed the PMM checklists for 12 individuals. The Monitoring Team found that the PMM Checklists were being completed in a timely manner, with the exception of one for which the 7-Day visit as one day late. According to the PMM, this occurred as a result of her absence due to illness. The PMM and APC should consider the development of a back-up plan to ensure timeliness in the event such circumstances recur. Although the PMM Checklists reviewed were largely 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 had recently begun to routinely visit each of the sites in which supports were to be provided, but during the last six months the PMM failed to visit both the living environment and the day program for six of 12 (50%) individuals at one or more scheduled monitorings. 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. The most recent PMM Checklists provided substantially more information as to the presence of supports that would allow the Facility to assess how well an individual is actually adjusting to his/her new environment. This was a significant improvement. Although the level of thoroughness and attention to detail was substantially improved, at least in the most recent monitorings completed, there continued to be some instances in which the Post-Move Monitor failed to follow up as needed to ensure supports were provided. Examples included: • For Individual #23, the individual was to have begun attendance at day habilitation by April 1, 2011. On 3/29/11, at the 7-Day visit, the Post-Move Monitor documented the individual had not yet been enrolled, but did not follow-up to ensure the support was provided until the 45-Day visit on 5/5/11. • For Individual #229, the individual was to have begun attendance at day habilitation by February 4, 2011. On 2/14/11, at the 7-Day visit, the Post-Move	Noncompliance

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		Monitor documented the individual had not yet been enrolled, but did not follow-up to ensure the support was provided until the 45-Day visit on 3/31/11. • For Individual #596, the individual was to have had a community hematologist identified by May 6, 2011. On 5/4/11, at the 45-Day visit, the Post-Move Monitor documented the hematologist had not yet been identified, but did not follow-up to ensure the support was provided until the 90-Day visit on 6/16/11. DADS was preparing to introduce the use of a revised and expanded PMM Checklist that required much more detailed information regarding the availability and provision of supports, including specific evidence the PST prescribed to be monitored. Both the APC and the Post-Move Monitor had attended DADS training in July 2011 to prepare for the implementation of this procedure. The Monitoring Team reviewed the sample PMM that was used during the training. While it is much improved in terms of detailed expectations, the sample did not always appear to provide adequate guidance as to how a PMM should verify supports. For example, in many instances it continued to indicate the evidence required to verify essential supports related to training were to be only a training roster. The Monitoring Team noted that there were additional questions to be answered later in the document that might expand upon the evidence, but the PST should clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster.	
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 still not every support was methodically observed and documented. For example, the PMM Checklist called for 24-hour awake staff, and for the evidence to be the staff roster. The Post-Move Monitor questioned the provider staff regarding this documentation, but it was not kept on-site. The Post-Move Monitor told the provider staff to be sure to maintain the documentation, but did not arrange to obtain it for review. There was also not adequate documentation of the individual's adjustment at the new home. There was a discussion observed between the Post-Move Monitor and the provider staff regarding a behavioral concern that was reported by the staff to have decreased. Upon interview, both the provider staff and the Post-Move Monitor acknowledged there had been some manifestation of this behavior since the individual moved, but that it seemed to be resolving. There was no documentation in any of the	Noncompliance

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		PMM Checklists regarding the course of this behavior since transition, which was not of an insignificant nature, given that the individual required knee pads at all times to prevent self-injury. It was commendable that the Post-Move Monitor and the provider staff were both aware of the situation and had clearly had discussion about it, but the Post-Move Monitor failed to adequately document it.	
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 -**		
	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	This provision was found to be not compliance. The Facility reported one individual (Individual #3) had been discharged pursuant to an alternative discharge as defined in the Settlement Agreement. This appeared to have been completed in a manner that would be consistent with CMS-required discharge planning procedures. The Facility did not currently have a policy and procedure in place specifically describing how it would comply with the requirements of this provision when such circumstances arose, but it did report discharge planning policies and procedures were being revised to address alternative discharges. The draft DADS Policy 018: Most Integrated Setting Practices addresses the requirements for alternate discharges and provides a template for discharge summaries for these individuals in Exhibit F. This policy should be sufficient to provide guidance for the pending revisions of the Facility-level policy and procedure.	Noncompliance

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	during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

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

1. The Facility should consider how it may use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. (Self-Assessment)
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. (T1b1)
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. (T1b2)
4. The Facility should ascertain the reason more CLOIP tours have not been offered as originally schedule and undertake remedial action to provide additional opportunities as planned. (T1b2)
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. (T1b1)
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. (T1c, T1f)
7. Given the deficiencies found in the CLDP process of identifying the essential and nonessential supports, the Facility should also develop a quality assurance process for ensuring that these supports are adequately identified to result in a safe and successful transition. (T1f)
8. 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. (T1e)
9. The Facility should ensure that data regarding individuals who are not referred for community living solely due to LAR choice are accurately reflected in the Community Placement Report. Additional training should be provided to PSTs regarding their responsibilities related to

identification of an individual's most integrated setting and the documentation required to track this information. (T1h)

10. The CLDP should clearly state that staff interview and observation are required to document provider staff training, in addition to the paper review of a training roster. (T2a)
11. 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. (T2a)
12. The Post-Move Monitor and APC should consider the development of a back-up plan to ensure timeliness in the event of the unscheduled absence of the Post-Move Monitor at the time a monitoring visit is due. (T2a)
13. 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. (T2a)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), dated July 12, 2011 2. Prioritized list of 61 Individuals with No Guardian By Priority, dated July 25, 2011 3. Restriction List with 66 individuals, dated July 28, 2011 4. List of individuals for whom a Legally Authorized Representative (LAR) had been obtained since January 2011 5. Personal Support Plans (PSPs) and Rights Assessments for nine Individuals: Individual #12, #14, #68, #247, #312, #407, #471, #485, and #576 6. Draft DADS Policy on Advocacy Program Policies and Procedures, undated 7. Draft DADS Policy 019 on Guardianship, undated 8. Draft Screening Assessment to Provide Legally Adequate Consent, undated 9. Step by Step Guide to Assessing Capacity to Consent, undated 10. Packet of materials related to Advocacy Program, dated 7/06 **People Interviewed:** 1. Cheryl Powell, Human Rights Officer (HRO) 2. Debbie Burgett, APC Specialist **Meetings Attended/Observations:** 1. Human Rights Committee (HRC) Meeting
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC POI. BSSLC indicated it was not yet in compliance with either of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI did not describe the Facility's self-assessment processes, but rather listed some actions the Facility had taken since the last visit, including updating the prioritized list of individuals to include the individuals with comparatively frequent need for decisions requiring consents along with the comparatively most restrictive programming. In addition, BSSLC had identified potential guardianship resources (family member/friend/volunteer that are currently involved in the individual's life) for individuals on the prioritized list and made contact by mail and phone. Responses were documented on the Restrictions List maintained by the HRO. Additional Action Steps the Facility has listed underway or to be undertaken at a future date were the following: • Develop State Policy with Functional Capacity to Render a Decision Tool (Work Group is developing the Policy and Tool), which was reported to be in process. • Revise the Local Rights Policy once the State Office Policy is approved, which has not yet started. • Provide guidance and training to PST members once State policy is finalized and ready for implementation, which was not yet started.

	These proposed Action Steps were appropriate and remained contingent upon the promulgation of pending statewide policies. The Facility did not include in this list its plan, reported elsewhere, to develop an Advocacy program, which would be an appropriate addition to the Action Steps.
	Summary of Monitor's Assessment: BSSLC was not in compliance with either of the provisions for Section U. **Provision U1:** This provision was determined to be not in compliance. The Facility provided drafts of pending statewide policies on Advocacy Program Policies and Procedures and Guardianship. For the purposes of this provision, however, these did not address certain key aspects of guardianship in any substantive way. While they did address the philosophical basis for informed consent and the responsibility of the PST in supporting the ability of individuals to make informed decisions, they did not address the standardized tools or methodology PSTs would use to assess and prioritize the need for an LAR. It was reported that a statewide workgroup had recently begun working to develop tools and/or processes that would be used to provide guidance to PSTs in the assessment of decision-making capacity, but no projected date for completion was known. It is essential that such guidance be provided in conjunction with the policies requiring the teams to make these assessments. The Facility did maintain a list of individuals without an LAR, and had recently updated the list using the criteria in the draft statewide policy. The HRO had undertaken some preliminary activity to identify specific rights restrictions for each individual on the list that might indicate a need for assistance in decision-making. This information was being kept in a file labeled as the Restriction List. This was a commendable step toward individualizing the process of determining each person's need for assistance. **Provision U2:** This provision was determined to be not in compliance, given that the required policies and procedures have not yet been promulgated. It was noted that the HRO had undertaken some preliminary activity in this provision as well. The Monitoring Team commended the HRO's appreciation of the need to carefully consider the level of guardianship needed on an individual basis, even as she undertook preliminary steps to identify potential resources. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, the Facility should ensure it has an appropriate methodology in place to determine the actual need for guardianship and to educated potential guardians as described above. DADS should complete development of policy, including guidance on such a methodology, as soon as possible.

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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	BSSLC had not updated any policy and procedure to describe 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 statewide Policy was finalized. It was reported this policy was anticipated to be released in the near	Noncompliance

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	individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	future. The Monitoring Team reviewed the pending statewide policies on Advocacy Program and Guardianship. While they did address the philosophical basis for informed consent and the responsibility of the PST in supporting the ability of individuals to make informed decisions, they did not address the standardized tools or methodology PSTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. As evidenced in the following paragraphs, the Facility's 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. In that regard, it was reported that a workgroup had just begun to develop guidance for the PSTs as to how to make an assessment of capacities for decision-making, with no projected date for completion. Since the pending guardianship policy requires the teams to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. Once the statewide policy and assessment process has been finalized, BSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements. As to its current status, BSSLC had continued to maintain a list of individuals who did not have a current guardian. The list was dated July 25, 2011 and included the names of 61 individuals. Each person was assigned a priority as follows: 25 individuals were assigned priority 1, No Family/Correspondent-Needs Guardian; four individuals were assigned priority 2, Medication-Behavioral Support Plan; and 27 individuals were assigned priority 3, Active Family/Correspondent. An additional five individuals on the list did not have an assigned priority. This process of prioritization still was not based on any standardized assessment methodology regarding decision-making capacity. 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 nine of the most recently completed PSPs and accompanying Rights Assessments. Seven of the nine individuals had LARs. • For zero of nine Rights Assessments (0%), the PST checked off that the person was able to give informed consent in any of the categories included in that section. • For zero of nine Rights Assessments (0%) and zero of nine PSPs (0%), there was	

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		discussion of the individual's own capabilities to make decisions or to participate in decision-making. • For four of nine PSPs (44%), there was no documentation that the PST decision regarding ability to give informed consent was referenced as a part of the PSP meeting, even when other rights restrictions were documented. • For zero of the nine PSPs (0%), the PSTs developed action plans to assist individuals to maintain or improve decision-making capacity related to any of the categories included in the Informed Consent section, other than a money management program tied to another specific rights restriction in that area. The Monitoring Team also attended a portion of a Human Rights Committee meeting. For zero of four Rights Assessments reviews observed (0%), there was discussion of the individual's capacity to give informed consent, or of any strategies to enhance the individual's decision-making capacities. The Committee should receive some guidance as to the need to consider the informed consent restrictions along with the other restrictions noted in the Rights Assessment.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	Compliance with this provision will necessarily be contingent to a certain degree on achieving compliance with Provision U1 as a pre-requisite—that is, as required by that provision, that a prioritization of need exists, based on a reasonable process that includes established criteria, so that the Facility can identify people at highest need. While there Facility needs to develop processes to solicit an LAR for certain individuals, it should ensure it has an appropriate methodology in place to determine the actual need and priority for guardianship before undertaking to recruit LARs on a large-scale basis. From January 2011 to July 2011 there had been two Guardianships obtained at the Facility. BSSLC also reported the followingl preliminary efforts toward obtaining LARs for individuals lacking LARs during this review period: • Initial contact was made with family and friends of individuals on the prioritized list of those in need of an LAR to determine if resources for advocacy and/or guardianship currently existed, and documented the findings on the list; • Family members or friends who expressed interest in becoming an LAR were provided with some basic information; • Local attorneys were contacted to see if any discounts might be available for obtaining guardianship; and • Potential members were identified to serve on the Guardianship committee that is expected to be a requirement of the pending statewide policy. The Monitoring Team commended the HRO's appreciation of the need to carefully	Noncompliance

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		consider the level of guardianship needed on an individual basis, even as she undertook these preliminary steps to identify potential resources. The HRO also reported that the Facility was planning to re-institute an Advocacy program once the Advocacy policy has been promulgated. The Monitoring Team reviewed a packet of materials that were expected to form the basis for this program, which appeared to conform to the requirements of the pending statewide policy on Advocacy that is currently in draft.	

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

1. 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 on Guardianship does not provide sufficient guidance in these areas and should be revised to include more guidance. (Provision U1)
2. As the pending guardianship policy requires PSTs to make a determination as to decision-making capacity, it is recommended that guidance and/or tools to be used by the PSTs be provided at the same time the guardianship policy is implemented. (Provision U1)
3. Likewise, as part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, DADS should complete development of policy, including guidance on such a methodology, as soon as possible. (Provision U2)
4. Once the statewide policy and assessment process has been finalized, BSSLC should refine and develop facility-specific policies and procedures to operationalize the requirements. (Provision U1)
5. The Human Rights Committee should receive some guidance as to the need to consider the informed consent restrictions along with the other restrictions noted in the Rights Assessment. (Provision U1)
6. Add the planned development of the Advocacy Program to the Action Steps in the POI. (POI)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 8. BSSLC Plan of Improvement (POI) 7/12/11 9. BSSLC July 2011 Presentations notes 10. DADS Policy 020 Recordkeeping Practices revised 3/5/10 11. BSSLC Policy Unified Record Keeping Practices, approved 12-17-2010 12. BSSLC Policy Personal Support Plan Process approved 12-10-2010 13. BSSLC draft Dental Policy approved 7/2/11 14. List of policies approved since last compliance visit 15. BSSLC Active Record Order & Guidelines (AROG) revised 10/28/10 16. BSSLC Master Folder Filing Instructions (Table of Contents) updated 10/28/10 17. Individual Notebook Record Order and Guidelines for Filing and Thinning 10/28/10 18. Active Record for Individuals #5, #26, and #437 19. Individual Record for Individuals #26 and #437 20. Master Record for Individual #437 21. PSP Notification Calendar for Individuals #56 and #390 supplemented by review of assessments posted on S-drive (shared drive) 22. Policy & Procedure Approval/Review Form 23. Examples of emails notifying staff of new and revised policies 24. Settlement Agreement Cross Referenced with ICF-MR Standards form 25. Chart Audit Tool blank form 26. Lists of individuals whose records were audited February-June, 2011 27. Email notifications of policy revisions 28. Class rosters documenting training on policies, undated 29. Nursing Department database of policy tests passed by nurses 30. Sample Nursing Department policy training materials and competency tests 31. Psychology Department meeting minutes of 6/17/11 and 7/12/11 and accompanying sign-in sheets documenting training **People Interviewed:** 1. Group interview of Margaret Zwerneman, Unified Records Coordinator (URC), Deborah Borah, Unified Records Coordinator, and Kim Littleton, Assistant Director of Programs (ADOP) 2. Group interview of program auditors: Jackie Gertman, Juanita Taylor, and Caitlin Connor 3. Joyce Carneghy, Central Records coordinator 4. Group interview of three QMRPs selected by the Facility 7/29/11 5. Group interview of three physicians 6. Susie Johnson, Settlement Agreement Coordinator (SAC) **Meeting Attended/Observations:** 4. Entrance Presentation by Facility Staff 1/10/11

	5. PSP Annual Planning meeting for Individual #56 6. Risk Meetings-Individuals #181 and #26 7. PFA Meeting for Individual #115
	Facility Self-Assessment: BSSLC submitted its self-assessment, called the POI; it was updated 7/12/11. In addition, the Monitoring Team reviewed information about status provided by the Facility during the compliance visit. The POI listed actions relevant to the provisions of this Section that had been implemented since November, 2010 (which was prior to the last compliance visit). No information was provided regarding reasoning for the compliance self-ratings or action plans to achieve compliance. The Facility rated all provisions to be noncompliant. The Monitoring Team concurs with those ratings. The Monitoring Team found that the Facility had taken the actions described, including completing the conversion to a new format for the records, establishing an audit of records that included a process to require corrections, and initiating an interview process to determine how staff use the records. However, the Facility incorrectly indicated that the audit was of randomly selected records; the selection was not random, as required by Provision V3. Following the self-ratings section of the POI, the Facility listed Action Steps planned to achieve compliance and the status of those steps. Unlike the Action Steps in most of the other Sections, these steps were in an order that could be cumulative rather than being a listing of actions that could occur in various orders. This is useful not only in providing the Facility with a path toward compliance, but also to permit the Monitoring Team to identify gaps, provide technical assistance, and conduct its review in an efficient manner. The Actions Steps appear reasonable. Again, the Facility needs to understand what is meant by "random" audits; the Monitoring Team provided technical assistance on this topic during the compliance visit.
	Summary of Monitor's Assessment: The Facility maintained a Unified Record for each individual. The Unified Record at BSSLC consisted of an Active Record, Master Record, and an individual notebook called the "All About Me" book. In addition, the Share Drive, although not part of the Active Record, provided the potential for information to be made available to all PST members. Recordkeeping was improved from the last compliance visit. The Active Records were more generally complete and legible. Nevertheless, continued improvement is needed. Although records were generally in order and, for the most part, complete and legible, none of the Active and Individual records met all the requirements of Appendix D or of Facility policy. There were a instances in which data were missing for programs. Although recordkeeping was improved, Provision V1 remained out of compliance. Provision V2 remained out of compliance. Policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. Both DADS and the Facility DADS continued to develop and revise policies. BSSLC had implemented several new policies since the last

	compliance visit. Each policy contains a statement of the training to be provided. For some policies, the training is clearly defined. The Nursing Department includes tests when providing training on departmental policies, an excellent practice. There is, for some policies, a competency check done by program auditors who interview a sample of staff each month on topics that rotate and include some essential policies, such as reporting of abuse. These processes should assist the Facility in reaching substantial compliance when the policies that address all areas of the Settlement Agreement are develop or revised, and are implemented accurately. The Facility had made significant progress toward compliance with Provision V3 but had not yet reached substantial compliance. The Facility had one audit process for review of five records per month and a second review process for additional records. The two Unified Records Coordinators (URCs) conducted the audit of ten records per month. Program auditors also conducted focused reviews of several records each month. Audits by the Monitoring Team of records that had been audited recently by the Facility found acceptable inter-observer agreement, indicating that the audits are likely to be accurate and valid. The selection of records to audit was not random; random selection is a requirement of the provision. Furthermore, the audit process did not ensure that assessments were available by the time of the PSP annual planning meeting. BSSLC had also taken steps to monitor whether staff routinely utilize records in making care, medical treatment and training decisions. The Facility had implemented a process to monitor how staff use the records. The URCs selected one individual per month. For that individual, they asked staff from the individual's PST a set of questions about use of the record and examples of using records to make decisions. Although all staff interviewed reported they could find all or most of the documents they needed, it was unclear to the Monitoring Team that this interview approach, although it has a great deal of potential, was yet being used to affect use of the record. The Facility had made progress both in making the records more useable, in actual use of the records, and in developing a process to evaluate and monitor whether records are being used. Further progress will be needed to reach compliance with Provision V4, specifically in ensuring the data from the monitoring are reliable and meaningful, and in training and coaching staff in use of information in records as part of an interdisciplinary process.

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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.	The Facility maintained a Unified Record for each individual. The Unified Record at BSSLC consisted of an Active Record, Master Record, and an individual notebook called the "All About Me" book. When documents are purged from the Active Record, they are to be sent to Central Records to be place in the Master Record; the Master Record also contains other documents, such as legal documents including birth certificate and guardianship papers. In addition, assessments and some other information were copied to a shared drive that was not considered part of the unified record but allowed information to be easily accessible to members of the PST.	Noncompliance

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		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 required in DADS policy 020.1 Recordkeeping (although those documents were, in fact, to be filed in the Master Record according to the Master Folder Filing Instructions). • 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." Active Records were filed in two, three, or (in a few cases) four charts, depending on the amount of documents involved. A Record Order & Guidelines listed the order of documents and the maintenance guidelines that stated how long each document should remain in the Active Record; this was filed in the front of every chart. When the Program Record or Medical Record needed to be separated into two binders, each was marked (for example, "Medical 1" and "Medical 2"). Per report from QMRPs and physicians, the separation of documents into two Program or two Medical binders did not cause difficulty in accessing documents. Recordkeeping was improved from the last compliance visit. The Active Records were more generally complete and legible. Nevertheless, continued improvement is needed. To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the Monitoring Team reviewed the complete Active Record for Individuals #5, #26, and #437. In addition, the Master Record was reviewed for Individual #437 and the Individual Records were reviewed for Individual #26 and #437. Although records were generally in order and, for the most part, complete and legible, none of the Active and Individual records met all the requirements of Appendix D or of Facility policy. For the Active Record, the Monitoring Team checked for the presence of each item on the Active Record Order & Guidelines (for Individual #5, this information was documented through the Physicians Orders section). Many documents are not applicable in every record. The Monitoring Team made an effort through review of other documents in the record to determine whether such a document, if not in the record, was applicable. For example, if an individual had in the record an action plan with a specific learning goal, there would be an expectation that a matching Specific Program Objective would be in the	

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		appropriate section of the record. Findings on percent of required documents in the records reviewed showed: • For the sections documented for the Active Record for Individual #5, 49 of 58 (84%) required items were present in the record. • For the Active Record for Individual #26, 52 of 71 (73%) required items were present in the record. For the All About Me book, 14 of 17 (82%) of required items were present. Data on SPOs were missing; the QMRP Quarterly Review commented on this for one SSO for two successive quarter, but data were still not present. • For the Active Record for Individual #437, 61 of 66 (92%) of required items were present in the record. For the All About Me book, 15 of 19 (79%) of required items were present. Furthermore, review by other Monitoring Team members found data missing for programs. For example, all data sheets for May, 2011 for Individual #20 were missing. Additionally, dates and times of entries were not consistently documented for nursing progress notes. The Facility was in process of updating the AROG. Plans are in place to add the Aspiration Triggers worksheet, among other documents. Other findings from reviews of the Active Records for these three individuals included: • In zero of three records (0%), all documents were filed in the order stated in the AROG. These were generally minimal errors, and the correct documents could be easily found. • In zero of three records (0%), purging was done according to the guidelines in the AROG; there were numerous documents found in each Active Record that should have been purged and sent for filing in the Master Record. • In one of three records (33%), corrections were not initialed. • In all three records (100%), there were no gaps between entries in documents. The Monitoring Team visited the homes of Individuals #26 and #437 and requested the Individual Notebook. Staff pointed out where the Notebook for Individual #437 was. Staff stated the Notebook for Individual #26 had inadvertently been left at the program services area when the individual returned; the Monitoring Team went to the program services area, where staff showed the book and stated they had let the home know it would be returned shortly. Findings regarding the Individual Notebooks for these two individuals included: • For Individual #26, 14 of 18 required documents (78%) were present. Although	

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		the Behavior Data Sheets were present, they were not filled in with any data. • For Individual #437, 15 of 19 required documents (79%) were present. • In neither of these two Notebooks (0%) were the Communication Dictionary, Communication System Pictures/Devices, or Level of Supervision documents present. The Master Record is divided into categories. Within these categories, filing is by date received rather than by type of document or date of the document. There is no easy way to determine whether all documents that should have been purged have actually been purged and sent to Central Records. Purging may be done by QMRPs at the time of annual PSP planning, so documents could be outdated by as much as a year. This does not affect compliance with this provision but is a practice the Facility might choose to review in order to ensure it is easy to find information. The Central Records coordinator reported that clinicians come to look at Master Record information frequently. The Master Folder Filing Instructions might also be updated; some documents in Individual #437's Master Record were not listed on the Master Folder Filing Instructions (including the medical problem list and enteral feeding record), and nursing assessments were listed on the instructions in both Medical and Progress notes categories. Although not considered by the Facility to be part of the Unified Record, the Share drive provided the potential for accessibility to assessments by all members of the PST. The Personal Support Plan Policy III.4.b, Step II.C requires PST members to file their assessments and recommendations on the Share drive 10 days prior to the PSP meeting, and requires PST members to review all assessments and "be prepared for a comprehensive, integrated discussion during the PSP meeting." A PSP Notification Calendar lists all the required assessments for the individual, and the PST member who posts an assessment is to put the date posted on the calendar, replacing an "X" put in the cell for each required assessment. The QMRP for the individual for whom a PSP annual planning meeting will be held is to review to ensure all required assessments are posted to the folder. As reported in Provision V3, filing of assessments was not consistently done prior to the PSP meeting, so this system was not yet fully useable for review by PST members. The Share drive was used in other ways to provide information of value to PST members. The Hospital Liaison placed a copy of the IPNs with information on status of individuals in the hospital on the S drive for all PST members to review. Given the improvement in records, the Monitoring Team expects that continuation of the auditing processes described in Provision V3 has the potential to bring this provision into compliance in the near future.	

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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.	As discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. 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 Physical and Nutritional Management was implemented 3/21/11. 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. The Facility provided a list of policies that had been implemented or revised since the last compliance visit. These policies were: • Physical Nutritional Management Plan • Physical Nutritional Management Team • Physician Procedures and Best Practice Guidelines • Restraint for Behavioral Crisis • Level of supervision • Protection from Harm—Abuse, Neglect, and Incident Management BSSLC Restraint for Behavioral Crisis Policy (6/8/11) and BSSLC Medical and Dental Restraint Policy (6/18/11) 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. In its document request, the Monitoring Team asked for a list of each new or revised policy since the last review, and "a copy of communication to staff to inform them of the policy, a description of training provided (with a copy of training materials), and/or blank competency evaluation tools." In response, the Facility sent a list of policies that were new or revised since the last compliance visit and a statement that "An email is sent out to all BRS users to notify employees of a policy." Per interview with SAC Susie Johnson, emails were sent, but training was also provided. The process for development of a new policy, as reported to the Monitoring Team (no policy or formalized process existed), was as follows: When someone recommends development of a new policy or revision of a current policy, the recommendation is given to the SAC, who chairs the Policy committee (originally, the QA Coordinator filled this role, but the position was vacant at the time of the compliance visit); the Committee consists of the SAC, Facility	Noncompliance

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		Director, Assistant Director for Programs, Assistant Director for Administration, Medical Director, CNE, Habilitation Therapy Director, Chief Psychologist, Maintenance Director, CTD Director, and Director of Community Relations. The Committee assigns someone to prepare a draft; this might be the person who recommended the policy. Copies of drafts are sent in advance of the Committee meeting for review. The Policy Committee discusses the policy and approves or identifies needed changes. The SAC reported that each new or revised policy includes a statement of the training to be provided. Emails are sent to administrative staff who have access to the email system when a new policy is sent out. These staff are then responsible to provide this information as needed to people within their chain of supervision. All newly developed or revised policies, including the draft Dental Policy approved by the Committee (but awaiting additional revisions) included a statement of training needed. Class rosters (sign-in sheets) documenting training on several policies were provided; however, these did not include the topics or dates of training. On the other hand, the Nursing Department provided samples of an exemplary process that involved knowledge tests on department policies along with a database that identified what tests had been passed by each nurse. The Psychology Department provided minutes of department meetings and sign-in sheets that documented training was provided. Extensive retraining was done on the revised Protection From Harm policy, resulting in generally accurate knowledge of the requirements. A practice that may ensure knowledge of specific policies is the competency check process carried out by program auditors. For example, BSSLC'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. This policy is further supported by the ongoing training provided to all staff and competency checks conducted by program auditors in the Quality Assurance (QA) Department. The Nursing Department had a tracking system listing all nursing staff and who had passed or needed to pass each test. There was evidence that all core State and Facility nursing policies, procedures, and processes had been finalized. The Facility had trained 100% of the nursing staff on all policies, procedure, and processes; and they had all been implemented. Training by the Nursing Department included tests for department policies and procedures. Other departments developed local policies and procedures to clarify and formalize their processes. In addition to the state policy, BSSLC developed a localized PNMT policy that defined the roles and responsibilities of the PNMT and the collaboration that was	

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		intended to occur with the Personal Support Team (PST). There was a defined criterion that stated what incidents must be referred to the PNMT and what may be referred to the PNMT. Nevertheless, there were still procedures that needed to be formalized into policy. For example, Pharmacy should develop comprehensive policy and/or procedures for each Settlement Agreement issue that clearly and comprehensively outlines their processes and will ensure that processes will continue long-term, despite staff turnover.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	The Facility had one audit process for review of five records per month and a second review process for additional records. The two Unified Records Coordinators (URCs) conducted the audit of ten records per month. Typically, one URC reviewed the Program records and the other reviewed the Medical records. Records for two individuals from each unit were selected from among records that had not yet been audited. The selection of records was not random. The URCs attempted to complete audits by the 22nd of each month. The Monitoring Team used the same Settlement Agreement Cross Reference with ICF/MR Standard form to audit two individuals' records that had been audited during July, 2011 by the URCs. Although some corrections might have been made prior to review by the Monitoring Team, there was not likely to have been significant change in the records in the interim. Findings showed the possibility of acceptable level of interobserver agreement, which is usually accepted at 80% agreement. • For Individual #5, the Monitoring Team and URCs agreed on 15 of 20 items (75%). However, the URCs marked "N" for items stating there was no evidence of falsification and no evidence of inaccurate recordkeeping practices but did not provide any comments describing those (and the Monitoring Team found no evidence in the record of either). • For Individual #437, the Monitoring Team and URCs agreed on 16 of 20 items checked by the Monitoring Team (80%); each noted two items incorrect, but they were different items. • One issue of concern in both records is that the URCs marked both as "complete" but the Monitoring Team found some missing documents. The URCs develop a monthly report of the items needing correction for each record. This report is presented to the QA/QI committee and sent to the QMRP and nurse case manager for the individual and administrative assistant at the unit; these individuals are expected to meet with the PST members who need to make the corrections. Corrections were due within seven days following the report. To confirm completion of the	Noncompliance

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		corrections, the QMRP, nurse case manager, and administrative assistant send an email to the URCs. Once the emails identifying completed corrections have been received, the URCs select 10% of the records to check whether corrections had actually been made. They select from the records requiring the most corrective actions. They reported they have found a few reported corrections that had not been completed. There was not yet a process to track and trend the types of errors nor the number or type of errors at specific units. For a quality assurance process to be effective at reducing errors in the future and improving procedures for record keeping, it must include a way to identify and track useful data over time. Establishment of such a process, along with randomly selection of sampled records, will be required for compliance. The second review process was carried out by program auditors. These staff had a number of program review responsibilities, including monitoring active treatment, doing mealtime observations, and competency checks on a rotating schedule of topics. Each of four program auditors is assigned three Active Record audits per month, one selected from each QMRP. The Chart Audit Tool used by the program auditors differed from the one used by the URCs; it covered many of the items on the form used by the URCs as well as additional items related to the appropriateness of content (such as whether the action plans reflect residents' priorities and whether Monthly Reviews address all Action Steps) but did not address other issues from Appendix D including legibility and complete signatures. Findings from these audits are sent to the Residential, Assistant Residential Director, and Lead QMRP for the unit, the QMRP for the individual, the Human Rights Officer, and the ADOP. There was not yet a process for integration of the two sets of reviews. These two processes would seem to offer an opportunity to determine interobserver agreement on record reviews, and the additional data could provide more information for implementation of quality improvement efforts. The Monitoring Team reviewed whether assessments were posted to the share drive 10 days prior to the annual PSP meeting. The QMRP is to audit for the presence of the required assessments; the Notification Calendar can be used as well as the actual assessments found in the folder. QMRPs reported that PST members do not always update the calendar when they post reports, and there is no automatic process for that to occur, so they must check each of the reports. Comparison of assessments actually found on the Share Drive against the Notification Calendars for two individuals verified that calendars did not list all the assessments that had been posted. For Individual #56, the Notification Calendar did not document five posted assessments of 10 assessments	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>posted (50%); for Individual #390, four of eight completed assessments (50%) were not documented on the calendar. For the calendar to be useful to the QMRPs, a process should be developed to increase accuracy.

Furthermore, the audit process did not ensure that assessments were available by the time of the PSP annual planning meeting. These meetings were held for both these individuals during the week of the compliance visit prior to the review of the Share drive. Many assessments had not yet been posted. For the following table, the completion date listed on the assessment was considered the date posted.

<table>
<tr><th>Individual #</th><th>Number of required assessments/not in timely</th><th># of required assessments/ not posted prior to PSP meeting</th></tr>
<tr><td>#56</td><td>15/9(60%)</td><td>15/5(33%)</td></tr>
<tr><td>#390</td><td>14/4(29%)</td><td>14/1 (7%)</td></tr>
</table>

The Facility is approaching compliance with this provision. To comply, the Facility needs a process to track, trend, and develop systemic improvement actions based on audit data so as to minimize recurrence of similar errors.</td><td></td></tr>
<tr><td>V4</td><td>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.</td><td>The Facility had implemented a process to monitor how staff use the records. The URCs selected one individual per month. For that individual, they asked staff from the individual's PST a set of questions on the Settlement Agreement Provision V.4—Interview Tool for use of the Record. The questions ask for an example of how the PST member used information from the record in making a decision about the individual and an example of how a report from another discipline helped the PST member plan a treatment or intervention, how the record is used in meetings, whether documents can be found, and how the PST member ensures staff in his/her department or discipline use information from the record in making decisions. For each PST member, the interviewer rates whether the answers do or do not indicate the record is used in making decisions. This information is provided to the ADOP; the Monitoring Team did not determine who else receives it. There was no process in place to assess interobserver agreement on the ratings or to track and trend any of this information. Nevertheless, this is a promising approach that could be extremely useful if the information is provided and acted on by department heads, unit coordinators, and others who could use it to coach staff.</td><td>Noncompliance</td></tr>
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		The Facility provided completed interview forms for one PST member each for seven individuals. All were rated as showing that the record was used in making decisions. Each included an example in which the record was used, although none specified how the information led to a specific decision. It was unclear in all but one interview whether the response about information used from another discipline referred specifically to information about the specific individual or was more general; one clinician specifically reported having no need to plan an intervention on the individual (and did not indicate any other need for information as part of serving on the PST). Therefore, it was unclear to the Monitoring Team that this interview approach, although it has a great deal of potential, was yet being used to affect use of the record rather than being simply another tool to be completed. The Facility should review carefully how this tool can be made effective. Nevertheless, all seven interviewees reported they either could find or for the most part could find documents; one stated that some documents may not be up to date and the presence of past history that should have been thinned made it more difficult to find information. The Monitoring Team also did a number of interviews asking the same questions. However, these interviews asked the questions in general rather than specific to an individual, and some interviews were in groups. The Monitoring Team will consider using the individual-specific approach for future visits. Recognizing that some Monitoring Team interviews included information from up to three individuals, the following was reported: • Five interviews reported documents can be found, one reported that there are occasional missing documents but the new system makes finding documents easier, and one said documents cannot be found, another reported documents were missing, and another pointed out the need for a system to ensure more timely posting of labs. • Regarding using information to make decisions about individuals, staff who serve on PSTs reported that they looked at histories and checked notes to confirm reports and impressions. They also reviewed results of labs, consults, and follow ups after falls. One reported using information from the records to prepare for risk assessment meetings. They reported that much of this information comes from other disciplines. During both risk meetings observed, the Monitoring Team noted the records were available and were used to confirm information. Observations at planning meetings confirmed use of records to confirm or find information about individuals. For example, at both risk assessment meetings observed	

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		by the Monitoring Team, the PSP looked in the active record to find health information. As noted in Provision V1, there were examples in which data were not available over an extended time. For one SSO, the QMRP Quarterly Reviews noted this, but no action had occurred. It was good that the QMRP noted this but just a report of this is inadequate; the Facility needs to ensure that data needed for decision-making are present. The Medical Record, Nursing Section, was better tabbed which made it easier to locate the various nursing related documents contained in this section. Occasionally a missed filed document was found and a wrong individual's record was filed in individual's the records. The primary problem expressed repeatedly by the QA Nurses, Infection Control Nurses, Nurse Managers, and RN Case Manager was the delay in filing clinical reports such as, consults, laboratory and diagnostic test results, and information from emergency room and hospital visits, which made timely decision-making based on this information more difficult. The Individual Notebooks provided information that could assist staff at the residences and activity sites to implement correct treatment procedures. The PNMP was located in the Individual Notebook or was otherwise readily available nearby. In most cases, pictures were available with the PNMPs related to wheelchair and bed positioning, and the use of orthotics or braces. The pictures provided were large and clear enough to show detail for staff reference. These instructional plans also usually had written cues and instructions, in addition to the photographs. Unfortunately, although this information was readily available, it was not always used for decision-making. Staff did not consistently implement interventions and recommendations outlined in the PNMP. The Facility had made progress both in making the records more useable, in actual use of the records, and in developing a process to evaluate and monitor whether records are being used. Further progress will be needed to reach compliance, specifically in ensuring the data from the monitoring are reliable and meaningful, and in training and coaching staff in use of information in records as part of an interdisciplinary process.	

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

1. Formalize processes to ensure and document relevant staff are trained to competent understanding as designated in the Staff Training sections of policies.
2. Consider implementing a process to integrate information from the record audits conducted by the URCs and program auditors. (Provision V3)
3. Develop a process to track and trend information from records audits in order to minimize recurrence of similar errors.

(Provision V3)

4. Develop a process to establish random selection of at least five records to be audited monthly.

List of Acronyms

Acronym	Meaning
AAC	Alternative and Augmentative Communication
ABA	Applied Behavior Analysis
ABC	Antecedent-Behavior-Consequence
ACP	Acute Care Plan
ADOP	Assistant Director of Programs
ACP	Acute Care Plan
ADL	Activity of Daily Living
ADR	Adverse Drug Reaction
AED	Anti-Epileptic Drug/Automated External Defibrillator
AFO	Ankle Foot Orthotic
AIMS	Abnormal Involuntary Movement Scale
ANA	American Nurses Association
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APC	Admissions/Placement Coordinator
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
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	Developmental Disabilities
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DMID	Diagnostic Manual-Intellectual Disability
DNR	Do Not Resuscitate
DOJ	U.S. Department of Justice
DRO	Differential Reinforcement of Other Behavior
DRR	Drug Regiment Review
DSHS	Department of State Health Services
DSM/DSM IV TR	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FFAD	Face-to-Face Assessment/Debriefing
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/HOBE	Head of Bed/Head of Bed Elevation
HRC	Human rights committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBW	Ideal Body Weight
IC	Infection Control
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICF/DD	Intermediate Care Facility for Persons with Developmental Disabilities
ID/DD	Intellectual Disability/Developmental Disability

IDT	Interdisciplinary Team
IED	Intermittent Explosive Disorder
IMC	Incident Management Committee
IMRT	Incident Management Review Team
IPN	Integrated Progress Note
ISP	Individual Support Plan
i.v./IV	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
MR	Mental Retardation
MRA	Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRP	Medication Response Profile
MRSA	Methicillin-resistant Staphyloccocus Aureus
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
NOS	Not Otherwise Specified
NP	Nurse Practitioner
O2	Oxygen
O2Sat	Oxygen saturation
OCD	Obsessive Compulsive Disorder
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OT/OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
PAO	Physical Aggression toward Others
P&P	Policies and Procedures
P&TC	Pharmacy and Therapeutics Committee
PBSC	Positive Behavior Support Committee
PBSP	Positive Behavior Support Plan
PBST	Personal Behavior Support Team
PCD	Planned Completion Date
PCP	Primary Care Physician

PDB	Physically Disruptive Behavior
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/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata/per necessary (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy/Physical Therapist
PTP	Psychiatric Treatment Plan
PTR	Psychiatric Treatment Review
QA	Quality Assurance
QDRR	Quarterly Drug Regimen Review
QE	Quality Enhancement
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
RRC	Risk Reduction Committee
ROM	Range of Motion
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SFBA	Structural and Functional Behavior Assessment
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SO	State Office
SOAP	Subjective, Objective, Assessment/Analysis, and Plan charting method
SSLC	State Supported Living Center

SPCI	Safety Plan Crisis Intervention
SPO	Specific Program Objective
SQRA	Standard of Quality for Risk Assessment
SSLC	State Supported Living Center
SSO	Staff Service Objective/Specific Service Objective
STAT	Immediate
STD	Sexually Transmitted Disease
TB	Tuberculosis
TD	Tardive Dyskinesia
TIVA	Total Intravenous Anesthesia
UA	Urinalysis
UIR	Unusual Incident Review or Unusual Incident Report
UTI	Urinary Tract Infection
VCF	Virtual Client Folder
VDB	Verbally Disruptive Behavior
VNS	Vagal Nerve Stimulator
VRE	Vancomycin-resistant enterococcus
x/o	Rule out